

Meeting the Needs of Children In Care –

Collaborative Team Around the Child

by

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Illustration by Tamika Ono-Knight
Rise Magazine Issue 28 Winter 2015

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in

Counselling Psychology City University of Seattle

2016

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Abstract

This thesis discusses the needs of children in care. This unique group of children are exposed to many stressors early on in their lives and often struggle through many disruptions in the care they receive through their childhood. These disruptions can cause a break in their attachment. This thesis supports the importance of attachment to the well-being of children. There is an emphasis on the building and nurturing of lifelong relationships. Children in care are raised within a system, while this is not ideal, but there are many ways in which the current system delivered by social services can be improved. This thesis puts forward one way, Collaborative Team around the Child (CTAC). This approach offers guidance and structure to the professionals working with children in care. It highlights the many barriers that the child and their family can encounter within social services agency and the care system. There is an emphasis on the role of the therapist for the child within the CTAC. This therapist needs to offer a service to the child that will meet her or his needs and to provide that service for as long as is needed by the child. The stories of children in care are shared with the reader in this thesis to illuminate the problems and possible interventions needed to support these children. Finally, there is an exploration of further areas of research and the limitations of this thesis.

Dedication

I am dedicating this paper to the children in care and their birth and foster families that I have met over the years while working as a social worker. I was inspired to write on this subject by the courage and optimism of the children. I have also been inspired by the work of the many dedicated and hard-working social workers and other professionals as well as by the love and nurturing of many amazing foster parents. I hope that the approach offered in this thesis inspires readers to see how a better system can be put in place to support this group of children reach their potential.

Acknowledgment

I want to thank all of the children and their families with whom I have had the privilege to work alongside over the years. I appreciate the enthusiasm and the courage that they have shown and I feel honoured to have been part of their lives. I want to acknowledge the support and encouragement of my family over the last few months while writing this thesis. I would also like to thank all the teachers at City University who have inspired me in my learning in particular.

Christopher J Kinman.

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CHAPTER 1 INTRODUCTION

“Every child deserves a champion – an adult who will never give up on them, who understands the power of connection and insists that they become the best they can possibly be.”

– Rita F. Pierson

The purpose of this thesis is to combine my clinical experience as a social worker working with children and young people in government care with a systematic review of the literature on therapeutic approaches that can improve the lifelong outcomes for these children. Children in care or foster children often experience difficulties in accessing therapeutic interventions that meet their needs (Vostanis, Bassi, Meltzer, Ford, & Goodman, 2008). It has also been my clinical experience in both the UK and Canada that many therapeutic interventions used do not meet the needs of this group of children. My clinical experience suggests that a collaborative therapeutic approach is needed, one that focuses on strengthening lifelong relationships for the child. A collaborative approach would involve extensive, ongoing consultation and support for the foster parents in particular but also include work with birth parents as well as social workers and school/daycare workers. The approach’s aim is to offer appropriate individual therapy to the child but also strengthen the skills of those working and interacting daily with the child. I will provide suggestions of how a collaborative therapeutic approach can be provided within the current government system of services offered to children in care.

Scope and Limitations

This thesis will explore the experiences of children that are in care due to neglect or abuse and where a return to the parents is unlikely or where the child has been made a ward of

the court. I have chosen this population as these are often the children that are most in need of long term¹ interventions. Children in long term foster care, face multiple difficulties including poor physical health, attachment disorders, compromised brain functioning, inadequate social skills, and poor mental health. (Jones-Harden 2004)

Situating the Author

I have worked as social worker for 15 years both in UK and Canada in a variety of teams including intake, family services, and guardianship. Since 2008, I have worked as a social worker in British Columbia with the Ministry of Children and Family Development (MCFD). My current work involves child protection investigations that often result in children coming into care. Most of the children that I have worked with in both UK and Canada spend, on average 1–3 years in temporary care. Over half of the children I have worked with do not return home to their birth parents. All of the children have struggled with past experiences of neglect and trauma as well as the experience of being displaced from their family of origin. Many foster homes have between 2-6 children in their home and all of these children struggle with various levels of emotional difficulties. Many foster parents are very experienced and have been fostering for 10-20 years, have a lot of skill, and all have a vested interest in the children they care for. However, despite living in communities with adequate therapeutic resources and skilled workers available, many of these foster children do not receive long term therapeutic services.

Available government funded therapeutic interventions for all children in care are offered through the Child and Youth Mental Health team in their communities. Interventions that are offered usually involve sessions of individual talk therapy to the child once a week in a clinician's office. The approach is most often from an individualised therapeutic approach

¹ long term interventions would ideally be for as long as is needed by the child.

focused on “fixing” the presenting behaviours of the child (Lewis 2011). While this is beneficial in short term, this individualised therapeutic approach does not offer the opportunity and time that children in care need to build trust with therapist to reflect on previous broken or damaged relationships with family. This approach also does not include the foster parents except for a quick check-in at the beginnings or endings of sessions. There is often little or no therapeutic consultation with the guardianship social workers, teachers, youth workers, or resources workers who work with the child and often no work done with the birth parents or biological family members.

The Importance of Attachment and Interpersonal Relationships to a Child’s Development

Children are born with a desire to connect with others. Babies in particular are driven instinctually to attach to their caregivers from birth (Fairbairn, 1952). Attachment for children forms the basis of how they learn to organize themselves both socially and emotionally (Bowlby, 1965). Bowlby’s attachment theory played an important role in our understanding of how a baby attaches to her or his primary caregivers. He introduced the idea that the early months of life are a critical period in the development of attachment. Bowlby (1965) pointed out that it is through the attachment with others that a child learns how to make sense of other people’s behaviour and make their world meaningful and predictable. Stern (1985) developed Bowlby’s attachment theory by further understanding how babies organize information they receive from their caregivers. Stern developed the idea of RIGs (Representations of Interactions that have been generalized). RIGs are developed by the baby from the chain of emotions and behaviours that come from their interactions with others. These interactions are repeated over and over again and the baby develops a representation of these interactions. The representation becomes part of how

the child organizes her or his core self. Through RIGs children learn to develop the “organizing principles” for their world and their interactions with others. Fonagy (2008) followed Stern’s theory by the idea of mentalization or reflective functioning. Reflective functioning is a developmental skill where the child learns not only to reflect on another person’s behaviour but on the other’s beliefs, feelings, attitudes, desire, hopes, deceit, intentions, and plans (Fonagy 2008). The child learns that the other person has many different qualities and these qualities affect how that person behaves and reacts towards the child. A child’s ability to develop and use this skill is affected by the quality of the attachment that occurs for them with their primary caregivers. It is a vital skill that a child needs in order to function effectively and safely in the world.

Attachment and Interpersonal Relationship Issues for Children in Care

“If you can help a child, you don’t have to spend years repairing an adult.” Joyce Meyer

For children in care or foster children their early attachment can be hampered with difficulties. Often they will have experienced neglect, abuse, or abandonment at a very young age due to drug and alcohol misuse and/or mental health issues of their parents. These children often have had many “broken” attachment experiences before they entered the care systems. These experiences leave these children at a higher risk of developing mental health disorders and emotional dysregulation than other children in the general population (Pilowsky 1995). If a child cannot develop stable organizing principles (RIGS) for their world that they can use to safely and appropriately reflect on others’ beliefs and actions, they will struggle to regulate themselves at an emotional and social level. Every young child needs a predictable, controllable, interpersonal environment to develop regulatory capabilities (Barnard, 1999; van den Boom, 1994). Although

it would be more beneficial for these children not to have had such difficult early life experiences, sensitive consistent caregiving after difficult events can repair the earlier damage (Heineman and Ehrensaft 2006).

It would seem the next step for these vulnerable children would be to provide them predictable and consistent caregiving. However, within the current care system there are many unavoidable barriers to these children receiving this level of caregiving. Often children come into care in an emergency type situation when the decision to remove them from their parents care is made with little or no notice. This emergency type situation does not allow for adequate planning. The social worker usually does not have much information regarding the child's early experiences and is often building a picture of the family dynamics from just a few incidents of neglect or abuse. At the time there is little opportunity to take a detailed history as parents are likely angry or distraught. An early history would allow a better matching process with a particular foster parent who may have more experience in meeting a particular child's needs. Usually there are too few foster parents to choose from, particularly if the social worker is working to keep siblings together. Often the child, or children, is or are received by foster parents with little or no information about their early experiences or attachment issues, and few personal belongings.

While this is a common way for children to enter the care system—and understandable under the circumstances—this situation gives little chance for both the foster parents and child to develop the sensitive and consistent caregiving needed to support these children. This situation often does not change with time, unless the social worker can build a good enough relationship with the parents or another family member to gather the necessary information. The foster parents need to be given the support from the start. This support and information needs to be

extended to the child's school or daycare and their biological family. The focus of the therapeutic work should be on building positive lifelong relationships for the child.

Therapeutic Work with the Foster Child and Family

“Two people see a thing that an individual does not see.” Irish proverb

Foster parents need ongoing consultation regarding an individual child's behaviour from the time that the child enters their care (Landsverk, Burns, Stambaugh, & Rolls Reutz 2006). This ongoing consultation helps the foster parent understand and manage the child's behaviour. The consultation needs to be open and accessible to the foster parent and needs to happen at a time that is separate from the child's time with the therapist. Many therapists get updates from foster parents by email but this is often one sided. Foster parents would benefit from an in home consultation (Heineman & Ehrensaft, 2006). This would involve sitting with the foster parent in the home environment and understanding the foster family's unique dynamics. Therapeutic work should also be extended to include the school and/or daycare as this is a big part of any child life. It is also an area where the child's interpersonal difficulties become evident. Schools in particular influence a child's interpersonal development. Children in care experience many changes of school due to moves within their family life or due to their behavioural issues. Any child can struggle with having to change schools and for a foster child this can be another broken attachment experience. Work needs to be done with teachers and foster parents to ensure that moves of schools are kept to a minimum. Teacher's reactions and support can be vital in helping children developing positive interpersonal skills with both peers and adults. The therapeutic work with schools and daycare should include helping the teachers to understand the core features of traumatic stress. Daycare workers and teachers often have an understanding of emotional dysregulation but it is important for them to understand that a foster child's emotional

dysregulation can be a response to trauma. A child may be dissociating in the classroom due to being triggered by events around them. A teacher may find it helpful to know that behaviour such as daydreaming or inattention may be a coping strategy for the child. Hyperactivity, which is a common behaviour for many children in classrooms, can be a sign of heightened arousal and vigilance. This too can be a coping mechanism for a foster child (Child Welfare Information Gateway, 2015). The therapeutic interventions with teachers and daycare workers for the child can involve introducing ideas to teachers around delayed maturation rather than emotional or behaviour problems. Often children in care just need more time than their peers to make the changes in their emotional or behavioural responses to others.

The Context

Based on my experiences as a social worker with children in care, the following is a fictionalized² account of many children I worked with and their struggles and perseverance are the reasons I was inspired to research the therapeutic needs of children in care. While the content of the story differs from youth to youth, the following is based on a compilation of themes that emerged from the work with the children and foster parents with whom I have worked with.

A number of the children I worked with had very poor outcomes including, secure care or prison before they reached adulthood. It is these children lives that inspired me to research the therapeutic needs of children in care in the hope of finding a better way of meeting their needs. While the content of the story differs from youth to youth, the following is based on a compilation of themes that emerged from the work with the children and foster parents with whom I have worked with.

² If this story bears resemblance to your own experiences or someone you know it is purely coincidental as all names and identifying story details have been changed and altered

Michael was three years when I met him and his two older siblings. They had come into care after their mother burnt down the family home while under the influence. They were removed from her care following this incident. All three children, aged three, five, and seven, had witnessed and experienced varying levels of abuse, neglect, and trauma over the time they were in their mother's care. Michael and his siblings were made permanent wards of the court when Michael was five years old. He and his siblings continued to have face-to-face supervised contact with their mother throughout their time in care. Despite social workers being involved since the birth of Michael's oldest sibling, there was little detailed information about the experiences of all three children while in the care of their mother. It appeared that the maternal grandmother had played a role within the care of the children before her death just before the children came into care. Michael's father and his involvement in Michael or his sibling's life were unknown. Michael was placed with his two siblings with the same foster parents from the age of three to 13 years. Michael received counselling early on in care but would never attend counselling alone and always wanted one of his siblings present. The foster parent had little idea of what was happening in therapy and only spoke to the therapist at drop off and pick up of the children. Michael displayed more and more difficult behaviour in the foster home and it became more and more difficult for the foster parent to get him to go to therapy, then therapy stopped. Michael often lied or made up "big" stories, and appeared to the foster parents to be continually "on edge." At this point his foster mum was struggling and was offered respite, which involved the children the going to a different foster home for a day or two once or twice a month. The foster parent reported that often the children's behaviour before and after respite was worse. Michael had few friends from school or his community. Michael received a diagnosis of Post-Traumatic Stress Disorder when he was 12 years old but refused therapeutic intervention. At this

point some therapeutic support was offered to his foster parents but focused mainly on grief and loss issues for the children. The therapeutic support did not focus on the PTSD diagnosis or attachment issues. Therapeutic support offered few strategies or suggestions to the foster mum in managing a very difficult relationship with Michael and his siblings. The foster mum, social workers, and therapist had lots of different information about what was happening for Michael in different settings. However, few structured conversations occurred between the therapists and foster mum, or social worker and therapist. A therapeutic consultation was offered to the three social workers that worked with Michael and his siblings. However the consultation focused on the social workers' personal working style rather than looking at or understanding Michael's issues. Michael moved through six schools from the ages 5-12 years of age. Many school placements broke down due to Michael's unmanageable behaviour that included running away. Even in a specialized school the teachers struggled to understand and manage his behaviours. It would have been beneficial for Michael's teachers to have a consultation from a mental health clinician around Michael's ongoing difficulties. Both Michaels' siblings left the foster home at 13 years of age as they struggled to follow any house rules and their early use of drugs and alcohol. The foster home broke down for Michael at 13 years old as he lit a fire in his room with the intention to burn down the home. Michael was placed in a secure residential facility from the ages of 13-18 years.

An Integrative and Collaborative Framework

Early collaborative therapeutic intervention is needed for these children from the time they enter care. The intervention needs to be extensive, ongoing, and supportive of the foster parents. Birth parents need to be included in the process where appropriate as well as social

workers and school/daycare workers. The framework for helping the child in care should be based on the following concepts:

- A cohesive team of workers including the guardianship social worker, therapist, foster parents, biological family, school representative and family workers should be formed at the time the child enters care;
- The team needs to meet regularly and work collaboratively to provide an integrative level of emotional and practical care for the foster child;
- Every child in care should be assigned a therapist from the start of their time in care to offer individual sessions to the child and their foster parent;
- If a birth parent is still involved the therapist should offer sessions with the birth parent and parent and child appropriate;
- The therapist should offer guidance and support to the social worker, foster parents and teachers regarding the child's psychological and emotional behaviour. This support should include a psycho-educational approach working towards an explanation of the child psychological and emotional difficulties;
- Support by the therapist should be offered in a way that works for the child for example it could take place in the foster home and/or the school and/or in the community;
- The aim of the therapeutic work is to provide a support to the child so that responsive and consistent caregiving can occur with a predictable routine.

The following chapters of this thesis will continue to explore the workings of a collaborative team approach and the benefits to the child. Chapter 2 will include a review of the literature of the current therapeutic approaches offered to children in care. Chapter 3 will explore the collaborative approach and show how the approach can be beneficial to a child in care through

more de-identified stories like Michael's. Chapter 4 will review the need for a collaborative or integrative approaches and the reason why this is the most effective approach for foster children. Chapter 5 will examine the benefits and challenges in bringing a 'collaborative team around a child in care' approach to the work with child in care and areas for future research.

CHAPTER 2 LITERATURE REVIEW

In this chapter I will review the literature on children in care and the therapeutic approaches that are offered to them. I will explore the various treatment options and identify the therapeutic approaches that work best for this particular population of children. Based on a relational-attachment perspective, I will outline the need for a collaborative therapeutic approach for those working with children in care and their caregivers. In this thesis, statistics have been provided for Canadian children in care. However much of the literature on treatment approaches are US based as there is a lack of Canadian literature on this issue. It is considered US studies regarding therapeutic approaches to children in care are relevant to Canadian children in care as there is a similar social, cultural, and economic climate in both countries.

According to a study done by the Public Health Agency of Canada (2008) there was an estimated 235,842 child maltreatment investigations in Canada in 2008 as compared to 135,261 investigations in 1998. Thirty six percent of the investigations in 2008 were substantiated (85,440) and 19,599 investigations resulted in a change of residence for the child. Four percent of the children involved moved to a foster care home and one percent moved to a group or residential home arrangements. The numbers of children in care in Canada have risen from 30,000 in 1992 to 67,000 in 2007 (Mulcahy and Tromé 2010). There has been a steady increase each year since 1992. The increase in child maltreatment cases and subsequent increase in child in care over the past 20 years could be the result of changes in the public and professional awareness of the problem, changes in legislation or case management practices, changes in definitions and/or the ways of recording data or changes in the actual rate of maltreatment occurring (Kozlowski, Milne, & Sinha 2014) or an increase in the need.

At this time it is difficult to get an accurate account of the number of children in care currently in BC. According to the Representative of Child and Youth in BC (RCYBC) there are

11,278 children and youth in care. Of 11,278 there are 3,988 under a continuing custody order (CCO) giving the government permanent care and responsibility of that child (RCYBC (2015)). According to information collected from publicly available documents for a study by Kozlowski, Milne and Sinha (2014) there were only 8,187 children in care in 2012. One of the reasons for the discrepancy in the numbers of child in care could be due to introduction of a new computer data system (ICM) incorporated by Ministry of Children and Family Development (MCFD) in 2012. This has led to some file records being duplicated. Another reason could be that in 2011 new legislation was introduced under Children, Family Community Service Act (CFCSA 2006). This law allows custody of children in care to be transferred to an appropriate family member after an assessment is completed by MCFD. Although these children are not returned to their parents, they do acquire a new permanent legal guardian and are no longer in the care system.

Aboriginal Children in Care

Aboriginal children are overrepresented among the children in care population. The National Household Survey (2011) indicates that there are 30,000 Aboriginal children in care across Canada. In BC, Aboriginal children make up 55% of the child in care population even though Aboriginal children only make up 8% of the total child population in BC (Aboriginal Children in Care working group 2015). Many of the reasons that lead to an Aboriginal child coming into care are rooted in the residential school system (Assembly of First Nations 2007). It has been my experience as a social worker that Aboriginal children come into care for reasons of neglect rather than for deliberate abuse by the parent. The neglect is often due to poverty, substance abuse, poor housing, and lack of supports from extended family members. It has also been my experience that Aboriginal children stay in care longer and more permanent ward applications are granted than for them than for non-Aboriginal children.

Foster Parents and Foster Children

Worldwide there is a shortage of foster parents available to children and youth in care. Currently it is estimated that there are 3,000 foster care providers available to children and youth in care in BC. This number has increased from 1998. Mostly foster parents are recruited through MCFD but some are contracted by MCFD through private organisations. Some foster parents are restricted foster parents in that they are only looking after children who are either their family members or they had a previous established relationship. Restricted foster homes have the same standards and checks as regular foster homes but only take on particular children and are not open to other children being placed with them.

With the exception of foster children who were placed into foster care at birth, nearly all children placed in foster care have experienced some level of neglect or abuse prior to their foster placement (Kohl, Gibbons & NSCAW Research Group 2005). Children who have experienced abuse and neglect are more likely to experience internalizing and externalising behaviour issues (Shonk and Cicchetti, 2001). They also show more social withdrawal, somatic complaints, depressive symptoms, and suicidal ideation than children in the general population (Kaufman & Cicchetti, 1989). In a US national study by Burns, Phillips, Wagner, Barth, Kolko, Campbell, and Landsverk (2004) it was found that 47.9% of youth in care accessing mental health services had a clinically significant emotional or behavioural problem. These children would benefit from mental health interventions yet only 25% of these youth received any mental health intervention. Many studies (Austin (2005), Landsverk, Burns, Stambaugh and Rolls Reutz (2006) and Marshall (2004) found that for children in care, there are several barriers to receiving mental health interventions. These barriers include:

- The lack of training for foster care workers and foster parents;

- A lack of coordination between social workers and mental health clinicians;
- A lack of initial screening assessments;
- Limited collaboration between social workers, foster, and biological parents;
- Instability of placements; and
- A lack of available mental health providers.

Training of Foster Care Workers and Foster Parents.

“Why hold on to someone when you know you have to let them go?” -A Foster Child

In working with children in care, all the professionals involved with the child, including the foster parents, need to have a clear understanding of the relational and attachment needs of these children. Most foster parents and social workers are aware of Bowlby’s secure attachment theories and understand how foster children in particular can develop other types of attachment (insecure, disorganised and/or ambivalent) that make it difficult for them to attach to their caregivers. However in the last 10 years, there has been huge increase in the research and understanding of how attachment works for children and their caregivers. Caregivers, social workers, and foster care workers need to understand how a child’s attachment is influenced by their earliest attachments experiences and how this impacts their internal world. Neufeld and Mate (2013) describe how attachment is at the heart of relationship building and social functioning; it forms the instincts of a child and of the parent. Neufeld and Mate (2013) argued that attachment orientates the child, gives them a sense of who they are and what is real in the world. Attachment to the caregivers helps the child understand the meaning of their interactions with others. According to Stern (1997) and Fonagy (2008) the repetition of experiences for the child with the parent or caregiver helps the child learn to make sense of other people’s behaviour. Children need to build of a repertoire of experiences that develop their abilities to

predict other people's behaviour. For foster children, their attachment can be complicated by early experiences. A foster child often has had experiences that are violent and/or neglectful. These traumatic experiences can overwhelm their senses and their capacity to make sense of the world. The ability to self-regulate becomes impaired.

For many children who enter the fostering system the situation is complicated by the fact that the parent was the perpetrator of their negative or traumatic experiences. This places these children in an emotional bind. The person the child wants or tries to reach out to makes them feel frightened. Their young minds become overwhelmed, which leads them into a perpetual state of heightened anxiety. Bion (1963) described how an intuitive parent takes their child's sensory experiences, manages it for them, and returns the experience to their child in a modified version that is suitable and "digestible" for their young minds. Bion (1963) described this process that most parents are able to achieve instinctually for their children as "containment." The process of containment involves the projection of a child's feelings into the parent, the parent containing the feelings and then responding back to the child in a way that teaches the child how to manage her or his emotions.

For some children, containment may not happen. Parents who are struggling with poverty, drugs or alcohol misuse, or violence can feel so desperate they cannot offer any containment to their children. Foster children enter the system with a fear of being abused, a lack of containment, and a belief that a concerned adult will not be present to help them with complex and confusing emotions. Heineman and Ehrensaft (2006) speak about the importance of foster parents understanding the internal world of the foster child and working through the confusing experiences the child has already lived through. A foster child who steals or lies or intentionally hurts others needs a foster parent who can understand that this behaviour may be a representation

of their internal world and not just bad behaviour. A foster parent needs to recognise that, although the child's behaviour could be a sign of sociopathy, it is more likely to be a sign of an unfulfilled need in the child's internal and external world. The negative behaviours displayed often serve some purpose for that child in their foster home (Heineman & Ehrensaft 2006). The behaviours may have helped them to stay safe in their family of origin or comforted them in some way. With the help of the foster parent the foster child needs help to learn that behaviour is not needed in their new home. Foster parents need time and opportunities to think and wonder about their foster child's experiences with a professional who is trained and experienced in early trauma and the effects on young children. The involved therapist needs to know the child and be in tune with their history to help that foster parent understand the foster child's behaviour as a survival or defense mechanism and not a delinquent behaviour. Heineman (2015) argues that the therapeutic relationship is the most powerful agent of therapeutic change for the child.

Heineman, Ruff, Clausen and Von Wiederhold (2012) put forward the need for long term psychoanalytically orientated relational play therapy for foster children. The belief is that long term relational therapy is needed to offer consistency to the child and show her or him through experience that relationships are not all temporary. Heineman et al (2012) argues that therapeutic intervention needs to be of sufficient length and intensity to allow for development of a trusting therapeutic relationship in which the depth of the experience of trauma and loss can be explored and emotional issues addressed.

All of the work that foster parents do with children is monitored by a social worker assigned to each foster parent (resource worker). It is important in a collaborative approach that this social worker is aware of the work that the foster parents are undertaking with the child and

therapist. Resource workers play a role in supporting the foster parents with their own issues in caring for a child in their care and have many supports they can offer to foster parents.

Trauma Effects on Brain Development

Traumatic experiences such as abuse or neglect can profoundly impact a child's brain development (Child Welfare Information Gateway, 2011). The first areas of baby's brain to develop are the brain stem and midbrain. These areas control automatic bodily functions such as breathing and heart rate. For a newborn these areas are well developed, however the higher regions of the limbic system and the cerebral cortex are not well developed. These areas control emotions, language, and abstract thought. These functions grow rapidly in the first years of life (Zero to Three, 2012). This time of development is also the sensitive period for developing attachment. Sensitive periods are windows of time when certain parts of the brain are most susceptible to particular experiences. Newborns to three years olds are sensitive to developing attachment to their caregivers (Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010). Positive experiences help with healthy brain development but negative experiences such as maltreatment or violence can negatively affect brain development. The effect on the brain can include changes in the physical structure and chemical activity of the brain and this can in turn affect the emotional functioning of the child (Child Welfare Information Gateway 2011). During the sensitive period, negative experiences for a baby can include unreliable appropriate reactions from their caregivers. If a child lives in a chaotic or threatening world with a caregiver who responds with abuse or frightening behaviour, the brain becomes hyper vigilant and does not fully develop (Siegel 2006). These children's brains can be affected in different ways, depending on the level of stressful events they are exposed to, their age and if there are any other protective factors. Research regarding maltreatment and the effects on the brain indicates many and varied

effects for children. One area that appears to be affected in young children is their cortisol levels. Children who have been emotionally maltreated or neglected have higher than normal morning cortisol levels (Bruce, Fisher, Pears, & Levine, 2009). High cortisol levels can harm cognitive processes, subdue immune and inflammatory reactions, or heighten the risk for affective disorders. A child's ability to respond to kindness and nurturance may also become impaired (Shonkoff & Phillips, 2000). Research by Siegel (2006) on childhood trauma and its effects describe neurobiological changes in the brain's makeup when children experience trauma. There is evidence that shows that the two hemispheres of the brain can be more separated in children who are traumatised. This means that both right and left hemisphere are not communicating well and this can lead to impairment in self-organization and integration. Trauma can have the effect of blocking the individual from developing the brain complexity needed for self-regulation and emotional well-being (Siegel 2006).

Trauma and Loss for Foster Children

Each foster child will have a unique response to trauma and loss. Foster parents, biological parents, child protection workers, and therapists need to understand how some of the behaviours that cause concern might be a response to or attempt by the child to recover from trauma. A foster child may present with some or all of the following behaviours (Child Welfare Information Gateway 2011):

- **Persistent Fear Response.** A foster child coming from a hostile environment may have a heightened response to frightening situations. One of the difficulties for foster children is that they may struggle to define which situations are threatening and which ones are benign. For a foster child without understanding and guidance, a fear response can develop into a generalised anxiety disorder, a social anxiety, or a phobia.

- **Hyper arousal.** Foster children who have been exposed to chronic stress learn to survive these environments by spending a lot of time reading non-verbal clues. However these behaviours can be maladaptive in their foster homes. As these children spend time scanning their environment for non-verbal information, they miss out on other important verbal or spatial information. They therefore may not be able to follow verbal instructions very well from foster parents, and their spatial awareness can be impaired or delayed. This “hyper aroused” state impacts the child’s ability to learn as they literally have less brain space available for taking in new information.
- **Increased Internalizing Symptoms.** As understood previously children who have been maltreated can have structural or chemical changes in their brains. Foster children can struggle with emotional regulation. There is evidence that early emotional abuse can affect serotonin levels (Healy 2004). Serotonin is an important neurotransmitter responsible for feelings of emotional well-being.
- **Diminished Executive Functioning.** Executive functioning includes a working memory, ability to filter information and cognitive flexibility (National Scientific Council on the Developing Child, 2011). Maltreatment can cause deficits in all these areas. Foster parents can worry that these children are not learning the independence skills or functioning at same level as their peers. Foster child can be assessed as having a lower IQ and therefore seen as not academically able as other children. The long-term effect can be lower educational or academic achievements for foster children.
- **Delayed Developmental Milestones.** A lack of stimulation that happens for children who are neglected can affect their neural pathways. If these neural pathways are not used then

they can wither and die (Witherspoon 2011). This in turn will affect a foster child's ability to meet their developmental milestones.

- **Weakened Response to Positive Feedback.** Some foster children may not respond to rewards or incentives that work with other children their age. A study of young adults who had been maltreated showed that they responded less positively to monetary rewards than their peers (Dillon et al., 2009).
- **Complicated Social Interactions.** Children who are in foster care may struggle in their interactions with their peer group. They often misinterpret their peers' facial or social interactions. Children or youth with past trauma may find it more challenging to navigate social situations and adapt to changing social contexts (Hanson et al., 2010).

Collaborative Therapeutic Work

Collaboration is “the process by which several agencies or organizations make a formal, sustained commitment to work together to accomplish a common mission” (Winer and Ray, 1994). Collaborative therapeutic work with children in care involves a group of professionals including the foster family and, where appropriate, their biological family working together to meet the child's best interests. Collaborative therapeutic work with children in care often means that workers and foster parents need to understand the functioning of the biological families. Madsen and Gillispie (2014) states that there is a need for workers to take a “relational” stance towards the families who are experiencing stress. The family and the child should feel that workers and foster parents are “in their corner.” Madsen (2007) speaks about the shift in relational stance from the “professional expert” to an “appreciative ally” for families. This approach encourages workers to ask questions that elicit, elaborate, and acknowledge the

families' skills and strengths. The workers "expertise" is the ability to access the clients' resourcefulness through a therapeutic conversation (Madsen, 2007).

This relational approach to the work involves all parties making an effort to work in partnership with the families. There should be a focus on the family as being the expert and respecting the family's "way of being." This is not just to accept the negative experiences that have happened with the family but rather to respect and understand how the family functions. The work should be about helping the family change aspects that build on their strengths rather than deficits. In working with children in care, the collaborative team around the child needs to understand the child's early experiences, and bring these experiences to a level of understanding for the foster parents and others working with the children.

A similar therapeutic approach is explained by Saxe, Ellis, and Kaplow (2007) who work at Boston General Hospital with at-risk impoverished families. Saxe et al(2007) propose a way of helping families through a Trauma Systems Therapy (TST) approach that is heavily invested in collaborative partnerships and advocacy for the child and the parent. As with Madsen (2007), Saxe et al. (2007) point out the importance of a collaborative approach from a team of professionals working from strength based approaches with families. There is also an emphasis on the family being the "expert" and building the families skills to sustain change. There is no attempt to minimise the difficulties or "sugar coat" the family situation but there is an emphasis on moving away from the negative aspects or deficits and look for the positive change for families. Saxe et al.'s (2007) therapeutic approach works with families at risk but not specifically with children in care and their caregivers. However, the approach raises many important points that are relevant to children in care. One point that is very relevant to children in care is that within the TST approach, integration of services is very important. Saxe et al. (2007) argue that

to help children with trauma the interventions must address the social ecology of the child. The clinician working with the child needs to address the social and/or environmental contributors. The idea is to target all the parts of the child's relational world, school, peer, family, and community. Services need to be offered, at times, outside of clinician office maybe in the child's home, school, and/or community. The TST approach advocates for the clinician going to the home to work with caregivers, to go to school and consult with teachers. TST is based on the assumption that the integration of services is the lynchpin of effective treatment.

TST approach focused on home based treatment, which involves doing sessions with the family within their home, or as Madsen and Gillespie (2007) calls it on the "family's turf." This point is relevant for foster children. Often these children present with different behaviours in many different areas of their lives. For a therapist to see the child in her or his foster home, and within the birth family home where appropriate, and in school, helps to get a better understanding of the child. It provides a more holistic screening of their needs. If a therapist has the opportunity to see children within their biological family and then within their foster families they get a clear understanding of some of the struggles of divided loyalties that many foster children experience. Therapists must attempt to understand this transitional piece that a child has to manage when they see children in their different social environments.(Heineman & Ehrensaft, 2006).

In Closing

Research into the effects of trauma for children and their subsequent emotional well-being is still developing. Some of the literature is pointing towards long reaching effects for children who have experienced trauma that will affect their cognitive and emotional functioning into adulthood and throughout their lives. Unravelling the issues for foster children in particular

takes years of committed collaborative work by a team of professionals working with the child and their family. These professionals need to take an approach with the child and their family that works on strengths and meets the family where they are at. These professionals need to be committed to their understanding of the child's trauma and the psychological and sociological effects on the child, their attachment and their relational development. Foster children need long-term relational therapeutic input in all areas of their lives to help them recover from their early experiences in order to the same chance as their peers at a successful adult life.

CHAPTER 3 METHODOLOGY

This chapter explores the working of a collaborative therapeutic team with a child in care. I will explore the need to assess foster children as they enter the care system, the forming of a multi-disciplinary team and the importance of a consistent therapist to work with the child and the foster parent. This collaborative therapeutic approach is based on the work of Madsen and Gillespie (2014) with multi stressed families, Saxe, Ellis and Kaplow (2007) in their collaborative work with traumatized children and teens and Heineman's (2015) work with children in care. I will discuss how this approach is the best option for children in care to assist them in their journey from their difficult start in life to becoming the best adults they can be. Finally, there will be a fictionalized account described to highlight these concepts in practice.

Assessing the Early Experiences of Children in Care

As children enter the care system they need to be assessed within their social context. Part of this assessment needs to ensure that a comprehensive history of the child's early life experiences is gathered early on as they enter the care system. Some children will be unknown to social workers and other professionals before they have come into care. However, my experience has been that most children will have a substantial history of involvement with professionals—particularly social workers—before a decision is made for them to come into care. Their history usually involves different care providers over time, as well as multiple moves in schools and at times social environments. It is important for social workers to gather as much accurate information as possible and with as much detail as possible about a child's early experiences. The information needs to be compiled in a way that tells the story of child's early life experience. Records from schools should be combined into this recording as they can provide

very useful developmental information for that child. It should always be remembered by the social worker gathering the information that a child has a right to access all of the information held on their child's services file as an older child or as an adult. A social worker's recording should be compiled in a way that is respectful and honours those early life experiences.

If a child is at risk of coming into care, social workers are usually safety planning with the parents so it can be a difficult time to acquire this information. It is important that two social workers are involved at this point with the family in order to get the background information. The first social worker would be safety planning with the parents. Safety planning for most families involves the social worker coming up with a plan with family members that ensures the safety of the child. When a decision has been made that due to the level of risk a child cannot stay in the home, then options with extended family need to be explored before bringing the child into care. This work is time sensitive and involves a lot of negotiation. The work of the second social worker gathering the information should focus on the attachment experiences of the child, understanding their emotional needs and developmental issues. As one social worker is focused on safety planning for the child, the other is focused on gathering information on early experiences.

The information gathered should establish who the child has lived with from birth, any breaks in her or his early care experiences, their behaviour towards her or his caregivers, day to day routine, and the ways he or she comforts her or himself. Heineman (2015) speaks about the importance of understanding the attachment pattern of the foster child. Whether a child has an insecure, avoidant, ambivalent or disorganised attachment it should be remembered that these attachment styles are not mental illnesses or psychiatric diagnosis. The child's style of attachment is just a term used to describe a characteristic way the child relates to others

particularly their caregivers (Heineman, 2015). Understanding a child's relational pattern is important information for foster parents so that they can be sensitive to the child's needs based on their earliest experiences. It is also important information for the therapist working with the child and the biological parents.

Another important area around gathering information is to understand other traumatic experiences that the child may have experienced in their early lives. It is important to know if the child has been a victim of violence, emotional, physical, or sexual abuse, as well as understanding if she or he has been subjected to neglect. This is important information particularly when dealing with refuge or immigrant children who enter the care system and understanding if and how they have experienced war or civil unrest. It is important for the second social worker to try and get an understanding of the child's experience of the trauma and not focus on gathering information for the sole purpose of investigating the child protection issues.

Assembling the Multi-Disciplinary Team

"One stick alone can break but in a bundle the sticks cannot be broken" Somali proverb

Saxe et al., (2007) describe setting up multi-disciplinary teams to work with families. The team's work is set up with the premise that treatment or interventions for these families cannot be accomplished by one therapist or social worker working alone in an office. Interventions need to be provided by a group of workers who together form a net to support the child and their families through difficult times. This team around the child needs to be set up from the time the child comes into care. The team should consist of the involved social workers, foster parents, family workers, resource workers for the foster parent, a school representative, and an assigned therapist and if possible the biological family. This team should meet as often as needed.

One of the important functions of this team is to act as a container for the members. As described in Chapter 2, Bion's (1963) idea of containment by a parent for a child is needed for the team. The multi-disciplinary team should work to contain the difficult experiences of the child and the family. The meetings become a safe place to discuss the heavy emotions that come from the trauma and the experiences of the child and family. The team works to digest these emotions among many professionals and put structures and containment around them to help make the work manageable and effective.

Another function of the team is to share information. This sharing of information can provide a space to educate the team around the trauma and the effect it is having on the particular child. This is a valuable discussion with the foster parents and the biological family (Saxe et al., 2007). This psychoeducational piece can also be helpful for teachers and classroom assistants who are working with the child in school. The space can also be used for the team to explore possible treatment approaches for the child. The presenting "problematic" behaviour of the child can be explored. Thoughts of how these behaviours may be part of a defensive mechanism that served the child in the past but is no longer serving her or him as a positive mechanism in their current situation can be discussed. It is important in these meetings that everyone is supportive of moving forward for the child and agrees on a way of working on the issues within the family and the child's presenting behaviours. Madsen (2007) "relational stance" in regards to the child and their family is important here. All members of the team must have an "attitude" that permeates the therapeutic relationship, where family member's thoughts, feelings and ideas are respected, and where a sense of "working with" the family is felt (Madsen, 2007, p. 23). Often caregivers including foster parents can focus on the child's "problem" behaviour and do not understand the

need for changes to be made on many different levels to help encourage positive change in the child's behaviours.

Another important component of collaborative team is helping bridge the divide between foster parents and biological parents. It is very important for the child to see that their foster parents and biological parents are able to interact positively. It is also important that foster parents and biological parents are able to have a good enough relationship so that visits for the child with their family can happen as informally as possible and information can be shared between parents regarding the child. Often biological parents feel shame and humiliation once someone else is looking after their child. Foster parents are often fearful of the biological parents. Due to this dynamic the social worker easily becomes an intermediary for family visits and communication between foster and biological parents becomes strained. Due to logistics for social worker, this can often result in reduced access for the parents and the child as the social worker becomes solely responsible for co-ordinating visits. Work with the family and the child slows down and the foster parents and biological parents see each other as adversaries rather than resources (Lewis 2011). The collaborative team has an important role in helping both foster parents and biological parents see each other's point of view and the point of view of the child. The resource worker for the foster parent has centralised role to play in encourage a good enough relationship between foster parents and biological parents for the child.

The Therapist for the Child

“One child, one therapist, for as long as it takes” (Heineman, 2015)

An important member of the multi-disciplinary team is the assigned therapist. Even though most people are aware that children that come into care with traumatic experiences, a child does not automatically have access to a therapist to help the child begin to make sense of

these negative experiences. Often social workers have to put together “a case” for why a child in care needs a therapist. Often therapy is only offered if the child has a diagnosis. Even if the social worker is successful in getting a child into therapy, it is very rare for the child to be seen by the same therapist over a period of several months (Heineman, 2014). For children in care, the experience of having many different therapists often reinforces the notion that relationships are temporary and transient much like their early experiences.

It is necessary that therapy for children in care is of sufficient length and intensity to address the complexity of their experiences. Therapy should have open access and give the child the opportunity to “unfold” the experiences that brought them into care and help them navigate their new family situation. Therapy can also provide a child with the needed skills to manage the strong emotions that they will experience as they move through the care system and as well as throughout their lives. Children become attached to their foster parents and may struggle with the loyalties they feel towards their biological and foster parents. Children in care need an automatic commitment from a government-funded therapist to offer them stable and consistent therapy that is open ended for the child. The child and therapist should be able to decide when the therapy should be terminated.

There is evidence from research that brief behavioural or cognitive-behavioural interventions can improve specific symptoms such as PTSD or ADHD (Landsverk, Burns, Stambaugh, & Reutz, 2006). However, it is my experience that relationship based therapeutic approaches have the most effective impact on children in care over time. It is important for young children to feel secure, welcome, and understood in their home. Making sure that foster children can adequately attach to their foster parents while away from their family of origin is fundamental to their emotional and psychological well-being. Research shows that attachment

behaviours are vital to young children emotional and at times to their physical survival (Spitz & Wolf, 1946). Older foster children need more time to attach themselves (Dozier, Stovall, Albus, & Bates, 2001). Best therapeutic outcomes for foster children are interventions that focus on increasing the foster parent's sensitivity to the child's needs and that are flexible to the needs of the biological parents and that secures and promotes relationships (Andel, Grietens, Strijker, Van der Gaag, & Knorth, 2014). All therapeutic interventions must focus on the needs of the child while facilitating and nurturing the foster parent relationship as well as taking into consideration the relationship for the child with their biological parents.

Another important component of the collaborative approach is ensuring that the foster parent and /or birth parent are involved in the therapeutic process. Research shows that caregiver involvement improves outcomes for the child (Dorsey, Conover, & Berliner, 2012). However, it is my experience that most often foster parents are only involved in a quick check in at the beginning and ending of the child's therapy sessions. It is also my experience that most foster parents and some biological parents want to be involved in the therapeutic process for the child. Most foster parents recognise the importance of therapy for the child and welcome the opportunity to discuss with the therapist how they can better meet the needs of the child in their care. Foster parents are a key component of the collaborative team and often have a wealth of information about the child's experiences. It can be therapeutically beneficial for the child if a foster parent can have the opportunity to debrief, celebrate, or strategize some of the experiences they are having with the child.

The therapist should also have the opportunity to work with biological family where possible. There will be occasions due to the level of child protection issues (violence or drug and alcohol issues) this work will not be able to happen. However, it has been my experience that

even if a permanent custody order is being sought for the child, work can be done with parents to look at the emotional issues for the child and make the parents part of the long term plan for the child. This work can involve helping the parents to see how child protection issues are influencing the child's emotional well-being. This important work can be fundamental to the future relationship that child has with her or his parents. It has been my experience that often when a child comes into care, a therapist sees the child, the parent/parents see a family preservation worker/therapist. Very rarely do the two workers discuss their work with each other. They often just give feedback to the social worker. Both workers are doing important work but without collaboration the impact on the overall emotional needs of the child is minimal.

Out of the Office and into the Child's World

Another important component of the collaborative team approach is bringing therapy to a child rather than taking the child to a therapist. The assigned therapist needs to be flexible in seeing the child in a variety of settings that works around the child's needs. For a particular child it may be necessary for the therapist to see the child at school or in the foster home or with his family. Madsen and Gillespie (2014) describe a service hierarchy within the delivery of human services. This hierarchy works like a class system of the disciplines including medicine, psychiatry, social work, and counselling. It appears that a situation has been created where the higher up the hierarchy the less the intimate contact with the 'helper' (therapist) (Madsen & Gillespie, 2014). This can have the effect of seeing home-based services as not professional. Offering therapy to a child while walking in the park or in the playground or while sitting on their bedroom floor looking at their favourite book may be seen as not offering a professional therapeutic service to a child. Yet a foster child might need less formal settings to express their

deep seated worries. They need to see their therapist as a flexible available person in their community, not a worker in an office in a government building.

A Foster Child and their Collaborative Team of Care

The following story about Jimmy and his family is based on my experience as a social worker. Jimmy's story is an example, albeit fictionalized, of the type of collaborative work a child in care can experience from a team around the child.

Jimmy came into care after when he was 10 years old. He was the youngest of five children and the only one living at home with his 58 year old mother. His mother had past issues with alcohol but currently is struggling with depressive and PTSD symptoms. The father had not been involved in the care of Jimmy since his birth and had no contact with him or his mother. The school had observed that the mother had been struggling to understand Jimmy emotional needs. At end of the day she would spend a long time in the playground, often they were the last family to leave, and the teachers noticed she would sit and watch Jimmy playing on the equipment but would "zone out." In the neighbourhood, Jimmy appeared to be alone a lot and in talking with social workers, the mother seemed unable to understand his need for supervision at home or in the neighbourhood. Jimmy had a lot of anxiety around his living environment. His home was situated in a poor part of town with many people in the neighbourhood struggling with addictions and past traumas. Jimmy had told school he had thought about harming himself when he got very worried. Jimmy was removed from the care of this mother after neighbours found home alone for three days when his mother had left to visit a family member. A foster parent for Jimmy was found in the local area.

A week after Jimmy came into care, a meeting with the multi-disciplinary team was organised. The mother's family preservation worker, foster mum, psychiatrist, school principal,

classroom assistant, resource worker, social worker, and assigned therapist attended. Jimmy's mum decided not to attend but have her family preservation speak on her behalf and agreed to a smaller meeting with her and the social worker later. Jimmy's assigned therapist and psychiatrist from the local child and youth mental health team were very active in advocating for Jimmy to return to school. This was very helpful for the school who were concerned at the level of risk that Jimmy could be at during the day while at school. A safety plan was agreed with teachers, therapist and foster mum to monitor Jimmy's emotional well-being regularly and feedback to each other throughout the day and week as needed. The social worker and family preservation workers were able to speak to the traumatic experiences that Jimmy and his family had experienced over many years. Advice was given by the psychiatrist around the mother's needs, which helped everyone understand her limitations when interacting with Jimmy. The foster mother expressed her concern around Jimmy's ADHD type symptoms and the difficulties of getting to school on time due to his anxiety. The psychiatrist and the team explored options around behaviour strategies as well as the option of medication required if needed (PRN). The therapist agreed to see Jimmy at school on Tuesdays as Jimmy struggled to leave school on time to go to any after school appointment. The therapist and foster parent set up a session to explore other strategies within the home to help Jimmy get along better with the other foster children and animals in the home. A follow up meeting was arranged in two weeks to review progress.

The Team around the Child in Care

If a team can be formed that offers the supports for a child in care and extends to incorporate the needs of the foster parent and biological parents then the possibilities of repair and understanding for the child and their family are greatly enhanced. Over the long term, this team can reduce or increase in size by losing or gaining members. The team around the child

should not just meet to crisis manage or problem solve but review the changing needs of a child as she or he moves through the care system. This meeting should be mandated from the time the child enters the care system. The meeting should not be used to gather evidence for child protection proceedings or make decisions around long term care options. The team should aim to establish as many lifelong relationships as possible for that child as they move towards adulthood. The child needs to know that even if their parents cannot be their life long caregivers, there are people who care and who are committed to his or her well-being over time. The team around the child should continue to meet until at least the child is 19 years of age, if the child remains in care. Depending on the age and the child's own feeling, they should have the opportunity be part of these meeting whenever they choose to.

CHAPTER 4 RESULTS

The following chapter will outline the framework of a collaborative team approach for a child in care. The approach will highlight ways to incorporate the themes presented in previous chapters and will provide the reader with a general sense of how the approach would be implemented for a child in care within a regular social services team. The team around the child approach is a plan to help social services workers address some of difficulties they encounter when meeting the needs of children in care within the current system. The objective is to ensure that the best interests of the child are met by holistically addressing the child's needs as well as addressing her or his early traumatic experiences. The hope is that by using a collaborative team approach to a child in care outcomes will be improved for them in adulthood. In this chapter, there will be an outline of the process involved when a decision is made that a child needs to be removed from the family. A timeline will be explored as to when the collaborative team should meet the objectives of the meetings and an exploration of the role of each member of the team. The final section of this chapter will give a fictionalized account of a child's experience with a collaborative team approach as the child moves through the care system.

Coming into Care Using a Collaborative Team Approach

Many children, who are removed from the care of their parents, have to leave in response to traumatic family circumstances. Removing children from the care of their parents should always be the last option when all other and less intrusive ways have been exhausted. Least intrusive ways would include removing a violent or offending parent from the home or agreeing that the child or children be cared for by another family member under an Extended Family Program (Section 8 of CFCS Act 1996). At times the risk to a child can be so high that workers have no choice but to remove a child until further investigation can occur. At times removals can

involve police, social workers, or extended family and the situation can become very hostile. Often social workers need to leave directly with the children as the parents are understandably distraught and angry. Although information is needed about a child's care, often information cannot be obtained at that time due to the high level of emotion and conflict. It is important that at the time of the removal, there are two social workers present. The family service social worker should explain the child protection issues and the process to both the child and family members. The other worker should try and develop an alliance with the extended family and/or parents to look at options within the family for the child, both short and long term.

When a child is removed, the social worker has a maximum of seven days under CFCSA regulations to present to court the information surrounding the child's removal. At this presentation hearing the judge decides whether the social worker was justified in removing the child from the parent's care due to protection concerns. If the judge decides that the social worker was not justified they can order the immediate return of the child to their family. If the judge believes the social worker concerns are legitimate then the family's case is either adjourned for a hearing or an interim order is granted. Interim orders last 45 days. When a case is adjourned, a protection hearing is set.³ A protection hearing can often take months to be organised as lawyers and judges need to coincide dates. The child remains in care during the time it takes to set and complete this hearing. The CFCS Act (1996) dictates how long a child of certain ages can be in government care. For a child five years of age or under, the time is one year. For a child 5-12 years old, it is 18 months and for a child 12 and older the total time in care is two years. The time is adjusted to youngest child if there is a sibling group. The legal clock for

³ A protection hearing is set up after a presentation hearing when the parents dispute the reasons as presented by the social worker for the removal of their child. Evidence is given by the social worker and the parent and cross examined by both lawyers. A judge makes a decision whether the removal was justified and in the best interests of the child

the children and their parents starts 45 days after the child is removed, if at the one year, 18 months or the two year mark the court view that the parents have not made enough progress then the social worker is directed to apply for a permanent custody order. This order ends the custodial rights of the birth parents and when granted allows the child to be placed for adoption.

When to Meet – Often

An initial collaborative team around the child (CTAC) meeting should be convened as soon after the child comes into care and no later than two weeks from the time she or he enters care. After two weeks of the child being in care the protection hearing will have been completed and there will be a timeline of how long the child and family might expect this process to last. A CTAC should consist of as many people that are involved in the child's life such as school teachers, biological family, social workers, family preservation worker, foster parents, and resource workers. It is also important that a child is assigned a therapist from the local Child and Youth Mental Health Team (CYMH) who can attend this initial meeting. The objective of this meeting will be explained in full below. A second meeting should be convened five weeks later, after the second court date and then another meeting should be convened every six weeks. This meeting is in line with the court time frames. A child that is removed and a judge grants an interim order will be in care for 45 days from when this order is granted. These meetings would focus on the needs of the child for consistency, stability, and connection to family particularly parents.

Meetings would be convened at any time when there is a major change in the child's life. For example if there is a change of foster home or school or there is a major change in the visiting arrangements for the parents or if a sibling is leaving or joining the foster home.

Objectives of First, Second and Subsequent Meetings.

The objective of the first meeting is to establish roles and start a working relationship between all members of CTAC. The initial meeting would help members to gain information about the child, understand the routines for school and family visiting. A focus of early meetings should also be to seek out family members that may be able to provide care or a connection to the child in care. A family member can include distant relatives, cousins, great uncles/aunts, as well as family friends. It is also an opportunity for foster, biological parents, and extended family members to discuss the child's needs for stability and consistency. The resource worker can get an idea of the challenges that the foster parents may be facing in regards to the child's behaviour, school schedule and/or visits for the child with their parents. It is a time for the regular social worker and the family preservation worker to be clear about goals for the parents in resuming care of their child. The second social worker can make time to meet with the family to gather more information. The therapist for the child can see some of the dynamics in regards to the child, the parents, and the foster parents. The therapist can explore if joint sessions with the child and the foster parent and the child and the biological parents would be helpful. It is important that this first meeting does not result in a re-examination of the child protection issues. The parents can be reassured that those issues can be discussed in private with the social worker at another time. The second and subsequent meetings should focus on continuing to build good working relationship as well as short and long term planning for the child. CTAC meetings should continue for the duration of time the child is in care and at regular three month intervals.

The Roles of the Individual Members of the CTAC Team

The Role of the Second Social Worker

It is very important that each child that comes into care is assigned a social worker who can focus on information gathering. This worker role is to establishing if there is a family members that can either provides long term care for the child or be a consistent family member (besides the parents) who can connect with the child if they remain in care. Children in foster care feel the difference between themselves and other children who are being cared for within their own family. It is the experience of this social worker that children in care will say that “ a foster family is not same as being cared for by their birth family”. Children describe feeling lonely in care, despite often being in wonderfully caring foster homes (Heineman 2015). The second social workers role is to foster meaningful life-long connections for the child. Every child has family besides parents and siblings. Time and work needs to be devoted early on when a child comes into care to finding and engaging them. The second worker’s role within the CTAC approach is very important as they are constantly looking to see if there is an option for the child to leave care and move to the care of a family member.

Role of Aboriginal Band Worker

As explored in Chapter 2, aboriginal children are over represented in the foster care system. Every aboriginal child belongs to a band, and this band should be identified and be included in the planning for this child from the time the child is moved into care. All aboriginal bands have representatives who can become involved in planning for the aboriginal children in care. An aboriginal band worker offers important supports to the parents, the child, and to the foster home. Some band workers will become more involved than others. For example, Squamish Nation workers have protocol arrangements with MCFD that all meetings with the

child and/or the parents should be convened only with a band worker present (Squamish Nation and MCFD 2009). If a Squamish Nation's child becomes a permanent ward of the court then the Squamish Nation guardianship social worker takes over the guardianship duties for that child. A good working relationship between the members of the CTAC team and the band worker is essential especially the second social worker and the foster parent in understanding and keeping the child connected to their culture.

Role of Family Service Social Worker

The Family Service social workers role within the CTAC meetings is to keep the group updated around the court process as well as ensuring that all of the child's needs are being met while in care. It is important to remember that Family Services workers have dual roles—they are the guardianship worker to the child as well as responsible for managing the child protection issues. While in the CTAC meetings, the family service worker should focus more on their role as a guardianship worker to the child but the other members of the team should remember the family service worker's overall responsibility of ensure the child safety and reducing the risk of harm to the child. All the needs of the child should be discussed including her or his connection with parents and extended family, school life, medical and dental needs as well as immediate and long term emotional needs. For all children but particularly aboriginal children, there should be a discussion around how the child is being kept connected to their culture. It is the family service worker's role to ensure that the CTAC meetings continue to occur frequently.

Role of Foster parent

A foster parent should attend all meetings and should have her or his resource worker present with them. The foster parent has the role of updating the CTAC members on the child's

needs and challenges while they are in care. It is important that other members of the team support foster parents in sharing all the issues they are facing with the child as positively as possible. Often foster parents will not highlight the challenges they are facing for fear that their parenting is criticised by other professionals present. Other foster parents will only highlight the challenges when they are feeling overwhelmed and a crisis has developed. All foster parents need practical and professional support of a team that can provide advice and guidance regarding the experiences of the child. The therapist and other members of the team can hear how the foster parents are working with the child and suggest interventions that might be helpful. CTAC meetings can also provide opportunities for the foster and biological parents or family members to build a good working relationship with the support of the rest of the team. The meeting can also allow an opportunity for foster parents to be very clear about how long they can provide care to a particular child. Often workers will assume that a foster parent will continue to provide care to a child for as long as it takes. However, it has been my experience that foster families are similar to all families. Events can occur in foster parents' lives that can make it difficult for them to continue on providing the needed care to a foster child. Illness or death of within their own extended family members, unemployment, the birth of a child or grandchild, changes in their own health, are examples of events that can radically change a foster parent's ability to make a commitment to a foster child. A lot of foster parents can be at a point in their lives where they are caring for aging parents and have grandchildren of their own. It is important that the CTAC team knows that some foster families can care for a child for only a particular length of time. The team should plan around this length of time and take this time into account in their long term planning for the child. Any further disruption in the continuity of a child's care should be avoided at best and planned for if unavoidable.

Role of Resource Worker

Each foster parent is assigned a resource worker. Resource workers usually have 3–5 years of experience working within child protection services before becoming a resource worker. Resource workers play an important role in the quality of care a foster parent can provide to an individual child. Each foster parent comes to fostering with unique hopes, wishes, and expectations of what being a foster parent will be like. Some foster parents are very realistic about the care they provide while others are not. Without the full information about a child's circumstances, guidance regarding presenting behaviours and support from their resource worker, foster parents will struggle to meet the needs of their foster child. Resource workers need to be well-trained in the signs and symptoms of trauma for a child at the varying levels of development. The resource worker may need to connect with the second social worker and family services worker individually to ensure they have as much information as possible regarding the child. Most resource workers have access to the child case file to gather this information for the foster parent. A resource worker also needs to be aware of the foster parents' limitations and what supports and challenges they will face. It is important that a resource worker ensure that at the time that a particular child is looking for a foster home to try and match the needs of the child and the abilities of the foster parents. Often a child or children are removed without an opportunity for planning and matching. Children can be placed in emergency foster homes that can only care for the children for a short period.. The foster parents are often asked to take on a child outside of what they had planned for until a more suitable home is identified as there no other homes available at the time of removal. The resource worker plays an important role to ensure that CTAC members do not place too much pressure on foster parents to carrying on regardless of circumstances. Moves of homes for a foster child should always be kept to a minimum so it is important that the CTAC members plan moves for a foster child with as much

planning, preparation, and matching of the child's needs to a particular foster parent. If a subsequent move for a child is necessary including moves to relatives or back home, this issue should be a key part of the CTAC agenda. The resource worker with the foster parent plays a big role in preparing the child and the foster parent in regards to settling into a new home, moving from a home, and/or moving back home to their family.

Role of the Therapist

The therapist assigned to the child in care plays an important role in advocating for the child's emotional needs throughout the time they are in care. It is important that the therapist is proactive in gaining as much of the child's history as possible. The therapist should understand why the child came into care and develop a working relationship with at least the foster parent but ideally with both the foster parent and the biological parents. The therapist is responsible to provide emotional support to the child through their individual session but can also offer support to the foster parent and biological parents. This can be done through session in which the foster or biological parent can focus on understanding the presenting behaviours of the child and speculating on the reasons for those behaviours. Interventions that promote emotional attachment can be planned.. This work can be very helpful to the foster parents in particular, if provided in a timely way it can improve the relationship between the child and the foster parent. A therapist can also work with the biological parent, particularly around visits with the child. Children in care often have weekly visits with their family. These visits can range from a supervised hour visit in an office to day visits at the family home or in the community depending on the level of risk the parent's poses to the child. The beginnings, endings, and lead up to these visits can be very emotionally for the child, the family member, and the foster parent. Biological family

members often benefit from guidance and exploration of the range of feelings that can occur for their child and themselves. Some biological parents have had care experiences of their own which can affect their ability to trust the care foster parents provide (Murray 2015). Often biological parents report an inability to trust the foster parents and they may need help to interact appropriately with the foster parents. The therapist can provide a safe space to explore those feelings that family members may have towards the foster parents and their children being in a foster home. This can be as straight forward as providing one or two sessions to the biological parents around this work. A therapist can also be in a position to refer the parent to other services that can help the parents explore their feelings in more depth if necessary. The child's therapist also has an important role to play in providing guidance to the CTAC team around the relational needs of a particular child in regards to long term planning for that child as they move through the care system. This work is built on the therapist developing a trusting long-term relationship with the child through sessions.

Tom – A Child in Need of Care

Tom and his family were known to child protection services since he was six months old. His teenage mother, Gloria, left Tom in the care of her mother shortly after his birth and had infrequent contact with him. Tom's teenage father had no contact with him. Tom's grandmother struggled to care for him due to her own issues of abuse as a child and domestic violence as an adult and addiction. Tom and his grandmother, both of Aboriginal descent, lived on reserve land. Over 10 years, Tom was found in need of child protected services on five different occasions due to being left unsupervised or home alone. Many services were put in place over the years, including supports to his grandmother and to other family members in an attempt to support them in providing better care for Tom. Tom presented at school with high anxiety about his own

safety and his grandmother. At 11 years of age Tom's grandmother came to social services with Tom and asked for him to come into care. She no longer felt she could provide the care he needed after she had recently been diagnosed with cancer.

Initial Meeting

The first CTAC meeting happened 10 days after Tom came into care. The court had supported the removal of Tom from his grandmother and agreed that Tom should be in care under an Interim Order. His foster parents, resource worker, band worker, Tom's therapist, family finder, family service worker, grandmother, and Tom's Grade 6 teacher were all present at the initial meeting. The second social worker was able to meet previously with the grandmother and had agreed to a further meeting with extended family who wanted to connect with Tom. The team heard from the grandmother regarding Tom's early experiences and the many different caregivers that he had experienced. The grandmother also reported months of time when she did not know about Tom's experiences and worried about the family members who had cared for him. She wondered whether Tom had experienced abuse during those times. The grandmother agreed to meet with the therapist with Tom and individually. The grandmother also identified several family members who would like to visit with Tom. Tom's mother was in a new relationship but had expressed an interest in meeting with Tom. Tom's school teacher was able to provide information regarding Tom's difficulties at school and Tom ongoing need for a psycho-educational assessment. The band worker was able to provide a space for family members to meet at the local band office and a youth worker for Tom who could meet with him after school and take him to local canoe club with other children from the reserve. The grandmother agreed to work with the family preservation worker to help address past experiences of trauma that were impacting her parenting and to connect her to a group of

grandmother's supporting their grandchildren in her local area. Tom struggled with being alone in another room in his foster home or at school even for short periods. Bedtimes were very difficult. The team worked on strategies around how to help him stay safe and tolerate anxiety when he was alone. Family service worker agreed to provide a cell phone to help Tom in times that he felt overwhelmed at school and needed to talk with his foster parent. School provided a high level of supervision to ensure that Tom does not have times when he is alone at school. The therapist agreed to consult with a psychiatrist regarding Tom's anxiety and to explore whether medication or more in depth talk therapy may be an option to help him through the next few months. A planned visit with the grandmother supported by the foster parent was agreed on and was scheduled to occur weekly at the local band office.

Subsequent Meetings

Tom has been in his new foster home for six weeks. His foster parents report that there have been many anxiety filled moments but overall Tom is beginning to be able to be alone for short periods. Bedtimes continue to be very difficult. His foster parents have been helping him with falling asleep with a good routine, bath, bed, and book, as well as melatonin at times. Tom was struggling to attend school but is better when he has one to one attention. His psycho-educational assessment was scheduled for next month. The second social worker had several meetings with the family and some discussions with Tom's mother. While she is unable at this time to provide full time care for him, she would like to see Tom. Several family members have offered to visit Tom and have Tom for overnight visits. Family Service worker was working to assessing family members for overnights stays. One cousin living in another province has expressed an interest in caring for Tom but would like to get to know him before committing to a long term home. Tom has had a first meeting with his cousin and her family. Tom has been

attending therapy weekly, he struggles to “open up” in therapy but will spend the time building models and talking through school and friendship issues. The therapist is finding out about some early memories of the many caregivers and is seeing the beginnings of some of Tom’s attachment styles. His foster parents report that he will often come home from therapy and be “very clingy” to foster mum for the rest of the day.

Tom’s story and the work of collaborative team show the many obstacles and practicalities that need to be discussed in regards to the care of Tom. The meetings provide a base for the exchange of information, plans on how to address issues and opportunity for review that is important in planning for Tom. The timing of the meetings also matches the flow of court process. It also allows for monitoring of Tom’s anxiety issues across a variety of settings. The meetings also focus on maintaining the connection between Tom and his birth family. This chapter has highlighted the need for collaboration with many professionals alongside the family and foster family. This chapter also highlight the importance of timescales. Court time scales need to be taken into account but also it is important that all the professionals working with the child in care ensure that there is no delay for the child in putting plans for them into place.

CHAPTER 5 DISCUSSION

This chapter will highlight the benefits of working collaboratively as a team around a child in care. The stories of Michael, Tom, and Jimmy will be reviewed and will highlight the difficulties for workers in meeting the needs of children in care. The children's life stories, albeit fictionalised, are a combination of the lived experiences of many children in care. Their stories give us an insight into their difficulties and key moments when an appropriate intervention could have changed or did change the outcome for these children. Tom's story in particular highlights how when the workers who are engaged in the lives of these children work collaboratively, significant changes can occur. This chapter will also look at the areas for further research and limitations of this thesis.

Michael's story highlights the role of the therapist in collaborative work with children in care and the importance of gathering as much information about a child's early life experiences. There is a focus in Michael's story on how a therapist can use the information she or he gathers about the child's early experiences and connects it to the child's day to day functioning. If a therapist had been able to link Michael's early experiences to the behaviour that the foster parents were managing and found a way to relate this to both Michael and his foster parents, this might have provided the vital attachment work needed to help Michael and his caregivers. Michael's story also highlights the need for children in care to do joint work with their foster parents and if possible their birth parents, to help all their parents understand how attachment and trauma affects a child's in their day to day behaviour. This is very important for children in care, particularly those who are in long term care.⁴ Therapists working with children in care should place importance in their work on increasing the foster and birth parents understanding of the child as well as finding strategies for the foster parent that promote the attachment between the

⁴ A child who is a permanent ward of the court or has been in care longer than a year.

foster parents and the child. Michael's story also highlights how some well-intentioned interventions that are offered to children in care such as respite to the foster parent can further damage already difficult relationships between foster parent and child. Respite for a foster parent is often offered to give caregivers a break. However respite for the child in care often means that different caregivers are introduced to the child or the child has to leave the foster home to stay for a day or two a month with another foster family. This intervention can exasperate the emotions of an already distressed child. Finally Michael's story speaks to the missed opportunities for exploring the past and possible future role of other members of Michael's extended families. Every child in care from the moment she or he comes into care, needs a significant amount of time dedicated by workers to a family finding process. This process needs to explore all sides of the family including the often "missing" father's family. Every child has two parents and it is important for the child that attempts are made early on to nurture and strengthen family relations and understand what members of the extended family can offer to a child in care.

Jimmy's story highlights the individual roles of the collaborative team. His story shows how collaborative teamwork can greatly benefit a child in care in particularly regarding their school placement. A child in care's school life is important and a lack of success at school can negatively impact her or his mental health (Pecora et al., 2005). Children in care often experience moves of school due to moves in their living arrangements. These moves may be unavoidable but these children can also lose their school placement due to their own emotional struggles. A move to yet another school is another break in their attachments that needs to be avoided as much as possible for a child in care. Jimmy's story highlights the need for psychoeducational support to his teachers and practical interventions to help the teacher with the child in their

classroom. The therapist and the social worker need to work closely with the foster parent on strategies before, after and during the school day. The therapist should also have the opportunity to go into school and offer types of support such as exploring with the teachers the purpose of some of the behaviours of child that the teachers are finding problematic. Jimmy's story also highlights the need for the team to work closely with the child's psychiatrist, if a child has a diagnosis. Medication should be part of the discussion and should not be seen as a last resort but as part of a temporary plan for a child to help them with behaviours that put them at risk of losing their school placement. It is also important that teachers and foster parents as well as the child are all monitoring the effects of the medication and ensure that its use is regularly reviewed. No child in care should stay on medication for long periods of time without exploring other strategies. This collaborative work with the therapist, social worker, foster parent, child, and their teachers can greatly improve the education outcomes for children in care.

Finally Tom's story and his collaborative team shows how even when a child comes into care in an emergency situation, a collaborative approach can offer an immediate structure to start to work on issues and make long term plans for Tom. One important area in Tom's story is the work of the second social worker in gathering information. Identifying the members of a child's extended family should be central to planning for all children in care. Every worker on the CTAC should be committed to finding options for the child that ends their time in care and places them with their family or their extended family. All CTAC meetings should have the focus of "birth family first" as the central to their approach. Even if a child cannot return to live with their birth parents, connecting, reconnecting or finding new family members is important to both repairing their early life experience and providing lifelong family relationships that are essential to these children when they age out of care.

Overview

Children in care are a uniquely vulnerable group of children that are looked after through a government system with many different workers undertaking many different roles. All the workers have the same aim in meeting the child's needs. However without a collaborative therapeutic approach the needs of children in care are not always met. There is a need for a change in the way that social workers deliver services to children when they enter care. Collaborative teams around the child (CTAC) help to focus on meeting the holistic needs of children in care. CTAC meetings are organised in a timeline and focus on the short and long term needs of the child. There is an emphasis on family finding for every child in care.

This thesis also highlights the need for all children in care to have therapeutic interventions that meet their unique needs. Every child in care should be assigned a therapist from the day she or he enters care. This therapist should not just stay connected to the child while in care but be a central member of the team around the child. It is understood through the literature review that secure attachments for all children are a key component to their emotional well-being. For children in care their early attachment experiences can damage their long term emotional well-being. Children in care need the opportunity for therapeutic interventions that are sustained, long term, and that focus on building or rebuilding relationships. Therapy with a child in care needs to continue as long as is needed by the child in care need the time to unfold their early experiences.

The purpose of this thesis was to elaborate on the needs of this vulnerable group of children and provide an approach that is both therapeutic in its presentation and collaborative in its delivery. No one worker, foster parent, or family member can meet all the needs of a child. A Collaborative Team around the Child (CTAC) is needed to ensure the best possible outcome for

these children as adults. It is my hope that this thesis has provided a structure for social service workers that could be implemented within the current childcare system.

Where to go From Here...

In an ideal world children would not need to be to be in foster care. A CTAC approach would be implemented by social workers for children who are at risk of coming into care. If a child does need to come into care, family first, should be emphasised. This thesis is advocating for a better system that ultimately works to eliminate the need for foster care. It is possible to achieve this “better system” with children and their families if works starts early on. Families where children are at risk of coming into care or are removed into care, need intensive work that has a focus on placing children with family members whenever possible. For children who need to come into foster care, the focus needs to be on shortening the period of time they are in care by finding permanent homes. Family members who step forward to provide a home for these children in care need to be given as much support as necessary to ensure they can provide for the child including financial, practical and emotional support. Therapy for the child and their family should be central to the planning for the child.

This approach also needs to be offered in a culturally appropriate way, particularly for Aboriginal children. Government agencies need to improve their working relationship with First Nations workers who are directly engaged with families in which children are in care or at risk of coming into care. Training that informs social workers and therapists about the long term effects of colonisation and residential school abuse on the current lives of children needs to be mandatory for all social workers and therapists working with children in care. A CTAC approach needs to include a band member and/or elder if a child is Aboriginal.

This thesis focuses on the needs of a child in care from a relational perspective. In researching this area, my understanding of the needs of this vulnerable group of children has increased. Children in care have similar needs to children not in care but they also have unique needs. Children in care need therapeutic intervention to develop healthy relationships as they grow and there needs to be a focus on cultivating, nurturing and maintaining long term relationships (Heineman 2015).

Areas of Further Research

Longitudinal studies that follow children through the care system would be very beneficial in understanding the needs of children in care particularly around areas of attachment and loss. This research would include talking to youth who have aged out of care. It would be beneficial to follow the recommendations or suggestions of these youth. There is also a need for more research around foster parents and their homes. Particularly a focus on foster homes that break down after the children have stayed there for a number of years. This research could focus on what would have helped these foster parents over the years that may have prevented the breakdown in the foster home.

In UK there is currently an approach referred to as Team around the Child (TAC) which is part of an approach to all children who are assessed as having additional needs or complex needs including children in care. The approach can be put into action by anyone working with a child who has additional needs, including teachers, health professionals, probation officers or foster parents. I would curious to know how this approach is being used, how is it affecting the work of professionals working with children in need and how the children and their families are experiencing this approach.

Limitations of This Thesis

The ideas of this thesis are based on my experiences as a social worker working with children in care in Canada and UK over the last 15 years. Therefore this thesis is limited by this experience. Although I have worked with families from many different racial and ethnic background and families from a variety of socio-economic backgrounds, a collaborative approach is going to be limited in its approach with different ethnic groups. It is therefore important that the social workers involved with the family work closely with elders and leaders that belong to the home community of the family.

The focus of this thesis has been on children in care where a return home is unlikely, it is unclear whether an approach as outlined would work with children in short term care and if there is need to modify the approach to meet the needs of children in short term care.

Last Words

Social services agencies need a structure that allows workers to work collaboratively, working as teams of workers around a child in care. Without this collaborative way of working children in care runs the risk of a being lost to the care system, aging out of the system isolated and unprepared for adulthood. The present delivery of services that provides different services to a child in care in isolation from each other is not sustainable. From the point of view of a child who is being cared for within system it is indefensible. By providing a collaborative team around the child in care, the child and their family can be supported and their needs met through providing services that are planned and delivered in a co-ordinated way. It is hoped that every child in care can have a team of workers who can provide integrated, high quality, co-ordinated supports for the child that will allow them to successfully transition into adulthood.

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