Ontario Association of Children's Aid Societies

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INSIDE

EARLY HELP, KINSHIP CARE, YOUTH ENGAGEMENT AND MORE

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

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JOURNAL

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MESSAGE FROM THE EXECUTIVE DIRECTOR

This past spring, the Ontario Association of Children's Aid Societies (OACAS) hosted a symposium for Ontario's child welfare professionals entitled *Early Help: The Right Services at the Right Time*. An evolving concept, Early Help is premised on the belief that protecting children involves providing support to families early on to prevent harm, with families identifying their own needs and services being delivered in partnership with the community.

Child welfare researchers and practitioners guided symposium attendees on the possibilities of Early Help, through topics that included integrated services (community development and child protection), mitigating adversity and building engaged worker-client relationships.

Symposium presenter, Kimberly Brisebois, has contributed an insightful piece to this issue of the OACAS Journal based on her work with our most vulnerable population: High risk infants. We've also included a practice note from the OACAS Education Services department on the importance of positive infant mental health for both short and long term health outcomes, translated into French.

Authors Rachel Birnbaum, Michael Saini, Lynn McCleary and Howard Hurwitz have contributed a piece on addressing the needs of high-conflict separated families that speaks to the inherent strength of community partnerships in the delivery of social services. Authors Marlyn Bennett and Yvonne Gomez reiterate this strength in their evaluation of a partnership undertaken by First Nations, Inuit and Métis service providers and the Children's Aid Society of Ottawa.

Also in this issue, the dynamics of kinship care in the Waterloo region are explored by Gretchen Perry and Martin Daly, while Ashley Quinn and Michael Saini speak to engagement in their review of what is known and not known regarding youth engagement in social work services. Finally, authors Laura Walker, Karen Bridgman-Acker, James Edwards, Joyce Bernstein and Bert Lauwers emphasize the importance of prevention in their analysis of risk factors associated with paediatric accidental deaths in children ages 11 to 15 in Ontario.

The message is clear: Supports provided early on in the interest of preventing maltreatment and mobilizing resiliency can ensure positive outcomes and bright futures for Ontario's children, youth and families.

Enjoy this issue of the Journal. As always we welcome your feedback at journal@oacas.org.

Mary Ballantyne
Executive Director

Ontario Association of Children's Aid Societies
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WHO PROVIDES KINSHIP CARE IN WATERLOO REGION, AND WHAT CHALLENGES DO THEY FACE?

By Gretchen Perry and Martin Daly

INTRODUCTION

In many jurisdictions, it is now preferred practice to place children who cannot remain in the parental home with "kin" rather than with unrelated foster parents (reviewed by Daly & Perry, 2011). According to Ehrle & Geen (2002), the main justifications for this preference are (1) that moving into the home of familiar, trusted, extended family tends to be a less traumatic transition than moving to a foster home, and (2) that kinship caretakers are relatively apt to feel a strong personal affection and commitment toward the children.

In Ontario, legislative changes in 2006 prioritized kin placements, which have subsequently increased in prevalence. Some are "kin care" placements, in which the child has been placed in the legal care of the child protection agency, and the agency then places the child in the particular kin home after the caregivers are approved as kin foster parents. These caregivers are then entitled to the same supports from the child protection system as traditional foster families. The other form of kinship care is "kin service" placements, in which the agency is not the legal guardian. These caregivers have fewer entitlements. We use the term "kinship caregiving" to encompass both kin care and kin service. Here, we use data from Family & Child Services of Waterloo (FACS Waterloo) to address two main questions: which categories of kin are children primarily being placed with, and what challenges do these caregivers face?

Dictionary definitions of "kin" limit the term to relatives by genealogical descent, marriage, or adoption, but in keeping with legislative guidelines, a "kin caregiver" in Ontario can also be a "neighbour or other member of the child's community" (Ontario Child Welfare Secretariat, 2006). We will refer to persons related to the child by genealogy, marriage or adoption as "related kin" and to others as "nominal kin". Perry et al (2012) found that FACS Waterloo placements with related kin were significantly more stable (longer-lasting) than placements with either unrelated foster parents or nominal kin; similar contrasts have been found in a Swedish study (Sallnäs et al, 2004) and an American study (Testa et al, 2010). Clearly, potential kinship caregivers are a heterogeneous group.

Also of interest is the relative incidence of maternal and paternal kin caregivers. One reason for examining this contrast is that the question of whether paternal kin are under-utilized as potential caregivers cannot begin to be addressed without actual incidence data. Readers will anticipate, correctly, that maternal kin predominate, if for no other reason than that many children who are taken into care had been residing with their mothers while the fathers were uninvolved and perhaps even unidentified. However, there may be some further reasons for differential participation, with subtler consequences. Many studies of kin as parental helpers, rather than primary caregivers, have reported differences between maternal and paternal relatives, especially grandparents, with respect to both their participation in child care and their impacts on child well-being (reviews by Coall & Hertwig, 2010; Sear & Mace, 2008; Flinn & Leone, 2006). Might such differences be manifested in differential willingness to provide kinship care, with the result that maternal kin caregivers not only predominate, but do so to an increasing degree as their circumstances become more challenging?

Although the benefits of kinship care noted by Ehrle & Geen (2002) are almost certainly real, they may nevertheless be counteracted, to some degree, by other disadvantages of kin placements. In both the USA and the UK, kin caregivers have lower incomes, less education, poorer housing, more children to care for, and more physical and mental health problems, on average, than unrelated foster parents, and are also much more likely to be parenting alone without the support of a partner (Barth et al., 2008; Cuddeback, 2004; Dubowitz et al, 1993; Ehrle & Geen, 2002; Farmer & Moyers, 2008; Geen, 2003; Gleeson et al., 1997; Grant, 2000; Winokur et al., 2008; Zinn, 2010). These contrasts are especially troubling when kin caregivers receive fewer institutional supports than foster parents, as is often the case (e.g. Dubowitz et al, 1993; Farmer & Moyers, 2008; Geen, 2003). Do kinship caregivers face similar challenges in Ontario?

THE CURRENT STUDY

The data considered here represent all children who came into care at FACS Waterloo (not necessarily for the first time) between January 1, 2008 and December 31, 2010, and who had one or more kin care or kin

service primary placements (i.e. not including respite placements) initiated in that 3-year period. We treat the individual placement as the unit of analysis.

The data set consists of 77 kin care and 312 kin service placements. Because some children had multiple placements and some caregivers took in multiple children, these 389 placements represent 352 individual children and 277 different caregiver homes. Eleven cases were administratively switched from kin service to kin care and one from kin care to kin service; since the children in these cases did not move, we treated any such case as one placement within the initial category.

We collected the following information from agency files: the child's age and sex; the primary kin caregiver's age, sex, and specific relationship to the child; whether there was a secondary caregiver and if so, the same demographic data as for the primary caregiver; and any available information on the caregivers' highest educational attainment, income, employment status, physical health status, mental health status, and criminal records.

RESULTS

Which "kin" are providing care?

Sixty-five of the 389 "kin" placements (16.7 %) were with "nominal kin", who were primarily either friends of the child's parents or unrelated members of the child's ethnic community. The remaining 324 placements (83.3 %) were with "related kin", of whom 214 (66% of related kin placements and 55% of all kin placements) were grandparents, and an additional 64 (19.7% of related kin placements and 16.5% of all kin placements) were aunts or uncles. Older siblings, cousins, great-grandparents, and other more distant relatives constituted the remaining 46 related kinship caregivers. These placements are broken out into kin care versus kin service placements in Table 1.

Table 1. Tally of Kin Service and Kin Care caregivers according to their relatedness to the child

	Kin Service	Kin Care	Total (n)
Nominal kin	43 (66.2%)	22 (33.8%)	65
Related kin	269 (83.0%)	55 (17.0%)	324
Grandparents	189 (88.3%)	25 (11.7%)	214
Aunts & uncles	48 (75.0%)	16 (25%)	64
Other relatives	32 (69.6%)	14 (30.4%)	46
Total	80.5% (312)	19.5% (77)	389

A significantly higher proportion of nominal kin placements were in kin care arrangements (33.8 %) than was the case for related kin (17.0 %; Chi-square, 1 df = 8.67, p =.003). This may be partly due to foster-to-adopt placements, but these are too infrequent to be the whole story. Since kin care provides more financial and other resources than kin service, this finding may indicate that the threshold for nominal kin to come forward is higher than for related kin. Alternatively, the difference might mean that during the placement decision process, the additional oversight that is available in kin care was more often deemed desirable in the nominal kin placements than in related kin placements.

Twelve related kin placements could not be coded as maternal or paternal, seven because the information was unavailable through our data retrieval process and five because the caregiver was the child's full sibling and therefore related through both parents. Of the remaining 312 related kin placements, those with maternal kin (N = 208) were exactly twice as numerous as those with paternal kin (N = 104). Table 2 breaks these numbers out in greater detail. It is noteworthy that although maternal kin substantially and significantly outnumber paternal kin among grandparents and "other relatives", this is not the case with aunts and uncles. In fact, uncles actually exhibit the reverse pattern, with paternal uncles significantly more numerous than maternal uncles.

Table 2. Numbers of related kinship caregivers, according to the specific relationship to the child and whether the relationship is through the mother or father.

	Maternal	Paternal	Total	% maternal	p (2-tailed sign test)
Grandparents	150	64	214	70.1	< .0001
Aunts	27	20	47	57.4	n.s.
Uncles	3	13	16	18.8	.021
Other relatives	28	7	35	20.0	.0005
Total	208	104	312	66.7	<.0001

The degree to which maternal grandparents outnumber paternal is not uniform across circumstances. Maternal kin comprise 57% of the 86 cases in which a pair of grandparents provided care to a child, 67% of the 55 cases in which caregivers were a grandparent and step-grandparent (i.e. a partner unrelated to the child), and 88% of the 73 cases where a grandparent with no partner was the primary caregiver (Table 3). This difference is highly significant (Chi-square, 2 df = 18.0, p = .0001). One possible explanation is that maternal and paternal grandparents may differ relatively little in their willingness to care for a grandchild under relatively favorable conditions, but differential willingness increases under more challenging circumstances.

Table 3. Tally of grandparents providing kinship care, according to the grandparent's own partnership status and whether the relationship is through the mother or father.

	Maternal	Paternal	Total	% maternal
Grandmother & grandfather	49	37	86	57.0
Grandmother & stepgrandfather	32	17	49	65.3
Grandfather & stepgrandmother	5	1	6	83.3
Grandmother, no partner	57	9	66	86.4
Grandfather, no partner	7	0	7	100.0
Total	150	64	214	70.1

Income, employment, and education

Kinship caretaker family income was recorded in some files as a specific monetary value. Others, however, indicated only whether families presented as poor, middle class, or wealthy, and many others had still vaguer information. We therefore used broad categories, and we grant that even so, their validity can be questioned. The categories were: (1) "poor": families with income less than $40,000 per annum, including both working poor and those subsisting on government subsidies (Ontario Works or ODSP); (2) "middle class" ($40,000 to $100,000); and (3) "wealthy" (over $100,000). Even with this crude 3-point scale, only 286 of the 389 kin placements could be coded, and percentages on the next page are based on those 286. As expected, a high proportion of kinship care families at FACS Waterloo face major economic challenges: 45.1% were coded as "poor". As shown in table 4, a significantly higher percentage of kin service families were poor than of kin care families; nominal kin were significantly less likely to be poor than were related kin; and maternal kin were slightly more likely to be poor than paternal kin.

Employment status was coded as (1) employed (if either the primary or secondary caregiver was employed); (2) unemployed (all caregivers unemployed and/or on a government subsidy); or (3) retired (including persons receiving CPP and Old Age Security). Of the 389 placement families, 274 could be coded; 115 lacked sufficient information. Caregivers were retired in only 7 homes, all grandparents; these are excluded from the percentages reported below. Perhaps few caregiving grandparents had attained retirement age, but we do not have the data on kin caregivers' ages; alternatively, such families may have limited retirement savings and need to work to supplement their government pensions. As shown in Table 4, contrasts in employment status between placement categories parallel those seen with respect to income: kin service caregivers were slightly, but not significantly, more likely to be unemployed than those in kin care; nominal kin were significantly less likely to be unemployed than were related kin; and maternal kin were significantly more often unemployed than paternal kin.

Information about the education level of primary caregivers was available through our data collection process for only 142 of the 389 placement families, and levels of schooling below high school completion were not consistently detailed. We therefore report only the proportionate incidence of having some post-secondary education, which in all but two cases meant completion of a college diploma or university degree. The specific percentages should be taken with a grain of salt: if, as we suspect, the highly educated are more likely than others to have their level of education recorded in agency files, then the percentages in Table 4 will exaggerate the prevalence of post-secondary education. That said, contrasts between kinship caregiver types are still likely to be meaningful. As shown in Table 4, kin care and kin service families again do not differ significantly, and although nominal kin are slightly advantaged over related kin, this difference does not approach significance either. The maternal-paternal contrast, however, is large and statistically significant.

Table 4. Percentages poor, unemployed and with post secondary education across placement types. *

Placement Type	Income: % Poor	Employment: % Unemployed	Education: % more than high school
Kin Service	50%	17%	35%
Kin Care	23%	12%	31%
Significance	P < .001	P=.38	P=.68
Nominal Kin	31%	5%	38%
Related Kin	48%	19%	30%
Significance	P = .04	P=.02	P=.39
Maternal Kin	50%	23%	24%
Paternal Kin	39%	10%	50%
Significance	P=.16	P=.02	P=.008

* Not all households could be coded on all these variables. See Text.

In sum, although missing information is a concern and not all contrasts are significant, these three measures tell a consistent story: nominal kin caregivers seem to be better positioned economically and educationally than related kin caregivers, and paternal kin are better off than maternal kin. The maternal-paternal contrasts reinforce the tentative interpretation that we offered for the partnership data in Table 3: if paternal and maternal kin differ relatively little in their willingness to provide care under favorable conditions, but maternal kin are more willing to come forward under adverse conditions, this would account for the observed differences.

Health challenges

The physical health of kinship caregivers was coded into five categories: (1) no physical health concerns; (2) minor concerns; (3) health issues that impacted daily functioning, but not caregiving of the focal child; (4) health issues likely to impair caregiving ability; and (5) unknown. There were 19 cases in which the most serious code (# 4) was recorded, all of which involved related (as opposed to nominal) kin, and all of which were in kin service (as opposed to kin care). Thirteen were maternal kin, 5 paternal, and one unknown. Examples of the conditions given code # 4 were late stage kidney disease awaiting organ transplantation; being in recovery from recent open heart surgery; severe arthritis that affected mobility; terminal cancer; and Alzheimer's disease.

Clearly, some related kin are willing to take on the care of children even when their physical health is an impediment. Many of the children placed in these homes had complex needs that would make them challenging for any caregiver. Additional supports to ensure the health and safety of both child and caregiver would obviously be desirable in such cases, and it is therefore especially troubling that all 19 such cases were in kin service, where financial and resource supports are relatively limited. Moreover, in 9 of these 19 cases, the physically compromised primary caregiver had no secondary caregiver in the home.

Caregiver mental health was coded on a scale similar to that for physical health, and as with physical health, we will discuss here only the most severe code: (4) mental health issues likely to impair caregiving of the focal child. Examples of conditions given this rating were poorly managed bi-polar disorder; current depression that made it difficult to get up in the morning; and hospitalization within the past 6 months because of suicidal inclinations. We were able to code only 291 of the 389 placement families on mental health, and the numbers to follow are based on those 291. As with physical health, only related kin, not nominal kin, presented with the most severe mental health issues, but unlike the situation with physical health challenges, severe mental health challenges were present in both kin care and kin service cases. Primary caretakers were coded as having severe mental health challenges in 13 related kin placements (4.5% of codable cases). In most of these families, a secondary caregiver without severe problems was available to help, but four primary caregivers with this rating had no secondary caregiver to call on, and in two cases, both the primary and the secondary caregiver had mental health issues warranting a code # 4 rating. It should be noted that these statistics are mute about other mitigating factors that may have been present in these situations, nor can we say how many of these placements were made on the basis of a court order or in a crisis situation prior to the completion of a homestudy.

Criminal records

Information on the criminal records of kinship caregivers was coded into four categories: (1) no criminal record; (2) minor offenses (e.g. shop-lifting as a teen); (3) more serious criminal involvement (e.g. history of driving while impaired convictions); and (4) recent serious offending (e.g. assault causing bodily harm; drug trafficking). We coded 265 of the 389 placements in this way; information was unavailable for the other 124. We consider code # 4 to reflect issues most likely to adversely affect the child, and confine the discussion below to the prevalence of this code.

There were 37 placements in which the primary or secondary caregiver had a code # 4 for criminal offending. One was a nominal kin placement, and 36 were related kin. In three cases, both the primary and secondary caregiver had the most serious offending code, in 16 only the primary, and in 18 only the secondary. Serious criminal offending ratings were slightly but not significantly more prevalent in kin service placements (14.7% of those that could be coded) than in kin care (10.4%). Under the SAFE homestudy rating process, this degree of criminal involvement should be deemed highly problematic, and would require significant mitigation. It is noteworthy that the higher threshold for approval in kin care did not preclude such placements, but again, we cannot say what mitigating factors may have been in place to offset these concerns. Some placements in kin homes may occur before the results of a requested criminal record check have been received, and such delays may partially explain the high incidence of unknowns. Once a child has been placed, information that might have precluded the placement may not always be deemed sufficient to interrupt it, and of course judges can, and sometimes do, both order placements without this information and disregard it if available.

DISCUSSION

We started this study by asking whether the challenges faced by kinship caregivers that have been noted elsewhere are seen in Waterloo Region too. Research in the U.S.A. and the U.K. that compared kinship caregivers to traditional foster caregivers showed that kin tended to present with higher rates of unemployment, lower income, less education, more physical and mental health diagnoses, and more criminal involvement (Cuddeback, 2004; Farmer &

Moyers, 2008; Geen, 2003). Similar challenges are indeed prevalent among kinship caregivers in Waterloo, and our results indicate that they are more severe among related kin than nominal kin.

Most prior research has treated kinship caregivers as a homogeneous category, but we have drawn distinctions. Relatedness to the child matters. Nominal kin are relatively infrequent caregivers, but they tend to have more resources (income, employment, education) and fewer challenges (physical and mental health challenges, criminal involvement); they are also more likely to be in kin care arrangements, where higher levels of financial and resource supports are available. Some of the contrasts between nominal and related kin may be due to the higher threshold of approval for kin care placements than for kin service, but differences persist when kin service and kin care are considered separately. We think it is noteworthy that even though nominal kin have better resourced homes than related kin, this has not translated into more stable placements (Perry et al, 2012).

Among related kin, maternal relatives provided more placements than paternal, and the latter were better resourced, with the paternal kin advantages in employment and education both being statistically significant. There were no clear differences between the two in health status or criminal involvement, but there was a striking difference in partnership status, especially in the case of grandparents: pairs of maternal grandparents outnumbered their paternal counterparts by only 49 to 37, but among lone grandparents without secondary caregivers, maternal kin outnumbered paternal 64 to 9. Thus, maternal kin seem to be providing care to children in need in the most difficult circumstances, but despite the challenges they face, Perry, Daly & Kotler (2012) found no difference between maternal and paternal kin homes with respect to placement stability, both substantially surpassing nominal kin and non-kin foster placements in this regard.

Are most kinship caregivers related through the child's mother because maternal kin are more motivated, on average, and come forward more? Or does their predominance reflect who agency staff have more access to, and are more likely to approach? There may be some truth to both explanations. Mothers are often the primary parties that the agency works with, making staff more aware of maternal family, and maternal kin may then be familiar with agency staff and the background to the situation, making them both more accessible and more willing to offer placement when a crisis occurs. It is also conceivable that workers are biased in favor of maternal kin, but we have no evidence that would speak to this possibility. We doubt that agency practice is the whole story, because of the ways in which the maternal kin predominance varies in relationship to partnership status and resources. These patterns are more readily interpreted as indicative of differential thresholds for accepting the onerous task of providing child care under difficult circumstances.

Better understanding of how kinship caregivers are obtained and what they require in order to commit to care for a child with complex needs is important for future planning and recruitment. Alternative caregivers are in high demand, and there is strong impetus to locate more kin placements and reduce the use of traditional foster care. Paternal family and nominal kin are sometimes seen as underutilized resources (The North American Council on Adoptable Children, 2005), but if our suggestion of differential willingness is correct, then recruiting paternal (and nominal) kin, and maintaining those placements, may require different supports. We think it possible that paternal and nominal kin may demand more support than maternal kin, which is a concern both because recruiting them may tax limited agency resources and because maternal kin may then face systemic relative disadvantage.

A notable finding in this study is that a minority of kinship caregivers present with extreme challenges. The high ratings for physical and mental health challenges and criminal involvement that we have noted warrant greater context. Families that present with these issues have children placed with them for multiple reasons, including placements made in crises before a homestudy can be completed, long delays in receiving criminal reference checks from the police, and court orders that contradict agency recommendations. Some such placements may be less problematic than they initially sound, because substantial mitigations have been implemented to address the challenges. We did not target these issues for data collection, but we should stress that they are serious. Do these placements sufficiently meet the needs of complex children throughout their development? Are grandparents with some of the health challenges that we have noted able to provide long term care, or were such placements emergency stopgaps, intended to be temporary? Whatever the reasons for these placements, once they occur it is problematic for everyone - particularly the children - to disrupt them. This then puts substantial pressure on the Society and the family to come up with sufficient mitigating supports to manage these challenges.

An issue related to the level of resources available within kin placements is what they provide that other

placements cannot. This study did not address the benefits that may be present in these homes, such as whether children feel more secure about caregiver commitment (Ehrle & Geen, 2002). Whether high-quality familial relationships offset resource limitations we cannot say. There are indications, however, that the increased demands of caring for complex children in resource-poor situations have negative effects on both kin caregivers and the children in their care (Kelley et al, 2011; Thupayagale-Tshweneagae, 2008; Hayslip & Kaminski, 2005). Long term implications and how these impacts may differ between kinship and non-kin foster placements are unknown, and warrant further investigation.

One potential indication of hardship is the high incidence of working grandparents. In only seven of 214 grandparent-headed placements were the caregivers retired. No doubt, many are not yet of retirement age, but one would like to know whether a substantial proportion of caregiving grandparents are postponing retirement in order to be able to support the children in their care financially. Such a circumstance must entail stresses. For this and other reasons, longitudinal studies with more measures, especially child outcome measures, are needed to determine whether children placed in kin homes fare better than in traditional foster placements (Daly & Perry, 2011; Winokur et al, 2009), and what resources are most effective in improving these outcomes. Based on the extraordinary personal and financial costs that kinship caregivers endure, enhanced supports are surely needed.

The use of kinship placements by this agency is an indication of how seriously they have taken kin caregiving and the children they are responsible for. They have clearly made substantial effort and commitment to incorporate the kin philosophy into their service provision. They have utilized families where significant challenges are present, necessitating significant mitigation of these challenges, time-consuming organizational efforts, and financially demanding resource provision. Pressure to provide kin placements for children has aroused greater interest in increasing the participation of paternal family and nominal kin (The North American Council on Adoptable Children, 2005); programs that include Family Finders are indicative of the increasing move toward kin placements within the broad definition of kin. This may be in the best interest of children and their families, but it does present challenges, and more research is badly needed. It has yet to be seen whether agency funding and resources can keep pace with kin caregivers' limited resources and needs for mitigation, and the high needs of the children.

In 2011, FACS Waterloo initiated a Kin Service team. This brought together staff whose jobs were devoted to completing kin service assessments and supporting kin service placements, and constituted a significant structural change from the practices prevailing during the period covered by this study (2008-2010), when assessment and support of kin service placements were largely integrated within the protection staff responsibilities. It is likely that this organizational change has enhanced support of kin service families while also increasing efficiencies, and it would be informative to compare more recent data with those that we report here.

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ABOUT THE AUTHORS

Gretchen Perry completed her Honors B.A. in Psychology at the University of Guelph in 1992 and her M.S.W. through the University of Flinders in 2010. Gretchen worked in child protection in Ontario for 18 years, and developmental services and mental health services for an additional 6 years. She is now working on her Ph.D. in cultural anthropology at the University of Missouri. Her research interests include cross cultural patterns of non-parental care of children (fosterage, adoption, and short term alternative caregiving). Her research has focused on kin placements at Waterloo CAS, a review of kin caregiving in small scale societies, and comparisons of the child care plans and preferences of families in Columbia, Missouri who are locals or immigrants.

Martin Daly (PhD, Toronto, 1971) is Professor Emeritus of Psychology at McMaster University and Research Professor in Anthropology at the University of Missouri. With research interests in both human and non-human behaviour, he has published more than 200 journal articles, book chapters, and reviews, as well as three books co-authored with the late Margo Wilson: Sex, evolution and behavior (1978, 1983); Homicide (1988); and The truth about Cinderella (1998). Daly is a former J.S. Guggenheim Foundation fellow, a past-president of the Human Behavior & Evolution Society, and a Fellow of the Royal Society of Canada. He is currently working on a book about the links between homicide and economic inequality.

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AUTHENTIC YOUTH ENGAGEMENT IN SOCIAL WORK SERVICES

By Ashley Quinn and Michael Saini

INTRODUCTION

In recent years, the concept of youth engagement has emerged as a promising practice approach to meeting the needs of youth. While there remains no clear definition of engagement (Centre of Excellence for Children's Well-Being, 2003, Checkoway & Guiterrez, 2006; Fox, Mediratta, Ruglis, Stoudt, Shah, & Fine, 2010; Mahoney, Schweder, & Stattin, 2002; Nakamura, 2001; Pancer, Rose-Krasnor, & Loiselle, 2002), there is a growing expectation that youth should be active partners in the delivery of social work services they receive and they should be engaged in organizational policy formulation and program development. This brief discussion paper reviews what is and is not known about youth engagement.

WHAT IS YOUTH ENGAGEMENT?

A policy framework is required to provide an overall vision for youth engagement and to guide the articulation of how best to engage youth within policy initiatives and the delivery of services geared for youth.

Ultimately, the goals of all youth engagement programs should be to promote positive youth development to ease transition into adulthood and to afford opportunities to foster active citizenship among youth, thereby encouraging them to become contributing members of the broader society and in their local communities, in particular.

WHAT DO WE KNOW ABOUT YOUTH ENGAGEMENT?

The literature shows that youth engagement increases their connection to school and commitment to other individuals and society as a whole (Eccles & Barber, 1999; Hamilton & Fenzel, 1988; Janosz, LeBlanc, Boulerice, & Tremblay, 1997; Johnson, Beebe, Mortimer, & Snyder, 1998; Jones, & Offord, 1989; Mahoney & Cairns, 1997). However, evidence regarding specific factors that produce encouraging outcomes remains far from well-established. In fact, in some areas (e.g., sport and youth engagement), the findings are far from conclusive (Barber, Eccles, & Stone, 2001; Larson, 1994; McHale, Crouter, & Tucker, 2001; McNeal, 1995). For example, it remains unclear what role gender plays in various types (e.g., academic, musical, athletic) of youth engagement programs.

Methodological challenges make it difficult to establish a cause-and-effect relationship between engagement programs and outcomes (Centre of Excellence for Children's Well-Being, 2003; Checkoway & Gutierrez, 2006). Furthermore, the lack of consensus regarding standard instruments to evaluate outcomes for youth engagement programs is problematic. It is thus understandable that the evaluation of current youth engagement programs has focused largely on quantitative outcomes (the number, frequency, and duration of activities); while the quality of programs, another significant measure of youth engagement, is generally under-researched.

WHAT ARE THE ESSENTIAL CHARACTERISTICS OF YOUTH ENGAGEMENT PROGRAMS?

Youth engagement programs need to find ways to actively involve young people in organizational structures and decisions that have an impact on their lives (see Table 1).

Table 1: Essential characteristics of youth engagement programs

Characteristics of youth engagement	Service delivery issues
a) *Provision of opportunities for skill development and capacity building.*	Youth development programs should seek to develop academic, intellectual, civic, emotional, physical, employment, social and anti-oppressive practices.
b) *Provision of opportunities for leadership.*	Leadership within the context of youth engagement necessitates a genuine transfer of decision-making power from adults to youth.
c) *Encouragement to reflect on issues related to personal identity.*	Opportunities should exist which support the development of a critical and political analysis of personal identity issues.
d) *Development of social awareness.*	As youth gain a greater awareness of their own identities, they are encouraged to develop a consciousness beyond the self.
e) *Provision of opportunities for peer support and networking.*	Opportunities should exist which provide youth with the emotional benefits of sharing with their peers.

WHAT CAN SOCIAL WORKERS DO?

Social workers widely recognize that youth engagement is a vital way of connecting with youth and should be a priority for youth services. There is, nonetheless, no single strategy which characterizes all approaches practised in youth engagement programs. For this reason, social service organizations that provide services to youth are encouraged to re-examine their programs within the context of the current knowledge about youth engagement and identify and address potential barriers to engaging youth, within their organizations.

An open and receptive organizational attitude and culture need to be cultivated in order to meaningfully engage youth. This involves focusing on youth assets as opposed to deficiencies; encouraging and supporting success while permitting failure; knowing when to let go; and, breaking down ageist stereotypes (Centre of Excellence for Children's Well-Being, 2003; Checkoway & Gutierrez, 2006; Fox, Mediratta, Ruglis, Stoudt, Shah, & Fine, 2010; Hart, 1992; Larson, 1994; Pancer, Rose-Krasnor, & Loiselle, 2002; Provincial Advocate for Children and Youth, 2011). Youth engagement also necessitates that genuine transferring to and/or sharing of decision-making power with youth. In youth-led and youth-directed activities, adults are involved in a supportive role and decision-making is shared. Opportunities for peer support and networking allow youth to lead others and explore new ways of advocating for youth (Sullivan, 2011; Shernoff & Vandell, 2008).

The concept of youth engagement needs to be implemented at all levels of service delivery. Social work educators, students and practitioners within the field need to understand the changes associated with this concept, which encompass policy formulation, research, service delivery, and training. Additionally, current knowledge about youth engagement needs to be translated into practice with attention paid to the considerations and cautions involved (see Table 2).

Table 2: Translation of youth engagement knowledge into practice

	Considerations	Cautions
Policy framework	Develop a vision for youth engagement and seek ways to ease the transition of youth into adulthood.	Lack of alignment of youth services in Ontario.
Service delivery	Engage and involve youth in the decision-making process.	Determine the degree of power your organization is prepared to share with youth. Be aware of the lack of appropriate service evaluation tools.
Empirical research	Better understand how youth engagement is linked to positive outcomes.	Lack of common measurement tools; however, be aware that there are a variety of options in understanding youth engagement (i.e., qualitative research).
Social work education	Students need to be equipped with the skills and competencies required to engage youth at the micro, mezzo, and macro levels. Align these with anti-oppressive practices.	Current education focuses are on clinical and individual practices with less emphasis on community development approaches.

NEXT STEPS

The meaningful engagement of youth by social service organizations that provide them with services and the provision of opportunities to participate in decisions that impact on their lives can have positive implications for youth development and the transition into adulthood. Similarly, providing opportunities for youth to connect to issues that are outside of the "self" helps to foster active citizens who contribute to society, in general and to their local communities, in particular. For the most recent discussion on youth engagement, please refer to the Provincial Advocate for Children & Youth Report to the Legislature 2010-2011 that highlights various youth engagement activities from over 500 youth across Ontario during the past year.

For additional resources, including self and organization youth engagement readiness checklists, toolkits and guidebooks, strategies and resources, as well as tips for engaging and involving youth in public processes, please refer to the following links:

- *The Green Street Guide to Authentic Youth Engagement* (2007) can be retrieved at: http://www.green-street.ca/files/GreenStreetYouthEngagementManual.pdf
- *Youth Engagement Toolkit – Working with Middle School Students to Enhance Protective Factors and Resiliency: A Resource for Health Professionals working with Young People (2011)*, Ontario Public Health Association can be retrieved at: http://www.youthengagement.ca/sites/default/files/OPHAYouthEngagementToolkit-April2011.pdf
- *Organizational Assessment Checklist* based on Youth on Board's publication, 14 Points: Successfully Involving Youth in Decision Making can be retrieved at: http://www.nww.org/contentcallsdocs/Org%20Assessment%20Checklist.pdf
- *Say Y.E.S. to Youth: Youth Engagement Strategies (2006*), Pennsylvania State University can be retrieved at: http://www.national4-hheadquarters.gov/comm/PA_yesbookweb.pdf
- *City of Vancouver Involving Youth in Public Processes Training Course* (2006), Vancouver Youth Outreach Team can be retrieved at: http://ftp.vancouver.ca/commsvcs/socialplanning/initiatives/cys/PDF/

YouthHandbook.pdf

- *The Art of Youth Engagement Readiness Checklist*, Ontario Centre of Excellence for Child and Youth Mental Health can be retrieved at: http://www.excellenceforchildandyouth.ca/sites/default/files/ye_readiness_checklist.pdf

- *Self-Evaluation Checklist: Assessing Your Organization's Capacity to Engage Youth*, Laidlaw Foundation can be retrieved at: http://www.laidlawfdn.org/sites/default/files/resources/youth-eval-checklist.pdf

- *Youth Engagement – Next Steps: Youth Friendly Meetings*, Nova Scotia Youth Secretariat can be retrieved at: http://gov.ns.ca/coms/families/youthsecretariat/documents/YouthFriendlyMeetings.pdf

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A COMMUNITY-BASED RESPONSE TO ADDRESS THE NEEDS OF HIGH-CONFLICT SEPARATED FAMILIES

By Rachel Birnbaum, Michael Saini, Lynn McCleary and Howard Hurwitz

Key words: separation and divorce, community collaboration, children and families

INTRODUCTION

The relationship between conflict, domestic violence and negative post separation adjustment for children and families has been well documented within the social science and legal literature. Despite the substantial body of evidence of the negative emotional impact of high levels of parental conflict on children post separation families (Amato & Keith, 1991; Hetherington & Kelly, 2002), there remains no clear or workable definition of "high-conflict" to guide professionals when working with these families after separation and divorce (Birnbaum & Bala, 2010; Birnbaum & Saini, 2007; Saini & Birnbaum, 2007). High-conflict families have been characterized as litigious, exhibiting poor problem-solving skills, and often experience difficulties in reaching parenting arrangements for their children and in some cases by family violence (Johnston, 1994; Kelly, 2003).

High-conflict families use a disproportionate amount of private and public resources compared to low-conflict families, due to their higher rates of litigation and use of multiple services, including child protection services (Birnbaum & Bala, 2010; Birnbaum & Saini, 2007; Saini & Birnbaum, 2007, 2009). High-conflict families are particularly challenging to child protection services, as workers are called to investigate repeated allegations of family violence, child maltreatment, poor parenting and children's exposure to the conflict (Brown, Frederico, Hewitt, & Sheehan, 2001; Jaffe, Johnston, Crooks, & Bala, 2008; Johnston, Lee, Olesen, & Waters, 2005), especially when parents vigorously deflect blame to the other parent (Jaffe, et al., 2008; Johnston, Lee, Olesen, & Walters, 2005).

At present there is little guidance for professionals working with these families. Given that multiple service providers are involved with these families; community-based approaches can enhance the capacity to collectively find ways to address the unique needs of these families. Community-based collaboration provides professionals from across disciplines to share resources and develop integrated responses to help children and families in high-conflict situations. This shift in addressing high-conflict at the community level fits with the recent emphasis on developing integrated collaborative teams to work together for the common goal of finding the most effective and efficient strategies to intervene early and respond proactively while using the best available evidence for service delivery (Saini & Birnbaum, 2007, 2009).

The purpose of this article is to explore the successes and challenges of a community based initiative that brought service providers together from various sectors (e.g., child protection services, police, not-for-profit mental health services, the courts, education, private practitioners, and academics). The goals of the initiative were to promote interdisciplinary collaboration amongst and between professionals, promote better and more effective coordination of services, and increase the knowledge base and skills for professionals working with high-conflict families. Exemplars will be used to highlight some of the challenges and successes (the exemplars are based on a qualitative online survey of the Forum participants. The authors are grateful for their time and thoughtful comments about this unique community initiative). Reflecting on the past ten years of the initiative provides for important lessons on how service-learning and capacity building can enhance community engagement and strengthen partnerships for responding to the needs of children and families in communities (Frazier, Abdul-Adil, Atkins, Gathright, & Jackson, 2007; Walter, 1997).

In the past 20 years, there has been an emerging literature devoted to community partnerships, but very few examples within child protection services (Saini, & Léveillé, 2011) and no known study to consider the challenges and pitfalls of working with high-conflict families after separation and divorce. Collaborative efforts to better respond to these families are especially important to engage with stakeholders and to find creative and meaningful strategies to respond to the complex and multi-dimensional needs of high risk children and families (Nadel, Majewski, & Sullivan-Cosetti, 2007).

THE FORUM

In 2004, a multi-service and community-based organization initiated the creation of the High-Conflict Forum (HCF) to respond to the gaps in service in working with high-conflict separated families in a large

urban city. Although the organization provides various services for children, families and the community (e.g., prevention programs, counselling and interventions for children and parents, educational programs and advocacy services), providing child protection services is a major service offered by the agency. As a multi-service organization, the agency was well positioned to take on the leadership role for the Forum, because of its strong connections in the community and existing networks with various agencies and services in the community. The agency first initiated a focus group in early 2003 with other service providers to discuss the challenges that the agencies were experiencing in working with high-conflict families. During the focus group discussion, the agency was identified as being in the best position (e.g., resources, supports, existing networks, etc.) to move the collaboration forward and to initiate contact with over 30 other organizations, service providers, private practitioners and the legal community in the area.

While discussing the unique needs of children and families, it quickly became apparent that professionals across disciplines were operating within 'silos' without the benefit of sharing knowledge, expertise and resources across community systems. More importantly it soon became evident that all sectors were struggling with providing effective services to this high-risk population.

The Forum provides the opportunity to bring concerned professionals together to: (1) address the unique needs of high-conflict families; (2) identify the challenges and barriers of working with high-conflict families across various sectors; (3) better understand the factors associated with high-conflict disputing families; (4) explore a common language, to identify high-conflict families; (5) develop a knowledge base to provide best practice strategies for working with high-conflict; and, (6) ultimately to provide training and consultation to multidisciplinary professionals who work with families involved with separation and divorce cases in the community. Membership in the Forum includes front line staff, senior managers and administrators, government representatives, academics as well as private practitioners (e.g., lawyers, mental health professionals).

The Forum is a community-based model that emphasizes the importance of networking, coordination, cooperation and collaboration among the diverse community membership (Zimmerman, 1998). The members share a common vision that when agencies and professionals collaborate, children and families benefit because community resources are more effectively deployed according to their unique needs. Working with high-conflict families is both challenging and complex given the emotional and legal implications, so providing support to families across sectors can also strengthen the community response needed to intervene in issues of conflict in separated families.

At the outset of the Forum, goals were identified by the group and it was agreed that a consensus-driven approach would be used for decision-making. Sub-committees were formed (see Appendix that depicts the organizational structure of the Forum). One sub-committee that was created was to examine the various definitions of high-conflict and to assess the community capacity to intervene in high-conflict cases. The sub-committee created a definition of high-conflict families as a point of reference for the larger group. Although the diverse practice wisdom provided the Forum with a unique vantage point to brainstorm on the possible definitions and factors associated with high-conflict, it was decided that an evidence-based review of the factors was necessary to summarize existing definitions of high-conflict in the legal and mental health literature and to begin a process for detecting high-conflict families involved in services. As a result, the Forum adopted the definition of high-conflict by Johnston (1994) that included ongoing or escalating conflict, where there were previous unsuccessful attempts to address the conflict and there was a significant amount of private or public system resources being utilized by the family. A research sub-committee was formed and was successful in obtaining funding to pilot a research instrument that would provide for the differentiation of different levels and types of conflict in post separated families (Birnbaum & Saini, 2007; Saini & Birnbaum, 2007). The success of this pilot research instrument lead to further research funding in collaboration with academics to explore the validity and reliability of the instrument in child welfare agencies, child and mental health agencies as well as in court-based services in two Canadian provinces, and one courthouse in Miami, Florida, USA (Birnbaum & Paulicin, 2009).

The early work of defining and differentiating high-conflict families from other separating families provided the Forum with the foundation to begin sharing the knowledge and expertise with other community services. For example, the Forum published two books, *Best Practice Guide with Families Experiencing High Conflict Separation and Divorce*, a best practices manual for working with high-conflict families (Litvack, 2008), *Best Practice Guide: Emotional Harm and Parent-Child Contact Problems in High Conflict Separation* (Fidler, Bala, & Hurwitz, 2013), and developed a training curriculum

called '*Children Caught in the Crossfire*', a two-day experiential training course designed with and for child welfare workers, mental health practitioners, lawyers, judges and other professionals who work with children and families experiencing the damaging effects of a high-conflict separation or divorce. The success of the two-day training has lead to further training requests, particularly in child welfare agencies across the province who work with servicing this difficult population.

The Forum meets every two months to strategize and to participate in case consultations shared by different members of the group. As a result, child welfare workers, in particular, often present cases to obtain assistance and feedback from the multidisciplinary group. This is an important component as the group provides not just clinical expertise but shares a wealth of diverse perspectives and clinical expertise in separation and divorce. Other exemplars include eight highly successful conferences that were organized and brought different disciplines together on topics of domestic violence, sexual abuse and child alienation (i.e., where a child refuses to visit with one parent or another), and high-conflict separation attracting between 300-500 professionals from all disciplines eager to learn and share with each other. Under the leadership and guidance of a child welfare agency the success of the Forum has since provided opportunities amongst and between the different sectors and disciplines to engage in further collaboration that would not have been imagined before. A secondary benefit that has resulted for the child welfare agency is that they are seen in the legal community as problem-solvers and not just a child protection service. While there have been many successes it was equally important to explore the challenges and learn from them. That is, what facilitators and barriers exist to interdisciplinary collaboration.

EXPLORING ELEMENTS OF SUCCESSFUL COLLABORATION

As previously described, the Forum has contributed to a number of important outputs to inform service providers about working with high-conflict families. Several key elements have been identified that have contributed to the success of the collaboration in meeting the needs of children and families stuck in high-conflict.

Clear expectations of purpose

Clarification of both the purpose of the collaboration and the roles of each member have been found to be important for establishing commitment among the members (Bowens & Martens 2006; MacDonald, Stodel, Casimiro, & Weaver, 2006). The purpose of the Forum included networking opportunities among professionals and an increase of knowledge among participants to further develop services and programs targeted to the needs of high-conflict families. The objective of the Forum has been to discuss issues related to high-conflict families and to provide a forum for various professionals who work in the field to meet and discuss these issues. In addition, the Forum provides professionals with the opportunity to develop and share best practices for working with families where there is high-conflict, to promote collaborative approaches, and to provide training and education and consultation. The focus on knowledge translation and dissemination has been a key element of its success in finding ways to disseminate best practices for working with high-conflict families. By being committed to collaborating among various sectors 10 years later and providing members with additional opportunities for training, education and building community capacity, members have been able to turn to the Forum to aid in community capacity to better respond to the needs of families in conflict. Although the Forum has evolved over the years, its commitment to the initial purposes and goals initially created by the various stakeholders has contributed to clear expectations of the members and has helped the Forum remain an important community initiative in responding to the needs of families in high-conflict. In fact, child welfare agencies across the province have engaged with the Forum to create best practice in working with families and to seek collaboration among the service providers to meet their needs.

Balance between participation and leadership

A key element to the success of the Forum has been its dedication to a partnership structure that supports a non-hierarchical, a flat organization, collegial, and consensus driven, that promotes a collegial atmosphere where everyone is respected and included as much as possible. A focus of the Forum has been to create and maintain an atmosphere that is cooperative and collaborative with frequent feedback to the larger group. Creating a collaborative process so everyone has input is desirable, studies have also shown that strong leadership is needed to guide the process (Borthwick, 1995; Buckenridge et al. 2002; Oakes, Hare, & Sirotnik 1995). But without strong leadership, it is doubtful that so much would have been accomplished. Strong leadership of the Chair was complemented by an active membership and sharing of information across sectors. Strong leadership includes skillful

management of the agenda for the meetings, facilitating discussions and bringing new and innovative topic areas to the discussion to continually engage members. The success of the Forum has been a good balance of leadership and participation of all members. All members continue to support the Chair and seek his guidance when there is an impasse amongst group members.

Balancing flexibility and commitment in membership

Rather than developing a structured membership system, the Forum has been established as a flexible community-based approach where professionals are free to attend meetings at their leisure and as their busy workloads permit. This flexibility means that not every meeting is well attended, but that members seem to enjoy knowing that they have the opportunity to attend a Forum meeting and participate as little or as much as they have time to commit. Members can participate in as many projects as they want and the Forum is open to new ideas. However, the challenge of equal input opportunities is that members are not as engaged as they may otherwise be, particularly when specific tasks are assigned to the group. Many members, for example do not return or attend infrequently at the meetings, suggesting that they may be less engaged to participate, are not clear about their roles within the collaboration, or perhaps are just too busy to find time to attend these meetings. Most studies that have explored partnerships suggest that commitment by all members is a key factor for successful collaboration (Bowen & Martens 2006; Cotter et al. 2003; Lantz et al., 2001; Maciak et al., 1999; Mercer, MacDonald, & Green, 2004). The challenge of the Forum is therefore to balance the flexibility of the group membership while enhancing the commitment of participants to remain interested and supportive of the Forum and to attend meetings to share experiences and provide input on an ongoing basis so that all views are considered within the collaboration. Other studies have suggested that attendance itself may not be a good indicator of commitment (Campbell et al., 1999) as it can also be expressed in terms of financial support, services outside of meetings, and providing additional resources to the team.

SUPPORTING NETWORKING

An important goal of the Forum has been to promote the opportunities for networking among various service providers and to find ways for service providers to work together. Research suggests collaborations have the distinct advantage over working within silos to provide a positive space to build relationships, to maintain contact among its members and to promote the sharing of information (McDonnell & Elmore, 19897 Saini, & Léveillé, 2011). Consistent with these findings, the Forum provides members with the opportunity to network, which is supported by regular meetings, the use of sub-committees, smaller working groups on specific tasks (i.e., research initiatives, conferences) and opportunities for members to meet other people working in the field. Even if members do not routinely engage in the Forum's activities, coming together during the training sessions can contribute positively towards feeling connected to the group as it also provides for community building at more formal and informal levels (Lee & Jackson, 1997).

Facilitators of the collaboration

Although there are various partnership structures (Bailey & Koney, 1997; Frank & Smith, 2000; Landry, Savoie-Zajc & Lauzon, 1996), Courtney, Vanapalli, & Birnbaum (2009) and Saini & Léveillé, (2011) found in their qualitative synthesis of partnerships that important factors for the success of collaborating include: (1) the active involvement of various professionals with diverse expertise and experiences; (2) the perceived shared benefits of group members; (3) the commitment of all members to the shared vision of the collaboration; (4) effective leadership; (5) clear direction and focus for the partnership; (6) special attention to the relationships among members; (7) the ability of the group to effectively address ambiguity and conflicts; (8) the constant contact among members; (9) clear and effective communication; (10) bi-directional respect and trust; and, (11) taking advantage of opportunities to connect and work together , even if unplanned. Gardner (1994) described similar ingredients for building community capacity and maintaining it.

There have been several factors that have contributed to the success of the partnership structure of the Forum, including the strong sense of leadership, common goals of the group, a good organizational structure, the hiring of a part time community development person, the willingness and commitment of the participants to attend, the members' commitment to outreach, the multi-sectoral make-up of the group which brings diverse views to the Forum and enhances learning, open-communication and ideas. The success of the Forum has been a careful balance of not placing more weight on leadership or active participation of all members given that both seem critical for building a solid foundation of community engagement.

BARRIERS/CHALLENGES OF COLLABORATION

Some of the challenges to the partnership included the periodic attendance of participants and not having enough time to meet to fully explore issues and cases presented to the group. The bureaucracy of each host organizations and the restrictions placed on some participants given the limited resource issues in many agencies can further exacerbate the challenges of making time to be actively engaged in the Forum's activities. Another area that has become more challenging as a result of the successes of the Forum has been on governance. As the Forum develops and broadens its activities, a new governance model must be addressed to ensure its sustainability so that it can generate new leadership both at the chair and committee levels.

Although significant strides have been achieved during the past 10 years, there continues to be a need for greater outreach of professionals across sectors and to attract a broader and more diverse group of professionals. Some of these professional groups include the police, teachers, physicians, psychiatrists, family law lawyers, and judges.

The Forum also needs to ensure that there is an active strategy to support professionals involved in the Forum and to find creative ways to consistently engage members involved with the Forum. The barriers for regular attendance by some group members include the loss of revenue for sole practitioners to volunteer their time to the Forum and the difficulties in making the time commitment given the resource needs and demands of busy agencies. Meetings are typically held in the afternoon for approximately three hours and often many members are not able to take time off work during the day. Therefore, it is important to consider alternate times and locations for the meetings, including meetings at noon and in the evenings to allow more participants to attend and web-based meetings so members do not need to leave their places of work, yet still be engaged in the Forum's activities.

LOOKING AHEAD

To build on the Forum's successes, the Forum must continue to respond to the needs of the stakeholders and continue to meet the community need for collaboration and support. These include: (1) enhanced professional development; (2) core staff funding to provide coordination of the Forum; (3) increased publications that showcase the work of the Forum; (4) more attention to the clinical issues of working with high-conflict families; and, (5) greater attention in providing training opportunities and enhancing its consultation functions.

Future research and evaluation of the Forum needs to explore whether and how the Forum has impacted on professionals working with children and families involved in high-conflict separation. Some of the potential impact may include: whether professionals are more knowledgeable in working with this population; whether the Forum has added to the body of knowledge in our understanding and comfort in working with high-conflict families; and, whether there is any spillover effect from the support offered to its members and the best practices being provided to children and families receiving the services.

IMPACT OF THE FORUM ON PROFESSIONALS

Since being a member of The Forum, anecdotal accounts suggest that working with high-conflict families has changed for many of the members, especially in terms of changes in knowledge about high-conflict and their perceptions of working with high-conflict families. Members seem to be more knowledgeable about resources and programs in their areas and how they work to respond to the needs of children and families in high-conflict. Even if members came to the Forum with a generally good understanding of high-conflict, the benefits of remaining with the Forum seemed to be related to the professional and personal connections facilitated by membership to the group. The Forum has seemed to create the needed space for working on best practices for high-conflict families, helping professionals stay current with regard to reading the social science literature in this area and providing the opportunity for professionals to connect with others in the field.

The Forum has seen ongoing collaboration amongst professionals and more co-operative casework and treatment planning on behalf of families involved in separation and divorce. Child welfare is working more closely with its community partners and this can only benefit children and families undergoing the stressful process of separation and divorce. Also, there has been an increase in the knowledge base for professionals around heightening their awareness and understanding of the impact of high-conflict on parents and children. Other secondary benefits have been a greater receptivity on the part of agencies to respond more competently to the service challenges inherent in working with high-conflict families. Historically, some agencies were adverse to working

with these families and denied service claiming that these cases were before the family court so there would be no point for community based agencies to provide service. This has since changed and families can now access services more easily. The Forum has developed a reputation for becoming an important venue for professionals to bring cases as part of a clinical case consultation opportunity. These dialogues have been useful in fostering increased collaboration amongst the professionals that attend. Finally, the membership of the Forum has continued to expand with the hiring of a community development position. The Forum needs to continue their efforts to attract other professional sectors to better represent the multiple service providers involved with high-conflict families, especially the police, teachers, physicians and judges.

The multidisciplinary nature of the Forum has provided a synergy and bonding amongst diverse professionals. Professionals donate their time and continually demonstrate their commitment to improve services for children and families. This is particularly evident with the lawyers, psychologists and social workers in private practice who lose income or billable hours, when participating and donating their time to various committees on behalf of the Forum.

Unintended consequences have occurred when very competent professionals sometimes 'bump heads' and conflict results around particular philosophies of service delivery and ideology. The Chair of the Forum has worked hard to problem-solve various situations where interpersonal difficulties and/or professional ideologies get in the way of doing the work. To date, there has been no situation that has not been able to be resolved. This speaks to the overall commitment of participants to the overall goal of providing better services to children and families in a collaborative, multi-disciplinary way.

From the synergy and collaboration of the partners, the Forum has produced two best practice books (Fidler, Bala, & Hurwitz, 2013; Litvack, 2008). These initiatives served to introduce current research and an orientation to best practice approaches in working with families that has been widely distributed to child protection services, family counseling and children's treatment agencies, lawyers and judges across North America. A curriculum for professionals about high-conflict families was also developed and delivered across different disciplines. Finally, the research instrument, Dimensions of Conflict in Separated Families Scale; DCSFS (Birnbaum, Bala, Jaffe, McCleary, & Cyr, 2009) that was initially developed by members of the Forum has been validated with agencies across Ontario and Quebec to differentiate different types and levels of conflict in separated families with the goal of matching interventions to different types and levels of conflict post separation. The instrument was also used in the family court in Miami, Florida (Birnbaum & Paulicin, 2010).

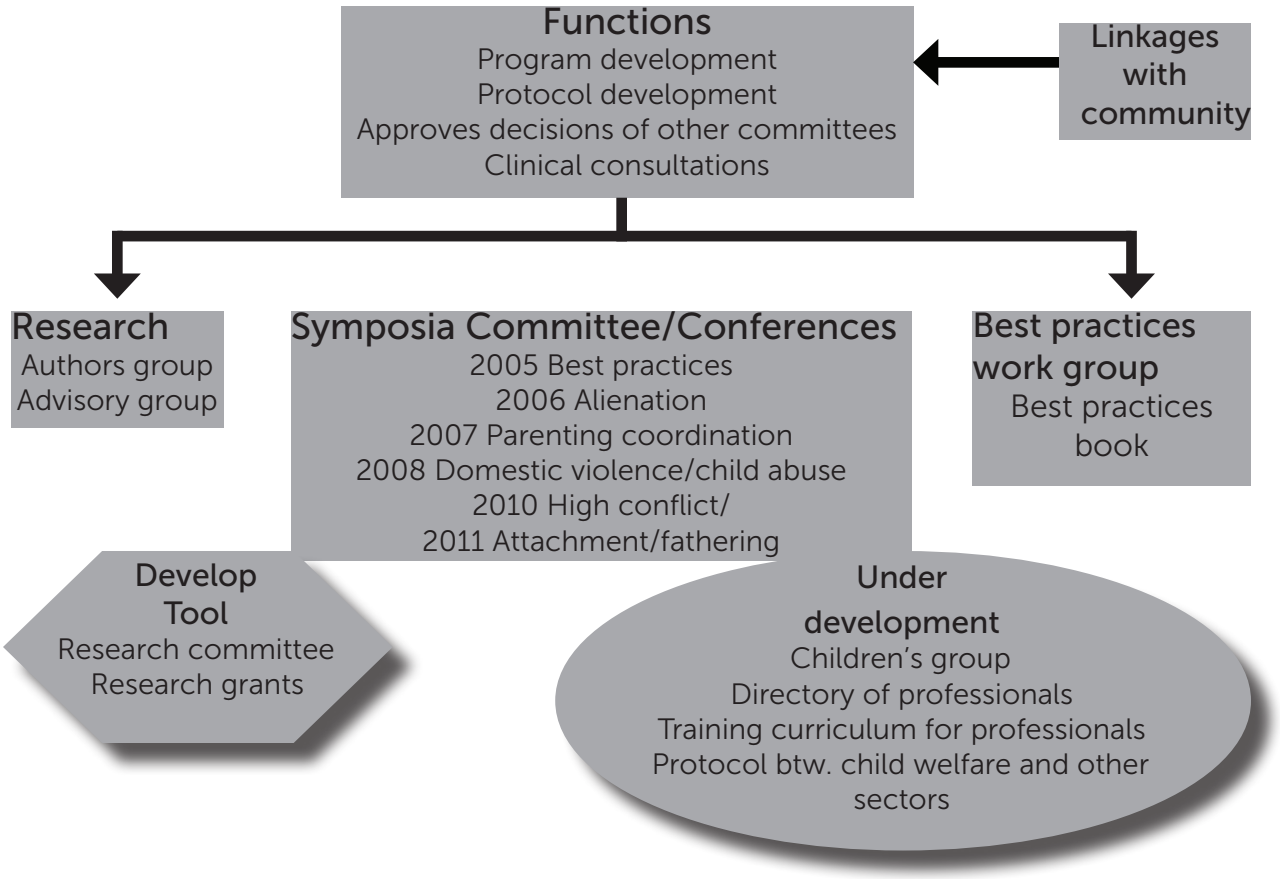
LESSONS LEARNED

Community changes take time. These lessons can be organized into the following headings: (1) membership—who is in and who is left out; (2) good strong leadership is a key; (3) a clear set of objectives and goals that need to be revisited from time to time to make sure that they are being met; (4) there must be agency support at the highest levels to allow for staff participation; and (5) ongoing evaluation and reporting back procedures on how well the collaboration is working or not. The Forum continues and is ever evolving with new initiatives being brought on board as new members join.

The Forum is an important demonstration of how professionals from across disciplines can come together to promote, advocate and develop strategies for working with vulnerable populations—children and families of high-conflict separation and divorce. Due to its commitment of collaboration and non-hierarchical sharing of information and resources, the Forum is well positioned to continue being a leader in this area. Since the inception of the Forum, similar initiatives have been developed in other jurisdictions across Ontario. This speaks not only to the need for similar types of interdisciplinary collaboration by different professionals, but how a grassroots initiative has been able to foster and build community capacity, warts and all.

APPENDIX

STRUCTURE OF THE HIGH CONFLICT FORUM



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Rachel Birnbaum - Associate Professor, Cross-appointed in Childhood & Social Institutions (Interdisciplinary Studies) & Social Work at King's University College at Western University, London, Ontario. Rachel has over 25 years of clinical experience working with separated and divorced families. Rachel has presented and published both nationally and internationally on child custody and access assessments, child legal representation, access to justice, children's participation in family disputes, working with high-conflict families post separation and divorce, and exploring the impact of children with neurodevelopmental disorders (NDD) and parenting post separation. Rachel was the President of the Ontario College of Social Workers and Social Service Workers for 4 years and is now the President of the Canadian Council of Social Work Regulators.

Michael Saini - Associate Professor at the Factor-Inwentash Faculty of Social Work, University of Toronto and the Factor-Inwentash Chair of Law and Social. For the past 14 years, he has been conducting custody evaluations and assisting children's counsel for the Office of the Children's Lawyer, Ministry of the Attorney General in Ontario. He has over 50 publications, including books, book chapters, government reports, systematic reviews and peer-reviewed journal articles. He is an editorial board member for the Family Court Review, the Journal of Child Custody, Research for Social Work Practice and Oxford Bibliographies Online. As well, he is a peer reviewer for 10 peer-reviewed journals and 4 international funding organizations.

Lynn McCleary - Associate Professor in the Department of Nursing, Faculty of Applied Health Sciences at Brock University. Her research interests include family caregiving in mental illness and knowledge translation.

Howard Hurwitz - Howard is a social worker, currently in private practice and specializing in working with families experiencing a separation or divorce. He was the former Director of Programs at Jewish Family and Child Service in Toronto for 16 years. Howard has an MSW and over 34 years experience in various child welfare, children's mental health and family counseling agencies. Howard is the creator and chairperson of the High-Conflict Forum and is frequently called upon to provide consultation to other professionals around working with high-conflict families.

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Ottawa: *October 16;* ***Toronto:*** *October 17;* ***Hamilton:*** *October 23;*
London: *October 24;* ***Thunder Bay:*** *October 31*

Participants of this workshop will explore the natural purpose of anxiety and how it can become 'disordered,' including the link with panic, depression, trauma and other health concerns. The main focus of this training will be to learn practical and accessible strategies to assist both adults and children in reducing anxiety.

DEPRESSION - Practical Intervention Strategies
Ottawa: *October 17;* ***Toronto:*** *October 18;*
London: *October 25;* ***Thunder Bay:*** *November 1*

This workshop introduces participants to a variety of effective strategies that can be used to help an individual who is struggling with depression make positive changes. Participants will learn practical strategies to help engage the depressed person on two levels: changing the negative relationship within oneself and changing interpersonal dynamics that perpetuate depression.

DE-ESCALATING POTENTIALLY VIOLENT SITUATIONS™
Toronto: *October 29;* ***Ottawa:*** *October 29;* ***London:*** *October 30;*
Hamilton: *October 31;* ***Kenora:*** *October 31*

This workshop is designed to teach people to de-escalate potentially violent situations through assertiveness and interpersonal communication. The training will explore how anger and violence interplay, including opportunities for self-assessment of personal styles.

UNDERSTANDING MENTAL ILLNESS
Toronto: *November 14;* ***Hamilton:*** *November 19;*
Ottawa: *November 19;* ***London:*** *November 21*

This workshop is designed for managers, human resource professionals, social service providers and anyone seeking a better understanding of the complexities that surround mental illness. Participants will learn about common adult mental illnesses and their symptoms, causes and treatment.

DSM-5 - What's New...What's Different *(Half-day workshop)*
Toronto: *November 15;* ***Hamilton:*** *November 20;*
Ottawa: *November 20;* ***London:*** *November 22*

With the release of the DSM-5 comes new diagnosis and changes to the way some mental illnesses are viewed. While not an exhaustive review, participants will learn about the more significant and controversial changes to the DSM. This workshop is intended for doctors, psychologists, social workers, senior clinicians and professionals working in the field of mental health.

RESTORATIVE JUSTICE - Guiding Principles for Communities & Organizations
Ottawa: *November 18;* ***Mississauga:*** *November 22*

This workshop provides a framework for incorporating restorative justice principles into your environment. The timeless philosophy of restorative justice invites people to look beyond a merely punitive view of justice and discipline, and instead emphasizes direct accountability, reparation, prevention, dialogue and, in some cases, renewed relation.

VIOLENCE THREAT ASSESSMENT- Planning and Response
Toronto: *December 2;* ***Ottawa:*** *December 4*

This workshop provides a communication and decision-making model to help businesses, schools, organizations and communities become more effective in their management of threats. Participants will learn strategies to help them identify, assess and manage individuals who may be escalating towards violence.

STALKING - Assessment and Management
Toronto: *December 3;* ***Ottawa:*** *December 5*

This workshop provides organizations, schools and businesses with a better understanding of the nature of stalking, including motivations related to different types of stalkers. Specific focus will be given to the complexities of assessment and management of situations related to cyber-stalking. Participants will review an informal assessment tool to help in determining the level of risk of stalkers.

SELF-INJURY BEHAVIOUR IN YOUTH - Issues and Strategies
London: *December 9-10;* ***Toronto:*** *December 11-12;* ***Ottawa:*** *December 16-17*

This workshop will begin with a general overview to assist participants in understanding the experience and motivations of adolescents who intentionally injure themselves. The content will then focus on practical strategies for working with youth struggling with this complex issue.

DISORDERED EATING - From Image to Illness
Toronto: *December 13;* ***Ottawa:*** *December 19*

Disordered eating can range from problematic tendencies such as excessive dieting to a mental health diagnosis such as anorexia or bulimia. Beginning with a general overview, this workshop will examine symptoms, contributing factors and the experience of living with an eating disorder. Participants will also explore practical strategies for supporting individuals struggling with disordered eating.

SUICIDE PREVENTION, INTERVENTION & POSTVENTION STRATEGIES
Toronto: *January 30-31*

The first day of this workshop will teach caregivers the skills needed to identify and assist those at risk of suicide. The second day focuses on providing caregivers with tools to minimize the impact of a suicide on survivors. Participants will gain valuable insights into why suicide postvention is also suicide prevention.

MOTIVATING CHANGE - Strategies for Approaching Resistance
London: *February 13-14;* ***Ottawa:*** *February 18-19;* ***Toronto:*** *February 20-21*

Drawing from the approaches of Motivational Interviewing, Positive Discipline and Internal Family Systems Model, this experiential workshop will equip helping professionals with an enhanced style and new strategies that will strengthen their relationships and maximize potential for motivating change.

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HIGH RISK INFANTS AND CHILD WELFARE: WORKING WITH OUR MOST VULNERABLE POPULATION

By Kimberly Brisebois

Infants living in high risk environments are known to the child welfare system as extremely vulnerable. These cases are intensely challenging and complex and require significant work and community collaboration to ensure infant safety and well-being. According to the Pediatric Death Review Committee Report (2008) "the vast majority of children's deaths reviewed by the Pediatric Death Review Committee resulting from acts of omission or commission were potentially preventable with increased or different intervention, education or monitoring." In addition, infants are disproportionately represented among child protection cases. According to the Pediatric Death Review (2006) in Ontario, 70% of the children who died were under one year of age. At the Windsor-Essex Children's Aid Society (WECAS), the number of infants in care doubled within a 12 month period; increasing from 48 children in November 2006 to 97 children in November 2007. These findings created the need for a differential approach.

To be clear, WECAS defines an infant as any child under the age of two years old. This is a particularly critical period in child development, and has a significant impact on outcomes later in life (Borowski & Weaver, 2006). "High risk" is more difficult to define and there is no single profile for a high risk infant (Queensland Government, n.d.). Risk to infants often results from an interplay of risk factors in the child's care environment. These include parental risk factors, child risk factors, as well as environmental challenges. "High risk infants" are those groups of infants who, in the presence of a range of risk factors in their care environments, are considered to be at greater risk of experiencing maltreatment (Weberling, Kirby Forgays, Crain-Thoreson, & Hyman, 2003).

According to Naylor, Breen and Myers (1999), it is recognized that children under the age of two are extremely vulnerable due to a range of factors including:

- Limited contact with service systems (Connell-Carrick & Scannepieco, 2006)
- Fragility, which increases the impact of physical harm (Hughes-Evans, 2004)
- Limited ability to communicate
- Total reliance on caregivers to provide for their needs (Rycus & Hughes, 1998)
- Lack of physical reserves which increases risk of dehydration (Manz, 2007)
- Increased parental stress associated with sleep deprivation and the need to respond to the demands of a young infant (Hiscock & Wake, 2002).

Due to the critical nature of this developmental phase and the elevated risk level, early help is necessary for our families who struggle in parenting their infants. For this reason, in 2009, WECAS developed a high risk infant team and implemented best practices to work with this vulnerable population. In keeping with our mission statement that we are "dedicated to the well-being and safety of every child by advocating for, and partnering with, our children, families and communities", we strive to ensure a unified, sensitive approach to dealing with these highly complex cases. To this end, WECAS understands the importance of early help for high risk infants. Specifically, our high risk infant team is dedicated to providing intervention and support to high risk families during pregnancy and with children up to the age of two years. For WECAS, early help refers to methods of intervention that are implemented at the earliest possible time in the life of a high risk infant. This includes early help that focuses on addressing risk factors and providing education pre and postnatally.

In an effort to reduce risk and enhance safety, this team is committed to building on family strengths through early help, education and collaboration with families and the community. Through coordinated efforts, service providers work toward the common goals of infant safety and well-being. Workers also utilize an empowerment-based practice through teaching methods and resources specific to the well-being of the infant. Concrete, user friendly tools have been developed in conjunction with the local public health agency and assist workers with parental teaching. Techniques such as simple instruction, task analysis, pictorial prompts, modeling, feedback, role-playing and positive reinforcement is utilized. Teaching strategies and focus depends on family needs but the workers on the WECAS high risk infant team ensure that the following areas are discussed with all caregivers:

- Safe Sleep
- Shaken Baby Syndrome
- Fire Safety
- Home Safety
- Postpartum Depression
- Substance Use
- Attachment

Best practices when working with high risk infants are also followed, and can vary depending on the predictor(s) of concern for any given family. These practices were developed after reviewing relevant literature; the Report of the Pediatric Death Review (2006) and the Pediatric Death Review Committee Annual Report (2009). The following are considered best practices for all high risk infant cases:

- Infants must be seen at a minimum weekly basis. Any deviation from this expectation is to be discussed with a supervisor and documented in a supervisory consultation note. Unannounced visits are expected.
- When a referral is received and an infant is involved, the response time will be minimally within 24 hours, regardless of the response time indicated by the eligibility spectrum rating. The decision to deviate from 24 hours, up to a maximum of 7 days should be made with supervisory consultations.
- Workers ensure that infants are seen awake and alert at each visit and document it in their case notes.
- Workers ensure that infants are seen fully unclothed during each visit to assess for marks, bruises, signs of neglect, rashes and weight loss and document it in their case notes. In an attempt to be sensitive with families, the workers ask to witness diaper changes and bath time.
- Workers document, diagram and question each bruise or injury.
- Workers observe regular care routines so that the caregiver and infant can be observed during interaction and document it in their case notes.
- Workers hold infants 12 months and younger during each home visit in an effort to assess weight gain.
- A home safety checklist is completed on all cases, and should be a priority for those cases where there is an allegation of inadequate housing, inadequate supervision, inadequate food or substance misuse. A new checklist is required every time a family moves.
- Workers maintain regular and ongoing contact with all service providers and medical personnel in an effort to provide collaborative services and to make informed decisions.
- The Nipissing Developmental Scales is used by the worker or health nurse to track the infant's social, emotional, and physical development.

Multiple risk factors in the infant's environment increase the level of risk of maltreatment. The effects of early abuse and neglect have been well documented in the research and show significant long-term consequences for children. Early assessment and help is essential to mitigate the potential negative effects to this population. As child welfare professionals it is incumbent that we develop best practice procedures in our agencies in an effort to increase safety and the quality of service to high risk infants and their families (Naylor et al., 1999).

ABOUT THE AUTHOR

Dr. Brisebois earned a Bachelor of Social Work degree from the University of Windsor in 1993; a Masters of Social Work degree from Dalhousie University in 2005; and her doctoral degree from Wayne State University in 2012. Dr. Brisebois has worked in the child welfare field in a variety of roles since 1993. She currently supervises the High Risk Infant team at the Windsor-Essex Children's Aid Society. In this role, Dr. Brisebois has developed specific policies; best practice procedures; and specialized training for social workers involved with high-risk infants. Dr. Brisebois is a certified trainer for the Ontario Association of Children's Aid Societies and delivers ongoing training to child welfare professionals. Dr. Brisebois was also involved in the Early Help provincial committee.

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AN ANALYSIS OF THE BEHAVIOURAL, SOCIAL AND ENVIRONMENTAL RISK FACTORS THAT ARE ASSOCIATED WITH PAEDIATRIC ACCIDENTAL DEATHS IN CHILDREN AGES 11 TO 15 IN ONTARIO

By Laura Walker, Karen Bridgman-Acker, James Edwards, Joyce Bernstein, Bert Lauwers

ABSTRACT

OBJECTIVE

The objective of this study was to determine the behavioural, social and environmental risk factors that are associated with paediatric accidental death in Ontario.

METHODS

Retrospective file reviews were conducted using coroners' reports and case files for all youth, ages 11 to 15, who died in Ontario due to accidental causes between January 1st, 2004 and December 31st, 2007, inclusive. A data extraction tool was created, enabling the documentation of behavioural, social and environmental risk factors, as well as general epidemiological data that were associated with the deaths. The 11 to 15 age category was subdivided into 11-13 and 14-15 age categories.

RESULTS

Overall, the primary cause of accidental death in both age categories was motor vehicle collisions where the child was a passenger, followed by drowning. The majority of accidental fatalities occurred in boys, and the majority of children in both age groups were actively involved in their death. In both age groups, over 33% of motor vehicle collision fatalities occurred when the child was not wearing a seatbelt. The overwhelming majority of children in both age groups involved in off-road motorized vehicle fatalities were wearing a helmet during the incident. However, approximately 67% of children in both age groups involved in biking fatalities did not use a helmet.

CONCLUSION

By increasing the amount of youth and parental safety education programs and enforcing stricter provincial legislation, many paediatric accidental deaths could be prevented in the future.

MeSH keywords: Child, Cause of death, Accidents, Risk factors

INTRODUCTION

Case: A 12 year old boy was riding north on his bicycle with head phones on and no helmet. As he waved to friends in a passing car to his right, he swerved left into the path of an oncoming tractor trailer, suffering a massive head injury. His blood was tested for alcohol and marijuana and was positive for THC (Cannabis product).

Cause of Death: Cranio-Cerebral Trauma

Manner of Death: Accident

The Office of the Chief Coroner for Ontario serves the living through high quality death investigation and inquests to ensure that no death will be overlooked, concealed or ignored. The findings are used to generate recommendations to help promote public and patient safety and injury and death prevention in similar circumstances (2010). The paediatric population is particularly vulnerable to unintentional injuries leading to fatality, which necessitates the need for primary prevention programs to reduce these risks. According to the Canadian Paediatric Society (2009), unintentional injuries are the leading cause of mortality in children ages 0 to 19 in Canada.

The 2009 British Columbia Child Death Review found that 43% of all childhood deaths reviewed were due to accidental causes, with motor vehicle collisions representing the largest percentage. In addition, this study found that 60 % of all childhood deaths were preventable. The most recent completed investigations from 2007 conducted by the Office of the Chief Coroner revealed that accidental deaths represented 35% of all investigated deaths in children ages 0 to 19 (Statistics Canada).

Depending on the particular paediatric age group, certain types of accidental causes of death are more prevalent than others. There are obvious biological and physical differences amongst children who are 0 to 19 years of age; thus, it is practical and relevant to separate this large age group into smaller age ranges. A recent study conducted by the Office of the Chief Coroner (2010) revealed that in children ages 5 to 10 in Ontario, the leading cause of accidental deaths was motor vehicle collisions where the child was a passenger, and the second leading cause was drowning. The causes of accidental deaths in other paediatric age groups in Ontario have yet to be analyzed. The focus of this study is to analyze the

causes and risk factors associated with paediatric accidental deaths in children ages 11 to 15 in Ontario and to provide a more comprehensive view of paediatric accidental deaths across a wider age range.

The Jakarta declaration (1997), a groundbreaking international agreement that focused on Health Promotion, stated that building healthy public policy is one of the five essential strategies that can strengthen health promotion in society. Education and legislation via healthy public policy is a powerful tool in preventing injuries and accidental deaths and promoting health in many societies. There are many examples in Canada that illustrate the positive impact of healthy public policy on the prevention of accidental injury and death in youth. When the Ontario legislation requiring all persons 18 years of age and younger to wear a helmet was implemented, bicycle-related mortality was reduced by 52% (Macpherson & Spinks, 2008)

Although educational strategies implemented by public health policies have proven to be overwhelmingly effective, there is still a sufficient lack of primary prevention policies that are currently implemented in Canada that are aimed at preventing paediatric accidental injury and death (Canadian Paediatric Society, 2009) For instance, the rate of all- terrain vehicle related injury not only increased between 1996 and 2004, it almost doubled, which illustrates the need for more effective policies regarding all- terrain vehicle regulation (Canadian Institute for Health Information, 2007). Furthermore, there are no consistent laws across Canada regarding the operation of snowmobiles in youth, even though snowmobiling is the leading cause of injury related to winter sports (Rowe et al., 1998).

Therefore, by elucidating the risk factors associated with paediatric accidental death in children ages 11 to 15 in Ontario, this research will enable the Office of the Chief Coroner to direct recommendations toward primary prevention programs in Ontario in order to create safer environments for children.

METHODS

This study retrospectively reviewed all paediatric deaths due to accidental causes in Ontario that occurred in children aged 11 to 15, between January 1st, 2004 and December 31st, 2007. The 11 to 15 age group was further subdivided into 11-13 year olds and 14-15 year olds to provide more homogenous groups with respect to risk factors. For each subgroup, the prevalence of various behavioural, social, and environmental risk factors was analyzed. The data for the retrospective analysis were obtained from the Office of the Chief Coroner reports and case files, which contained data about the date of death, gender and age of the deceased, geographic region of death, the death environment, and cause of death. Case files contained additional information, such as police and fire marshal reports, pathology and toxicology reports, and, in some cases, Children's Aid Society reports. Both coroner reports and case files also contained "cause of death-specific" data, such as information about seatbelt, helmet, and life jacket use, alcohol and drug use during the incident, as well as smoke detector status, weather conditions, and types of vehicles driven (where applicable). No family members or any other live persons were contacted during this research. In order to ensure confidentiality, study-specific ID numbers were used when collecting data from these reports and case files.

This methodology satisfied all the criteria found in the Canadian Institutes of Health Research Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans (1998) and was approved by the University of Toronto Research Ethics Board.

RESULTS

Overall, there were 158 children, ages 11-15, who died in Ontario due to accidental causes between 2004 and 2007. Out of these 158 children, 66 were 11-13 years of age, and 92 were 14-15 years of age.

In the 11-13 age category (Figure 1), the number one cause of accidental death was motor vehicle collisions, which represented 26% of deaths. The second highest cause of accidental deaths was drowning (18%), followed by fire-related deaths (12%).

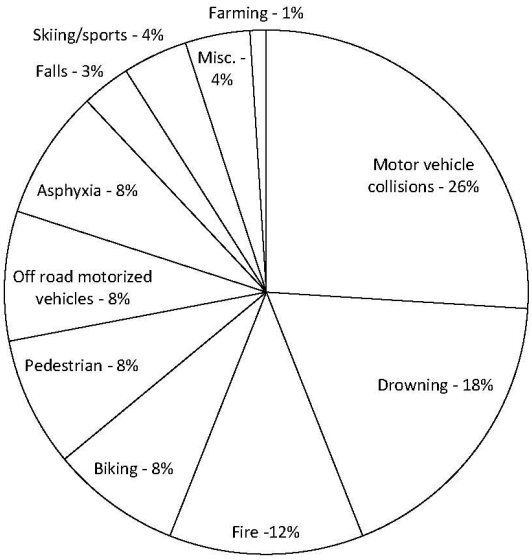

Figure 1. Types of accidental deaths in Ontario, 2004-2007, ages 11-13. n = 66.

In the 14-15 age category (Figure 2), the number one cause of accidental death was also due to motor vehicle collisions, which represented 29% of deaths. The second highest cause of death was also due to drowning (15%), however, the third highest cause of accidental death was due to off-road motorized vehicle fatalities (13%). In this older age category, there was also a significant portion of accidental deaths due to drug overdoses, while there were no cases of fatal drug overdoses in the 11-13 age category (Figures 1, 2).

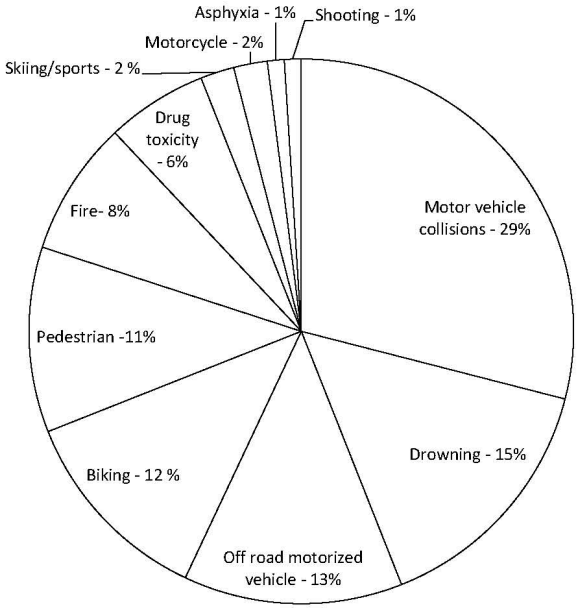

Figure 2. Types of accidental deaths in Ontario, 2004-2007, ages 14-15. n = 92.

In both age categories, the overwhelming majority of accidental deaths occurred in boys, who represented 76% and 66% of accidental deaths in the older and younger age categories, respectively. The majority of accidental deaths in both age groups were active in nature, meaning that the children were doing something illegal or dangerous which ultimately led to their death, such as riding a bicycle and running a red light. Fifty percent of accidental deaths in the 11-13 age category and 58% of accidental deaths in the 14-15 age category were active in nature.

Finally, when the active and passive nature of accidental deaths were segregated according to gender, it was found that in the 11-13 age category, both males and females had similar proportions of active involvement in their death. However, in the 14-15 age category, males were actively involved in their death 69% of the time, whereas females were actively involved in their death only 35% of the time. These differences may be reflective of gender specific biological changes that occur in maturing youth.

There were forty-four motor vehicle collision fatalities in the combined 11-15 age group between 2004 and 2007 (Figure 3). In this combined group, 38% of the children were not wearing seatbelts at the time of the accident. All of the children in the 11-13 age category were passengers in the motor vehicle that was involved in their accident. This is contrasted with the 14-15 age group, where 15% of the children were drivers of the vehicle.

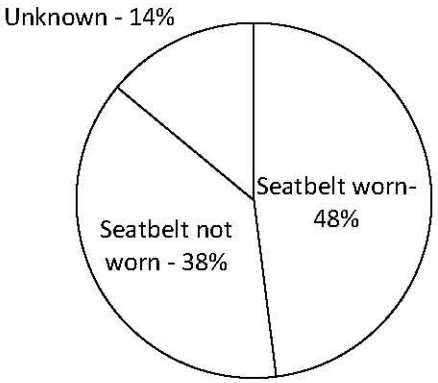

Figure 3. Seatbelt usage among Motor Vehicle Collision fatalities in Ontario, 2004-2007, ages 11-15. n = 44.

There were seventeen off-road motorized vehicle fatalities in the combined 11-15 age group that occurred between 2004 and 2007 (Figure 4). In this combined age category, 88% of the children were wearing helmets during this type of accident. The majority of off-road motorized vehicle fatalities that occurred in the 14-15 age category were due to snowmobiles, whereas the majority of this type of fatality in the 11-13 age category were due to all-terrain vehicles.

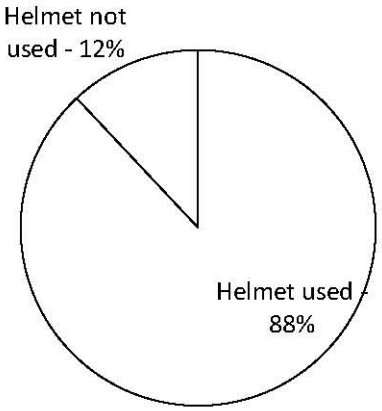

Figure 4. Helmet usage associated with Off-Road Motorized Vehicle associated fatalities in Ontario, 2004-2007, ages 11-15. n = 17.

There were sixteen biking fatalities in the combined 11-15 age group that occurred between 2004 and 2007 (Figure 5). Sixty-nine percent of children in this combined age group were not wearing a helmet during the time of the fatal biking incident. In both age categories, over 80% of the children were actively involved in their biking fatality.

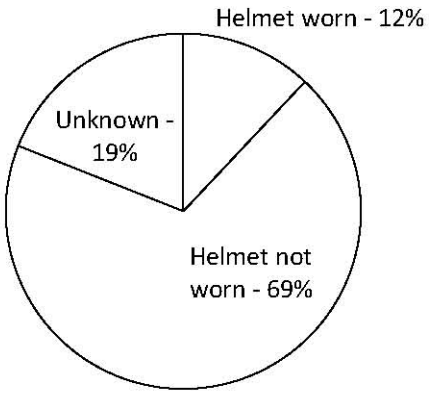

Figure 5. Helmet usage among biking fatalities in Ontario, 2004-2007, ages 11-15. n = 16

DISCUSSION

By analyzing the behavioural, social, and environmental risk factors associated with paediatric accidental deaths in children ages 11 to 15, various trends have been elucidated. Overall, deaths due to motor vehicle collisions, drowning, fire, off-road motorized vehicles, and biking represented significant proportions of accidental deaths in both age groups, making these modalities potential targets for interventions. In addition, boys were involved in the majority of accidental deaths in both age groups, thus, future primary prevention strategies should aim to target this demographic. Finally, the majority of accidental deaths in both age groups occurred when the child was actively involved in his or her death. This has implications for developing future primary preventative strategies, in that child behaviour needs to be a prime target for these interventions.

With respect to paediatric accidental deaths caused by motor vehicle collisions, it is evident that a significant portion of both age groups were not wearing a seatbelt during the incident. Provincial legislation states that all drivers and passengers must wear a seatbelt while traveling in a vehicle. If a passenger is under the age of 16, it is the driver's legal responsibility to ensure that the passenger is belted (2011a). Evidently, this legislation is insufficient to enforce the universal use of seatbelts in minors. Since children in the 11-15 age category are still under 16, it is the driver/parent's responsibility to ensure that the child is belted in their vehicle.

Therefore, it is recommended that there be an increase in driver/parental education across the province with respect to seatbelt safety. It is also recommended that there should be more education regarding seatbelt safety, as well as general motor vehicle safety, in elementary schools and high schools across the province in order to empower these children to make their own smart decisions while traveling in a vehicle.

In addition, stricter penalties for disobeying provincial seatbelt regulations could be considered. Currently, the maximum fine for failing to wear a seatbelt in a motor vehicle is $1000 and two demerit points, which, based on the deaths reviewed, has not been sufficient to engender 100% compliance with seat belt use in children (2011a).

With respect to deaths due to off-road motorized vehicle accidents, it was evident that all-terrain vehicles were the leading cause of these fatalities in the 11-13 age group, whereas snowmobiles were the leading cause of these fatalities in the 14-15 age group. Interestingly, the majority of children in both age categories were wearing helmets during their accident, which is in accordance with Ontario legislation. That law states that all operators of off-road motorized vehicles must wear a motorcycle helmet at all times (2010a). Although this is true, helmets

are not enough to prevent serious injury and death when this type of vehicle collides with a tree or another motor vehicle, or rolls onto its occupant. Currently, Ontario legislation allows children over 12 with a valid motorized snow vehicle operator's license to operate a snowmobile (2010a). In addition, provincial laws allow children with a valid driver's license to operate all terrain vehicles (2011b). However, given our findings in this project, the use of off-road motorized vehicles should be restricted to persons at least 18 years of age and older. Children may be too inexperienced to operate such potentially powerful and dangerous vehicles.

Finally, when analyzing the paediatric deaths due to biking accidents, it was evident that approximately two thirds of children in both age categories were not wearing helmets during the incident. Current Ontario legislation mandates that all children under the age of 18 must wear a helmet while riding a non-motorized bicycle on any public road (2010b). Evidently, this current law is not sufficient to compel youth to wear helmets while riding their bikes. Hence, we recommend that there should be mandatory bike safety training in all elementary and high schools across Ontario.

These recommendations can all have a positive impact on healthy public policy in Ontario. By increasing youth and parental safety education programs, and by enforcing stricter provincial policies, many paediatric accidental deaths could be prevented in the future. By targeting the specific behavioural, social, and environmental risk factors that were found to correlate with paediatric accidental deaths, it is our hope that these unnecessary fatalities can be prevented leading to a healthier society.

ABOUT THE AUTHORS

Laura Walker, BMSc is currently a medical student at the University of Toronto. She received her Bachelor's Degree in Clinical Biochemistry from the University of Western Ontario in 2009. During her medical school career, she completed her research at the Office of the Chief Coroner for Ontario. She is currently in her final year of medical school and will be starting her residency career in Internal Medicine in 2013.

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Dr. Bert Lauwers is the Deputy Chief Coroner-Inquests for the Office of the Chief Coroner in the Province of Ontario and former chair of the Deaths Under Five and Paediatric Death Review Committees. Dr. Lauwers is a graduate of the University of Toronto Medical School and has a Fellowship in the College of Family Physicians. He is appointed as an Assistant Clinical Professor in the Faculty of Family Medicine at McMaster University. He is a former president of the Ontario Coroners Association. In the last two years he completed three death reviews which were publicly released including the Drowning Review, the Death Review of the Youth Suicides at the Pikangikum First Nation and the Pedestrian Death Review.

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PARTNERSHIP: THE EXPERIENCE OF SEVEN ABORIGINAL SOCIAL SERVICE PROVIDERS AND THE CHILDREN'S AID SOCIETY OF OTTAWA

By Marlyn Bennett and Yvonne Gomez

INTRODUCTION

This article reflects on an evaluation that was undertaken by the First Nations Child & Family Caring Society of Canada in 2011 regarding a partnership between the First Nations, Inuit and Métis service providers and the Children's Aid Society of Ottawa (CASO)(2012).

The following are the community partners;

- Makonsag Head Start (http://www.makonsag.ca)
- Minwaashin Lodge - Aboriginal Women's Support Centre (http://www.minlodge.com)
- Odawa Native Friendship Centre (http://www.odawa.on.ca)
- Ottawa Inuit Children's Centre (http://www.ottawainuitchildrens.com)
- Tewegan Transition House (http://www.urbanAboriginal.ca/tewegan/)
- Tungasuvvingat Inuit (http://www.tungasuvvingatinuit.ca)
- Wabano Centre for Aboriginal Health (http://www.wabano.com)

This article provides an overview of the initiative, including the purpose and the scope of the evaluation, the methodology and data collection methods used, as well as the findings and recommendations in two parts from the narratives obtained from the staff of CASO and the Aboriginal service organizations of Ottawa. The full report is available online at http://www.fncaringsociety.com/sites/default/files/docs/FN-I-M_CASO_evaluation_WEB2.pdf

BACKGROUND AND OVERVIEW

Ottawa is located on Algonquin territory; this said there is no respective Band for the jurisdiction that the CASO covers. As Ottawa is an urban center where many Aboriginal cultures and peoples reside, the partnership has been formed with the service providers that serve Aboriginal people in Ottawa, it is acknowledged that there is a vast diversity within the urban Aboriginal experience and the commonality is the families, youth and children that all partners serve.

The Aboriginal service organizations of Ottawa understand the importance of reconciliation in their service approaches to working with the First Nation, Inuit and Métis families. In recognizing this, they approached CASO to begin a dialogue on implementing changes to the way they would like to see the agency engage with Aboriginal populations on child welfare matters. In response to this request, an ongoing process of truth telling, acknowledging, restoring and relating (Blackstock, Cross, George, Brown, & Formsma, 2006) was undertaken by CASO to strengthen its relationship with the Aboriginal communities. Reconciliation was seen as important for improving the agency's linkages with Inuit, Métis and First Nation service providers within Ottawa. Efforts to strengthen these relationships were guided by principles derived from the "Touchstones of Hope" movement developed by Aboriginal and non-Aboriginal leaders in child welfare (Blackstock, et al. 2006). The Touchstones of Hope principles embody a community-based philosophy for re-visioning child welfare practices when working with Aboriginal children and families.

In the winter of 2007 CASO hosted two community consultation sessions with the Aboriginal community - one with service providers and one with community members – both of which focused on ensuring a "full and truthful accounting" (Blackstock, et al., 2006) of child welfare practice as experienced by Aboriginal families in Ottawa. Challenged by the "anger" and "palatable pain" shared by the Aboriginal community (Engelking, 2009), the consultations created space for CASO to acknowlede these truths and to work to restore relationships and relate in creative ways with the Aboriginal families residing in Ottawa. These consultations acknowledged the role that child welfare has played historically as agents of colonization, and that presently, child welfare, specifically the CASO can be carrying out the child welfare mandate in a collaborative way through community partnerships.

Description of the partnership

The two consultations that occurred in 2007 with the Aboriginal community resulted in the development of two committees—an internal Forum of CASO staff

(members responsible for learning about the histories, practices and cultures of First Nations, Inuit and Métis peoples and sharing this knowledge with fellow employees) and a Liaison Committee (comprised of representatives from CASO and First Nations, Inuit and Métis service providing organizations), which was tasked with developing stronger relationships between CASO and the Aboriginal service organizations and Aboriginal communities within Ottawa.

CASO has since undertaken a variety of actions to change how the agency and its staff work with Aboriginal families, including the implementation of an alternative dispute resolution (ADR) program called the Circle of Care. The development and implementation of the Circle of Care Initiative was, and continues to be, guided by the Liaison Group, and is derived from traditional practices but was not a focus of this evaluation.

Scope of the evaluation

The scope of the evaluation was based on reviewing the partnership and the collaborative working space that evolved between CASO and the Aboriginal service organizations as a result of the community consultations. Specifically, the evaluation encompassed: (1) A review of the partnership between CASO and the First Nations, Inuit and Métis service providers; (2) A reflection on whether the actions as taken by CASO were meeting the expectations of community partners; and (3) Isolating and understanding of the impact of these actions on the community, both from the perspective of CASO staff and its Aboriginal community partners.

Methodology and data collection methods

The original evaluation framework was based on a qualitative research process. The intent of the qualitative approach was to ensure that rich open-ended feedback was obtained in response to questions posed to the CASO and the First Nations, Inuit and Métis service providers about how the partnership was working and where there might be challenges, and this was done primarily through open-ended narrative interviews. The particular data methods of inquiry involved:

- Key information interviews
- Observations
- Informal review of the documentation flowing from the partnership activities and initiatives

The data obtained ensured a diversity of perspectives from both Aboriginal and non-Aboriginal individuals involved in the partnership and produced data that was rich and in-depth. The data collection spanned a two-week period in August 2011.

Analysis methods

The major sources of data for this evaluation primarily flow from the personal interviews conducted with members of CASO and the Aboriginal service organizations and the documentation flowing from the partnership's activities and initiatives. The textual analyses of the data from the transcripts involved multiple readings and interpretations of the raw data that was generally "inductive' in nature. *Inductive analysis*, as noted by Thomas (2006), refers to an approach that uses detailed readings of raw data to derive concepts, themes, or a model of interpretation made from the raw data by an evaluator or researcher. Organization of the interview transcripts and data analysis were conducted with the assistance of NVivo, a software program that organizes raw data and links them with other project related documents or "data bites" which the researcher coded and made analytical notes about, and then edited and reworked ideas as the project progressed (Bazeley, 2007).

Limitations

There are some general limitations to this evaluation that should be acknowledged at the outset. Readers need to be aware of the limitations of the qualitative material as they read through the findings (Rao & Woolcock, 2003). First, the individuals participating in the evaluation were small in numbers and have not been randomly selected making it highly problematic to draw generalizations to the wider population. Because the participating individuals for this evaluation were chosen on the basis of recommendations from the parties to this specific partnership, it would be difficult to replicate and thus difficult to independently verify the results. Secondly, the analysis of the narrative content contained within the transcripts involved interpretative judgments on the part of the researcher and therefore caution must be emphasized that outside researchers and/or readers looking at the same data may arrive at different interpretations (Polkinghorne, 2007).

These limitations should not be taken to devalue the approach taken, or the data obtained nor the findings of the evaluation. Most of these limitations are general to qualitative research methodologies and not specific to this evaluation (Walker, 2005).

PART I: NARRATIVE FINDINGS – CASO MANAGEMENT AND STAFF

CAS interview participants

Interviews were conducted with 13 individuals employed as frontline staff, supervisors and/or legal counsel within CASO.

Understanding the relationship

We learned from our discussions with the staff and supervisors that exposure to the Aboriginal community was nonexistent prior to the community consultations that were held in 2007. A shift in thinking in terms of how to develop a relationship with the Aboriginal population and service providers of Ottawa began to emerge. We consistently heard from Society staff that the real impetus behind the changes in working with the Aboriginal population came from two specific sources. These two sources are discussed briefly below.

a. The reconciliation movement and the community consultations

We learned from the staff that the reconciliation movement in child welfare played a major role in helping staff become more aware of the consequences of taking Aboriginal children away from their families and the long-term effects to both the children and their families. The consultations held with the Aboriginal community and service providers, were considered by CAS staff as a defining moment in the agency's history. One CAS staff shared the following:

> "...If we hadn't heard the messages or the pain, I don't think that we would have the groups we have today or have taken the steps forward that we have taken thus far. That is not to say there haven't been a couple of mistakes made along the way. We may have taken a couple of steps back from time to time but we regroup and continue to move forward." (The Aboriginal Service Providers of Ottawa, The Children's Aid Society of Ottawa and the First Nations Child & Family Caring Society of Canada, 2012, p.40).

b. The commitment of leadership

We consistently heard in our interviews with CAS staff that certain people (staff in the community and within the agency) saw opportunities and pushed for change. The commitment to change was explained by CAS staff as coming from a "top-down" perspective. In particular it was noted that the resulting changes were because of paradigm shifts in thinking coupled with political will at both the governance and leadership levels within the CAS agency and among the leadership of the First Nations, Inuit and Métis service providers within Ottawa. It was noted by CAS staff that what brought about change is the important fact that people and leaders on both sides were open to discussing, listening and being less defensive. There was a common understanding from all directions that services delivered to the Aboriginal families involved with CAS, needed to be improved.

The Aboriginal forum and Liaison Committee

The early work that initiated change within CASO started first with the development of an internal forum and a Liaison Committee. The CAS staff interviewed for this evaluation shared with us their involvement in one of these two particular initiatives.

The forum was described as an internal forum, which is comprised of staff from within the agency that are expected to expand their knowledge about Aboriginal peoples and share it with their colleagues. Staff indicated that there is representation from all the departments on the forum. The Liaison Committee is a more formally structured decision-making body with a yearly work plan with only CAS management and representatives of each Aboriginal service providers within Ottawa. The members of the Liaison Committee bring issues to the table and they work together to come up with solutions. Members of this committee are committed to starting the meetings with good news stories, which were hard to find at first, but over time good news stories have begun to emerge.

One of the other areas CASO believes has brought about significant change and understanding was the opportunity and openness extended to agency staff to participate in educational and cultural teachings provided by Aboriginal people. Through education and training, staff within CAS began to understand what it means to be an Aboriginal child and the connection to the impact of colonization over generations, the sixties scoop and how CAS was a part of this history through government policies. The majority of learnings have been undertaken with partner agencies, and community Elders. The focus has been on history and the importance of culture. Community partner agencies have taken the lead on identifying gaps of knowledge, and preparing training geared at child protection workers. CASO continue to attend a variety of community lead events; gatherings, celebrations, Pow Wows, lectures, Elders talks, as it is seen by the Liaison Committee as vital to learning about Aboriginal culture in Ottawa's diverse urban setting. An example of

this is custom adoptions in the Inuit tradition; CAS staff have received teachings on this topic from families that have custom adoptions, and it how this is recognized in the North. These educational and cultural trainings are delivered with community identified Elders, teachers, and services providers.

How the relationship feels today

The CAS staff that we talked to indicate that relationships with the Aboriginal communities and their service providers have gotten better and are now very positive. The Aboriginal communities that are referred to here is the joint community of families that community agencies and CAS service. CAS staff view these relationships as ongoing and are of the opinion that they will continually grow and get better over time. They indicate that relationships are now more welcoming especially since the Aboriginal services providers have become familiar with CAS staff. "Any relationship has to grow and change and there is some ups and downs and we got to learn how to dance the dance with every relationship and that's what it is." (The Aboriginal Service Providers of Ottawa, The Children's Aid Society of Ottawa and the First Nations Caring Child & Caring Society of Canada, 2012, p.45). Primarily this can be illustrated in the relationships and the development of culturally appropriate approaches, which are listed below.

Development of culturally appropriate approaches

The relationship feels more positive, and the following are what the CAS staff reflected on eight approaches they have taken in their efforts to work more cohesively with Aboriginal families and the Aboriginal service providers within Ottawa:

- The Involvement and Support of the Aboriginal Service Providers;
- Development of the Designated Teams;
- The Aboriginal Liaison Worker;
- Cultural Training Opportunities and Understanding Historical Aspects; (as explained earlier)
- Access Visits and Maintaining Community Connections;
- Kinship and Customary Care Arrangements;
- Adoption and Inter-Provincial Relations; and
- Alternative Dispute Resolution Processes.

Reflecting on further improvements

CAS staff reflected on where further changes and improvement needed to occur. The following suggestions for improvements were made:

- Foster parents should receive more training about Aboriginal people and the history of colonization and the role of Child Welfare, much the same as they have received.
- Expand the partnership to include other workers from within CAS in order to facilitate best practices in working with Aboriginal clientele are engrained across the agency and not just with the designated teams which are known as West Pod and Francophone 1 team internally at CASO.
- Staff need to have a better understanding around the number of Aboriginal children and youth being placed in residential facilities and in non-Aboriginal group homes by other child welfare agencies that operate from outside of Ottawa. There is a need to have a sense of what is going on nationally.
- CAS needs to consider recruiting and employing First Nations, Inuit and Métis staff.
- Consult frontline staff more often – staff noted the Liaison Committee should involve them in the decision making and include them in meetings because "no one really knows the work they are doing out in the community."
- CAS should increase its representation in the community by attending more community events to increase the agency's exposure in the Aboriginal community.
- Frontline staff need assurance that when they make mistakes they can talk openly to supervisors and the community about their mistakes and learn how to do things differently in the future.
- A strategic plan for evaluating programs and services offered to the Aboriginal community was cited as some of the areas that need further planning and strategic direction.

PART II: NARRATIVE FINDINGS – FIRST NATIONS, INUIT AND MÉTIS (ABORIGINAL) SERVICE PROVIDERS AND MANAGEMENT

Aboriginal interview participants

Twelve individuals employed by seven First Nation, Inuit and Métis community service organizations within Ottawa,as identified in the introduction, were interviewed.

Understanding how the relationship was previously perceived

The Aboriginal service providers shared that many of the decisions made in the past were based on racism and a lack of knowledge and understanding of Indigenous cultures, the role of colonialism and the intergenerational impacts of residential schools and the sixties scoop. The following sentiments were shared by various service providers:

> "There was a lot of mistrust. We did not trust each other."
>
> "So we realized that there was a lot of broken things going on and we kept saying 'we're sick and tired of saying the same thing, why do we have to tell this and this worker, all of them, that a women wears a traditional jacket and we carry kids on our back.'"
>
> "We didn't know who to talk to then because there was no email and there wasn't really good communication set up with the community, so it was sporadic and frustrating... " (The Aboriginal Service Providers of Ottawa, The Children's Aid Society of Ottawa and the First Nations Caring Child & Caring Society of Canada, 2012, p.74).

The partnership between Aboriginal service providers in community based agencies and the Children's Aid Society of Ottawa has been working on a relationship through shared goals and projects and this continues today.

What does the relationship look like today? The perspective of the community agencies

The movement toward reconciliation and community meetings where Aboriginal people and their community advocates talk openly with the staff of CASO helped in changing how Aboriginal service agencies view CASO and their staff. They believe there is now more trust and a commitment to change by staff within the Society to work in a better way with Aboriginal families and the advocates who know the Aboriginal community best. Aboriginal staff believe that the Society understands the important role that their service agencies play in advocating for and in meeting the needs of Aboriginal communities in Ottawa. They know that CAS recognizes that Aboriginal service providers are critical to the work of Society staff while advocating and helping families to move forward. The following thoughts were shared by Aboriginal staff;

> "Yeah, we're not in the dark as much. We're not, 'who do we talk to next?'"
>
> "We find we can call anyone in the Inuit pod and say, 'what's going on with this file?' and they (Society staff) will listen."
>
> "...I think when I first started doing this work, I was really angry with CAS. I'm still kind of angry with them and some of the decisions they make. My experience has changed in that I'm now in a position to speak to people who can authorize and facilitate change...I have access to information and decisions and the reasons for decisions that I might not have had before..." (The Aboriginal Service Providers of Ottawa, The Children's Aid Society of Ottawa and the First Nations Caring Child & Caring Society of Canada, 2012, p.76).

As a result of these concerted efforts to implement change, Aboriginal service providers view communications as being more open and transparent.

What made change possible?

The community consultation was considered a defining moment in the development of a better relationship between the partners. Aboriginal staff identified key events that brought the relationship a huge step forward. This included acknowledgement of past wrongs, offering a genuine apology, a willingness to listen to the Aboriginal community and a commitment to looking at common issues with fresh eyes. Furthermore, it was observed that CAS was open to working with the organizations that advocate for Aboriginal families. The Aboriginal community and service providers were clear on what they wanted and they supported the proposed changes developed in partnership with CASO. The leadership across all the partner organizations were identified as being the catalysts behind the change.

Reflecting on the changes

Aboriginal staff from the community were asked to reflect on some of the approaches that the Society had taken in their efforts to work more cohesively with Aboriginal families and their organizations. Aboriginal service providers reflected on a wide variety of initiatives developed by CAS. During interviews the Aboriginal staff mentioned nine specific initiatives:

- The Role of the Liaison Committee;
- Relationship Building with Society Staff and Management;
- Development of the Designated Teams (West Pod and the Francophone 1 Team);
- Creation of the Aboriginal Liaison position;
- Community Meetings and Access Visits;
- Maintaining ties in and to the Community;
- Kinship Services and Adoption;
- The Circle of Care; and
- Cultural Sensitivity, Training and Education.

Narratives of significant change

Aboriginal service providers identified a number of changes that they considered as being the most significant of the changes that have been made to date. Excerpts of narration can be found in the full report. Some of the changes they reflected on included that:

- CAS is ensuring their staff become more culturally aware;
- CAS is open to exploring creative solutions to working with Aboriginal families. As a result, more Aboriginal children are staying with their families and adoption of some Aboriginal children is being done in a way that is open and inclusive;
- Relationship building is not only being done with Aboriginal families but that relationship building is happening with and among the staff employed within the Society;
- There is now an Aboriginal liaison worker from the Aboriginal community working within CAS at the Telesat office;
- The designated teams created by CAS are helping to streamline services to the Aboriginal population which has reduced the number of CAS staff that Aboriginal service agencies must deal with; and
- Past wrongs and mistakes have been acknowledged and getting a genuine apology by CAS are really the most significant changes that spearheaded systemic change.

Identifying challenges and areas of improvement

One of the biggest challenges noted by some of the Aboriginal service staff is the fear that the Aboriginal community might think they are siding with the Society when working with CAS. This was viewed as a double-edged sword for Aboriginal service providers because they need to have the trust of CAS but they also needed to maintain the trust of the Aboriginal people for whom they advocate. One Aboriginal Staff explained the tension between supporting a client and being an active partnership member as an ongoing struggle, "You have to be real careful when you tell them (client) that 'I sit on this committee because I want to change the way things are going" (The Aboriginal Service Providers of Ottawa, The Children's Aid Society of Ottawa and the First Nations Caring Child & Caring Society of Canada, 2012, p.93). Throughout the interviews, Aboriginal participants were adamant that having the trust of the Aboriginal population was more paramount than the partnerships developed with the Society. The Liaison Committee works through this challenge through a work plan that is endorsed and carried out by all partners, and it is referred to often when considering projects and priorities. There is an ongoing need to have the Liaison Committee and Aboriginal liaison coordinator report back to the larger Aboriginal community which continues through the format of community consultations.

LESSONS LEARNED

Both CASO and the First Nations, Inuit and Métis service providers report a general satisfaction with the way the relationships have developed. Each of the parties to this partnership are pleased with the changes that have occurred to date. The Aboriginal service providers view the changes implemented thus far as working to benefit Aboriginal families.

The evidence of relationship building between CASO and the Aboriginal service providers is probably the most significant outcome of the partnership between these organizations. The partnership has opened the door to reconciliation and the participants involved in this evaluation are committed to forging

stronger relationships with one another. Through the Touchstones of Hope's guiding principles, the Aboriginal services providers and CASO have promoted the idea of reconciliation through the building of positive relationships to better service Aboriginal children and families living in Ottawa.

Despite the positives however, each of the parties to this partnership recognized areas needing improvement. There were five common suggested areas of improvement made by partnership which are identified as being:

- The need to hire more Aboriginal staff at CASO from the First Nations, Inuit and Métis populations to work in liaison positions housed either at CASO or within Aboriginal service agencies;
- Solidify strategies for collecting and reporting on the statistics regarding the Aboriginal families serviced by all departments;
- Consider developing long-term strategies that plan for the future of the partnership, the Aboriginal liaison position and the Circle of Care program;
- Ensure that the Circle of Care program is evaluated for effectiveness;
- Ensure that the voices of Aboriginal families are included in future evaluations.

Additionally, the following recommendations were made:

- Strengthen relationships with the Métis families and community service organizations that may exist within Ottawa, as at present there is no working relationship with a Métis agency;
- Promote learning from the changes implemented by CASO and identify implications for future development in the agency's work and relationship with the Aboriginal community in Ottawa.

The parties to this partnership also need to celebrate the successes that have been achieved since this partnership was created. Today there is simply no way that goals can be accomplished in building healthy, vibrant communities without having strong partnerships and working together to encourage positive changes. No matter how one looks at things, partnerships are critical and the relationships that are forged in the process of building partnerships, are sacred.

There are key elements important to the ongoing maintenance of the partnership between CASO and the Aboriginal service partners of Ottawa. From reviewing the narrative findings the following key elements exist:

- Maintaining honesty and trust;
- Ensuring ongoing and open communication;
- Listening leads to understanding;
- Being flexible;
- Promoting teamwork and collaboration;
- Sharing resources;
- Accepting that change is part of growth;
- Knowing when to compromise; and
- Growing the partnership (which requires on going revision and renewal).

Continued application of these elements will ensure that the relationship between CASO and the First Nations, Inuit and Métis communities, along with their respective service providers, can and will become stronger as they learn to "walk together in a good way" over time.

A full version of the evaluation report "Exemplifying the Sacredness of Relationality: An Evaluation of the Partnership between the First Nation, Inuit and Métis Service Providers and the Children's Aid Society of Ottawa" can be found at http://www.fncaringsociety.com/sites/default/files/docs/FN-I-M_CASO_evaluation_WEB2.pdf or by contacting the Children's Aid Society of Ottawa.

ABOUT THE AUTHORS

Marlyn Bennett: A member of Sandy Bay Ojibway Nation in Manitoba, Marlyn has worked in the field of child welfare as a researcher for over 16 years. Marlyn is the Director of Research for the Winnipeg based research office of the First Nations Child and Family Caring Society of Canada and the Principal-Editor-in-Chief of the First Peoples Child & Family Review online journal. She is currently an Interdisciplinary PhD student. Her doctoral studies focuses on the transition toward adulthood by First Nations youth leaving First Nations child welfare care in Manitoba. She serves on the boards of the Canadian Centre for Child Protection, Sandy Bay Child and Family Services and is the Chair of the Board of Animikii Ozoson Child and Family Services, as well as the President of the Elizabeth Fry Society of Manitoba.

Yvonne Gomez: Yvonne was born to immigrant parents, and identifies as a Spanish-Canadian, that is a visitor on Algonquin Territory. She completed her BSW at York University and her MSW at the University of Victoria. Yvonne's thesis involved a narrative analysis of power and front-line workers. Yvonne has practiced in the field of Child Welfare since 2002, presently she is a project management coordinator at the Children's Aid Society of Ottawa where her focus is community partnership development.

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Practice Note
Infant Mental Health

What is Infant Mental Health?

Infant mental health is the social, emotional and cognitive well being of infants and young children. This includes a young child's capacity to:

- experience emotions
- regulate emotions
- express emotions
- form close and secure relationships
- explore their environment
- learn

Why is Infant Mental Health Important?

The mental health experienced by an infant or toddler has the potential to impact short and long term developmental outcomes for a child. It is during these years that babies learn some aspects of their mental health such as the ability to regulate emotions, thoughts, behaviour, communications and relationships. Early adversity is a threat to an infant's mental and physical health especially when there is an absence of protective factors to buffer such adversity and stress. Relationships are what infants and toddlers depend on to buffer or protect themselves from the stress and support positive growth and development. Experiences gained through relationships during the first three years shape the architecture of the brain and create the foundation for short and long term health outcomes.

What Do Infants Need to Support Optimal/Positive Mental Health Development?

During the early years, mental health development is profoundly influenced by:

1. A secure attachment to a responsive caregiver
2. Relationships where the caregiver's response is based on child's developmental needs

What is the Relationship between Infant Mental Health and Brain Development?

In the early years of life there are 700 connections being made between brain cells every second. By 18 months of age, most of the brain is hard wired. The profound effect of this wiring for a young child results in:

- their understanding of who they can rely on in their world to be their champion
- their sense of belonging and being loved
- their ability to begin to regulate some emotions

Between the ages of 0 and 18 months care-givers must provide experiences that nurture and strengthen the security of attachment to avoid imbalance of the brain architecture which may lead to anxiety, fear, behavioural dysregulation, conduct disorders or learning problems (etc.). Due to the plasticity of the brain, these less desirable connections *may* subsequently be altered. However, it takes a considerable amount of time and corrective effort to do this and the outcome is not always favourable. This is because beyond 18 months of age, synaptic pruning and elimination begins and the brain connections that are being used, keep on getting stronger.

Can we Screen for Mental Health in the Early Years?

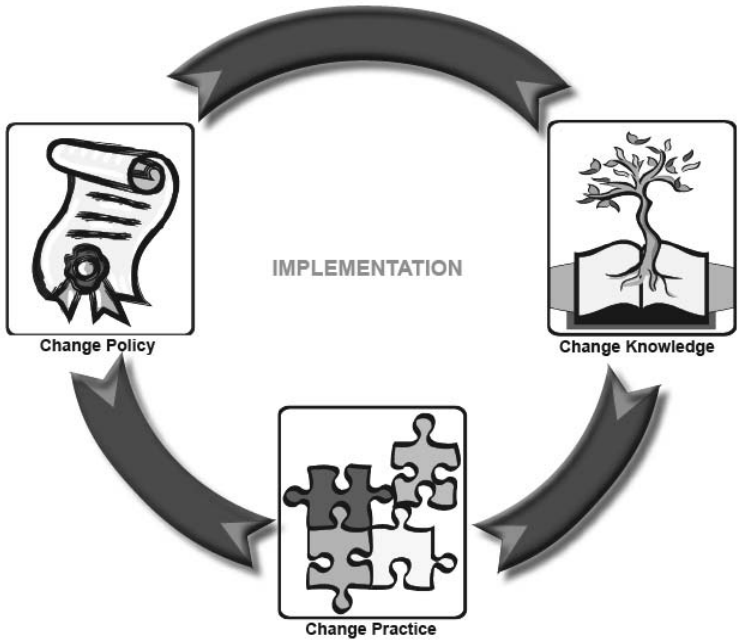
Yes. Screening for a child's development including mental health should include multiple sources of data. Infant Mental Health Promotion (IMHP) is available to train those within child welfare to use the following sources:

- Detailed observations of the child's behavior and development
- Use of a validated screening tool such as The Ages and Stages Questionnaire 3 and the Ages and Stages Questionnaire Social Emotional. Both are reliable screens and help the practitioner know when a child's development is vulnerable or delayed.
- Whatever tool is selected, it is strongly recommended that it includes a strong component, or a separate questionnaire to look at social emotional development.
- Parent interviews
- Other Caregiver/Teacher/Professional interviews or screens if applicable

When mental health is a concern, are there things that we can do?

To support the mental health of young children, a plan of action needs to be implemented which would enhance the knowledge in this field and change the associated policies and practices. System wide change is needed. But as we work through that process there are actions each of us can undertake:

1. Start using a developmental screening tool on all infants your agency serves
2. Create plans that will give parents some suggestions for managing the challenges their child may be facing as they wait for more intensive services
3. Build networks with community agencies and facilitate access for parents when needed
4. Provide training on infant mental health to staff
5. Adopt the Best Practice Guidelines developed by Infant Mental Health Promotion (they are free and online at www.IMHPromotion.ca in the Resources section)
6. Be an advocate with services and policy makers
7. Start collecting data about the infants and toddlers your agency serves



OACAS and IMHP at The Hospital for Sick Children (SickKids) will be working collaboratively to create an implementation plan that promotes training and understanding of infant mental health.

For more information on infant mental health please visit www.IMHPromotion.ca.

Avis de pratique
Santé mentale des nourrissons

En quoi consiste la santé mentale des nourrissons?

La santé mentale des nourrissons consiste au bien-être social, émotionnel et cognitif des nourrissons et des jeunes enfants. Cela inclut la capacité d'un jeune enfant :

- de vivre des émotions;
- de maîtriser des émotions;
- d'exprimer des émotions;
- de former des relations étroites et solides;
- d'explorer son environnementl;
- d'apprendre.

Pourquoi la santé mentale des nourrissons est-elle importante?

La santé mentale d'un nourrisson ou d'un jeune enfant peut avoir une incidence sur les résultats développementaux à court terme et à long terme d'un enfant. C'est durant ces premières années de vie que les bébés découvrent certains aspects de leur santé mentale comme la capacité de maîtriser leurs émotions, leurs pensées, leur comportement, leurs communications et leurs relations. L'adversité précoce constitue une menace pour la santé mentale et physique d'un nourrisson, particulièrement lorsqu'il y a absence de facteurs de protection pour atténuer une telle adversité et un tel stress. Les relations représentent ce sur quoi les nourrissons et les jeunes enfants comptent pour atténuer le stress et se protéger contre celui-ci ainsi que pour favoriser une croissance et un développement positifs. Les expériences acquises par l'entremise des relations durant les trois premières années façonnent l'architecture du cerveau et établissent les assises des résultats de santé à court terme et à long terme.

De quoi les nourrissons ont-ils besoin pour favoriser le développement optimal et positif de la santé mentale?

Au cours des premières années de vie, le développement de la santé mentale est profondément influencé par :

1. Un attachement solide envers une personne responsable réceptive
2. Des relations dans lesquelles la réponse de la personne responsable est fondée sur les besoins développementaux de l'enfant

Quelle est la relation entre la santé mentale des nourrissons et le développement du cerveau?

Au cours des premières années de vie, 700 connexions sont créées chaque seconde entre les cellules du cerveau. À l'âge de 18 mois, la plupart des connexions du cerveau sont raccordées. Les répercussions profondes de ce « câblage » chez un jeune enfant se traduisent par :

- sa compréhension relativement aux personnes de son monde sur qui il peut compter en tant que champions;
- son sentiment d'appartenance et le sentiment d'être aimé;
- sa capacité de commencer à maîtriser certaines émotions.

Entre 0 et 18 mois, les personnes responsables doivent offrir des expériences qui nourrissent et renforcent la solidité de l'attachement pour éviter le déséquilibre de l'architecture du cerveau, qui pourrait mener à de l'anxiété, de la peur, un dérèglement comportemental, des troubles du comportement, des problèmes d'apprentissage, etc. Compte tenu de la plasticité du cerveau, ces connexions moins souhaitables pourraient ultérieurement être modifiées. Cependant, il faut beaucoup de temps et d'efforts pour corriger ces connexions, et les résultats ne sont pas toujours avantageux. Cela découle du fait qu'au-delà de 18 mois, l'élagage et l'élimination synaptiques commencent, et les connexions du cerveau qui sont utilisées se renforcent constamment.

Promotion de la santé mentale du nourrisson
PSMN

Association ontarienne des sociétés de l'aide à l'enfance
Unis pour le bien-être des enfants de l'Ontario

Peut-on évaluer la santé mentale au cours des premières années de vie?

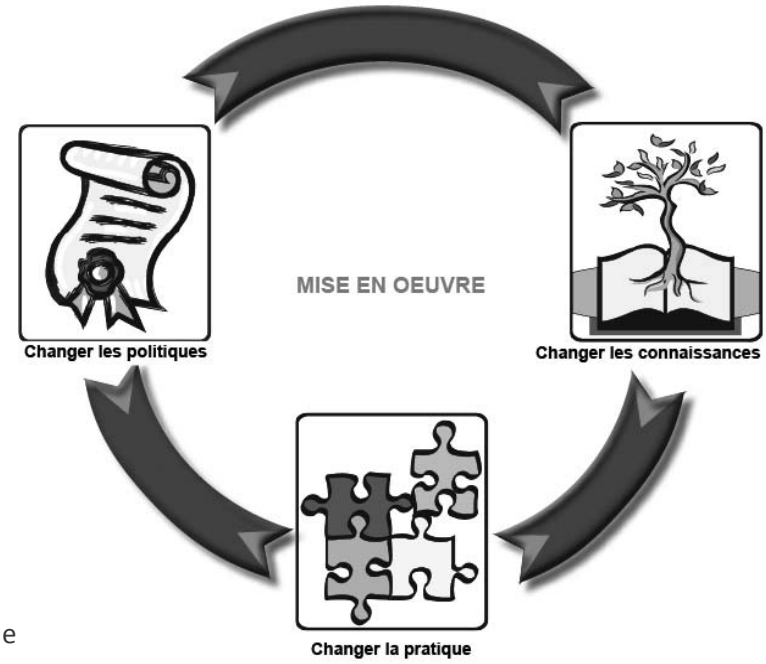
Oui. L'évaluation du développement d'un enfant, y compris la santé mentale, doit comporter diverses sources de données. Promotion de la santé mentale du nourrisson (PSMN) offre de la formation à l'intention des professionnels du bien-être de l'enfance pour qu'ils puissent utiliser les sources suivantes :

- Des observations détaillées du comportement et du développement de l'enfant.
- L'utilisation d'un outil d'évaluation homologué, comme les questionnaires intitulés *The Ages and Stages Questionnaire 3* et *Ages and Stages Questionnaire Social Emotional*. Ces deux outils sont fiables et aident les praticiens à détecter si le développement d'un enfant est vulnérable ou retardé.
- Peu importe l'outil choisi, on recommande fortement qu'il comporte un important composant permettant d'observer le développement socioaffectif ou un questionnaire distinct à cet effet.
- Des entrevues avec les parents.
- Des entrevues avec d'autres personnes responsables, des professeurs et des professionnels, ou des évaluations de leur part, au besoin.

Lorsque la santé mentale devient préoccupante, peut-on y faire quelque chose?

Pour favoriser la santé mentale des jeunes enfants, on doit mettre en oeuvre un plan d'action permettant d'améliorer la connaissance de ce domaine ainsi que de changer les politiques et pratiques connexes. Un changement à l'échelle du système est nécessaire. Mais alors que nous cheminons en ce sens, chacun de nous peut entreprendre des démarches :

1. Commencez à utiliser un outil d'évaluation développementale pour tous les nourrissons que votre agence sert.
2. Élaborez des plans qui offriront aux parents des suggestions pour gérer les défis auxquels leur enfant peut faire face, alors qu'ils sont en attente de services plus intensifs.
3. Établissez des réseaux avec des organismes communautaires et facilitez leur accès aux parents, au besoin.
4. Offrez au personnel de la formation en santé mentale des nourrissons.
5. Adoptez les directives intitulées *Best Practice Guidelines* élaborées par Promotion de la santé mentale du nourrisson (elles sont offertes gratuite ment et en ligne à www.IMHPromotion.ca, dans la section « Resources »).
6. Faites de la représentation auprès des fournisseurs de services et des décideurs.
7. Commencez à colliger des données concernant les nourrissons et les jeunes enfants que votre agence sert.



L'AOSAE et PSMN à The Hospital for Sick Children (SickKids) collaboreront à l'élaboration d'un plan de mise en oeuvre qui favorisera la formation et la compréhension en matière de santé mentale des nourrissons.

Pour obtenir plus de renseignements sur la santé mentale des nourrissons, rendez-vous à www.IMHPromotion.ca.

ADOPTION
TRAINING DAY

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

LET'S GET IT RIGHT: MULTISYSTEM-MULTILEVEL ASSESSMENTS IN THE HOME STUDY AND POST-PLACEMENT SERVICES

Child welfare professionals and private adoption practitioners are invited to attend the workshop: Let's Get It Right: Multisystem-Multilevel Assessments in the Home Study and Post-Placement Services presented by Dr. Wayne Duehn, Ph.D.

Description:

This workshop will explore the "cutting edge" of recent methodological assessment approaches to adoptive home selection and post-placement services delivery through a conceptual framework which bridges systemic and behavioral interactional perspectives and techniques. The presenter will argue for the necessity of multilevel-multisystem assessment procedures that match the system level of the family being assessed, and emphasize that assessment judgments should be based both on what people say and how they behave. Workshop participants will encounter a didactic and experiential format which incorporates videotapes, simulations, assessment and problem solving exercises, skill demonstration, role playing and small group discussion.

Learning Objectives:

1. To acquire knowledge and skill in multisystem-multilevel family assessments.
2. To acquire knowledge in a systemic conceptual framework of the family into which a wide variety of assessment techniques and procedures may be applied.
3. To gain an appreciation of how the family's various ethnic, social, cultural, racial factors and values influence and affect family functioning.
4. To acquire skill in selecting family assessment methodologies consistent with the system level of observation.
5. To acquire knowledge of and skills in utilizing the recently developed wide array of instruments, interactional and behavioral assessment techniques related to family assessment and family interventions.

Biography:

Dr. Duehn is currently engaged in clinical research on sexually abusive parents and juvenile sex offenders. As a national lecturer and trainer, Dr. Duehn is also consultant to many institutions including The Casey Family Programs, National CASA, Big Brothers/ Big Sisters Association, National Network of Children's Advocacy Centers, and has conducted training for law enforcement personnel, schools, CASA staff/volunteers, and social service/mental health agencies throughout the United States.

WHEN: Tuesday, November 19, 2013 9:15 AM - 4:00 PM

WHERE: Sheraton Centre Downtown Hotel
123 Queen St. West
Toronto, Ontario M5H 2M9

REGISTRATION: http://ow.ly/psQnj

The training qualifies for credit as part of the MCYS annual training expectations for adoption agencies, licensees and approved practitioners in Ontario.

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The webcast series explores the integration of the three frameworks that together form the Ontario Practice Model (OPM): Structured Analysis Family Evaluation (SAFE); Parent Resources for Information, Development and Education (PRIDE); and Ontario Looking After Children (OnLAC). Using the themes of Teamwork, Permanence, Culture and Identity, and Well-Being, this four-part webcast series demonstrates how the three frameworks of the OPM are integrated to support a whole-agency approach to strengthening in-care services for infants, children and youth. There is a companion guide available for downloading that can be used to support the learning for an individual user or a group of users.

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Public Access:

Contact your local Children's Aid Society and request to be connected to the Agency Training Designate.

www.oacas.org

NICK
Athlete
Entrepreneur
Chief

"I Am Your Children's Aid."

"At fourteen, I asked Children's Aid to remove my brother, sister, and myself from the abusive home of my father. In foster care, we all thrived. Encouraged by my foster parents and coaches, I became a wrestler and went on to win a Gold Medal for Canada at the 2002 Commonwealth Games. In December 2008, I was invited back to Nigeria, where I was born, for a great honour—my coronation as Chief Ikuku. Ikuku means 'air,' as in 'air gives life.'"

OCTOBER IS CHILD ABUSE PREVENTION MONTH.
Help protect children in your community.
GET INVOLVED WITH YOUR CHILDREN'S AID. GO TO USEYOURVOICE.CA

Ontario Association of Children's Aid Societies

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