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Contents

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Editorial

Explorations into Diverse Relational Interventions

Dr Rika Swanzen

At the end of 2020 many of us mirrored the resilience we found within reflection and care. Another year has passed with some delayed dreams and for some immense sadness. This space of reflection within the context of relationships remains the place where we find deep treasures within ourselves, others and our practice. Someone once told me that what we focus on outside reflects what we feel inside. I have been amazed at how those in our field continued to show that their focus is on the care of young people. Claude Monet said that it's on the strength of observation and reflection that one finds a way; so, we must dig and delve unceasingly. With the reading of this last issue of 2021, I trust that you will also have admiration of how much other have delved into the space of relational child and youth care.

From KwaZulu-Natal in South Africa, you will find results of a study on food security for child headed households. The piece shares direct voices from these youths and highlights where they typically find support for themselves and their siblings in their community context. On the other side of the intervention spectrum an alumni study on youth aging out of the Udayan Care *Ghars'* LIVE model in India, unpacks the ways in

which the care leavers received help to adjust to independent living. Again, these youths' voices are represented in the findings of what support they find most useful and what services may be lacking, including findings on the impact Covid had on their mental health. From New Westminster in Canada an exploration is done on embracing interdependence that is part of emerging adulthood for youth who age out of care. An interesting analogy with an exoskeleton is used to propose (and critique) the acceptance of an additional developmental stage, to fully understand and support a neglected part of our population who are often identified as being at risk.

Further representation of various levels of intervention is supported by an exploration from the United Kingdom, on how 'co-adventuring' creates a space to be in the moment as an alternative to traditional concepts of therapy. A context created to understand suicidality in residential care, from Calgary in Western Canada, offers two proposed forms of interventions: intentional day-to-day activities focusing on addressing the effects of trauma, and mindfulness or emotional regulation group sessions. In a similar vein we find deeper explorations of 'vulnerable little hearts' by speaking to the enduring of adverse childhood experiences, the collective efforts of resistance, and the 'blanket of healing'. From Gauteng in South Africa the strive for a relational response to the global pandemic is unpacked. Lessons learned are shared on how the balance between adhering to regulations, while meeting the needs of children were managed.

Moving further on the continuum of interventions to secure care recidivism is critically reviewed from Novia Scotia in Canada, through an investigation of various programmes focusing on reducing reoffending by young people in conflict with the law. With restorative justice being such a key focus in the juvenile justice system in countries like South Africa, the effectiveness of an approach requiring remorse is questioned.

Within the education and training space the continuing theme of delving into our practices took us to the need of educators to use teaching strategies intentionally to support students, relationally, through their post-secondary adjustment challenges. Out of Nisichawwayassihk Neyo Ohtinwak Collegiate the concept of time from a Jamaican frame of reference is explored with regard to its social cultural reality.

With all the contributions to this journal issue, real-life, practice-based evidence is provided from lived experiences that focus on the notions of care. We soldiered on this year, to respond to the needs of those we took responsibility for. Among the many debates we had to position ourselves in; to vaccinate or not, public safety versus freedom of choice, to isolate or socialize; and to consider physical or mental health – we still know, what matters most is the relational space. May you fully appreciate the space you have this new year, where you can authentically say that you are safe relationally.

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Food insecurity and hunger: The experiences of child-headed households in a selected community in Kwazulu-Natal, South Africa

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Abstract

Child-headed households (CHHs) is a global phenomenon. Children heading households often lose access to adequate food when their parents die or when parents abandon them. This paper aims to share insights into the experiences of CHHs regarding food insecurity in a community called Ingwavuma in KwaZulu-Natal Province, South Africa. Individual semi-structured interviews were conducted with twenty children who were the heads of their households. The results of this qualitative research revealed two main themes: access to food and gaps in social support networks.

Introduction

Child-headed households (CHHs) became more prominent in the past twenty-five years due to the AIDS epidemic that has resulted in the death of adult caregivers, leaving children orphaned and having to bear adult responsibilities (Marongwe, 2014). While CHHs is a phenomenon across the nine provinces of South Africa (SA), KwaZulu-Natal (KZN) has been the focus of this paper. The study setting in KZN was chosen because

one of the researchers worked as a social worker in that area for eight years and, during that period, she came across many CHHs who, amongst other psychosocial issues, were greatly affected by hunger due to the absence of an adult provider and regular income.

The targeted population group in this study were children from CHHs in the Ingwavuma area of Jozini Municipality, KZN. Ingwavuma is a rural town where people are greatly affected by poor service provision, high poverty and lack of development, with CHHs at greater risk of food insecurity (Integrated Development Plan [IDP], 2013). In 2011, Ingwavuma had a total population of about 1 303 people (Statistics South Africa [Stats SA], 2013). Most of the population (90%) earn less than R1 600/month/household, and about 49% of the population have no stable income (IDP, 2013). As a result, there is a vicious cycle of poverty and CHHs are at greater risk. Most families, including CHHs depend on social grants from the government as their main source of income (Stats SA, 2013).

Challenges with accessing food

Most of the children in this study did not live with the people that were receiving the child support grants on their behalf. As a result, they had to travel every month to those people to fetch the money to buy food. One participant said that she receives her siblings' grant and the other three stated that their adult relatives received the grant on their behalf. Although the majority had some form of support from relatives, it remained their responsibility to provide food for their siblings.

> It is my responsibility to provide my three siblings with food. I have to see to it that in the house there is food and other basic needs. I must go to my sister in Bhambanana and fetch the child support grant (CSG) that she receives for my siblings and then see to it that there is food in the house. (Participant H)

> It is my responsibility but my brother who works in Johannesburg mines sends me money every month and I use that money to buy food. (Participant B)

> I'm the sole provider for my siblings, for everything you can think of. (Participant F)

This finding concurs with a study by the Gauteng Department of Social Development (DSD) (2008), Mogotlane, Chauke, Van Rensburg & Human, (2010); and by Ndaleni, (2012), who found that children heading households do various care-giving responsibilities which, besides supervising their younger ones, includes fending for their siblings and ensuring that they have food and clothing.

Only three participants reported eating three times per day. The rest stated that they ate two meals per day. The third meal most of them ate was at school and this was only during school days. On weekends and holidays, most of them ate only twice. They only ate twice a day for the food to stretch until they could buy food again.

> I eat last night's leftovers in the morning, then eat at school and only cook supper. During the weekends and holidays, I eat only twice per day because there is not enough food to last us the whole month if we cook more meals. (Participant P)

> I eat only twice a day, at school and dinner at home. If I don't go to school, I eat from my neighbours and then in the evening at home. We only cook once. (Participant J)

This finding was confirmed in other studies (Blaauw, Viljoen & Schenck, 2011; Gauteng DSD, 2008; Mogotlane et al., 2010; Thwala, 2018), who found that most children in CHHs ate only once or twice per day. According to the United Nations International Children's Emergency Fund (UNICEF) (2014), these children often go to bed on an empty stomach because of lack of food in the house.

Food such as rice, canned fish, stiff *pap* (maze meal) and beans was the most consumed food by sixteen participants. All participants indicated that this was not their food of choice, but it was cheaper, lasted longer and made them full.

> I usually eat rice with tinned fish and stiff pap with beans. If I change, it will be rice and beans and stiff pap with tinned fish. (Participant K)
>
> I eat bread most of the time, bread with sour milk, bread with vegetables and sometimes just bread with peanut butter. (Participant J)
>
> I usually eat stiff pap and vegetables such as cabbage and spinach and also rice and tinned pilchards. (Participant T)

Similar findings were reported by Oxfam (2014), as well as Ngidi and Hendriks (2014) who found that households that experienced hunger relied on less preferred (beans than meat) and inexpensive food every day. Mthethwa (2009) found that children in CHHs consume less preferred food due to poverty. It can therefore be concluded that children heading households do not necessarily take into consideration the food quality and diversity in terms of different food groups when purchasing food due to their financial constraints.

Sub-theme: Not having enough food to last a month

Most participants said that their food was usually finished in a week and sometimes days before the end of the month. Only two participants had enough food for the whole month. Those who ran out of food before the month ends, begged for food from neighbours and relatives. They first asked for food or money from their relatives, who usually helped them, before they asked from neighbours.

> We run out of food towards the end of the month, usually a week before month ends. I then will call my aunt and ask for money or food. (Participant A)
>
> Food always gets finished a week and some few days before we get the social grant again and we just have to wait or ask for help from the neighbours. (Participant P)
>
> We only have food the first two weeks of the month and then after that I have to buy more food on credit from our local tuck shop and

> still it doesn't last the whole month but I can only buy a little on credit otherwise we won't be able to pay back the money. (Participant L)

These findings are congruent with the findings of the Gauteng DSD (2008), Gorongo & Moyo (2013), Mthethwa (2009), Ndaleni (2012), and UNICEF (2014), who found that most children in CHHs never had enough food to last them the whole month due to their minimal monthly incomes. Ngidi and Hendriks (2014) found that, in Jozini, people resorted to buying food on credit when they were faced with hunger and that increased short-term household food availability.

Support from relatives

Half of the participants expressed gratitude for the support they received from their relatives who lived elsewhere. They indicated that with the help from relatives, they were able to go to bed with at least something in their stomachs. The other half stated that they did not get any help from their relatives. The ten who received help said that this was sometimes in the form of money to buy food but in most cases they were given food items such as cooking oil, sugar, salt and mealie meal. The other ten said they had no relatives in South Africa as they were originally from Swaziland and they never asked for help.

> My only relative who helps us is my grandmother who lives in Ntabayengwe. She is receiving the FCG for my three siblings and whenever we need help I ask her. She is the only one who helps us. (Participant G)

> I don't have any relatives around here. I'm originally from Swaziland and all my relatives are there. I don't ask for any help from them because they are also poor, struggling more than us. (Participant O)

Multiple studies (Farzana, Rahman, Sultana, Raihan, Haque, Waid, Choudhury & Ahmed, 2017; Nziyane & Alpaslan, 2011; Thwala 2018) found that extended families are often a source of support. Thwala (2018) found that orphaned children who received

support from extended family, had better access to basic needs compared to those who had no support from relatives. The HIV and AIDS epidemic has further eroded the traditional system of fostering orphans due to socio-economic factors (UNICEF 2014). As a result, relatives are finding it hard to help children in CHHs as they are also struggling to meet the basic needs of their own families (UNICEF 2014). Therefore, CHHs remain vulnerable to food insecurity as extended families are not able to integrate them into their own families due to economic hardships, among other reasons.

Support from neighbours

Twelve participants indicated that they depended on the kindness of their neighbours for food; and that their neighbours were generous to them as they gave them cooked meals.

> Yes, we get help from our neighbours. They give us whatever we ask. Sometimes they just call us to give us cooked food and other things if they have surplus. Our neighbours are so kind to us. (Participant B)

Some participants did not receive help from their neighbours, and the reasons included that their families did not have good relationships with neighbours, and they feared being poisoned. It was clear that the children's families did not have good relationships with the neighbours (mesosystem) even when the children's parents were still alive. Therefore, it can be concluded that the relationships of CHHs with their microsystem such as neighbours, have an impact on children's access to food and support in general. In this study, the bad relationships between eight participants' families exacerbated the children's vulnerability to hunger as neighbours would not help them with food or anything else.

> I don't get help from my neighbours. They are not good to us since my parents were still alive. We never asked for anything from them. I even fear that they can poison us. So we would rather die of hunger. (Participant C)

> No, I don't get help from my neighbours. They are the ones who come and ask for food from us. They are struggling more than us. (Participant H)

Neighbours can be a great source of support to CHHs; however, due to strained relationships between families and also economic hardships, most neighbours are unable to help (UNICEF, 2014), which has left many CHHs vulnerable to hunger as they lack support from their neighbours and the community. Also, due to economic hardships, neighbours are also greatly affected and not always able to help. However, the relationship between children in CHHs and their neighbours is crucial as it determines the support that neighbours will give. Bad relationships exacerbate food insecurity in CHHs as neighbours cannot help with food or the children in CHHs will not ask neighbours for food.

Support from the church

Only six participants reported receiving help from the church, and these were churches that they are affiliated to. The rest said that they did not get any help from the church. Of the fourteen who did not receive any help from the church, eight did not belong to any church and six stated that they never asked for food from their churches.

> I don't get any help from the churches around here and I also don't go to any church. They want offerings but they don't give to the poor. I stopped going to church. (Participant K)

> I don't get any help from my church, maybe because I also don't ask for help. (Participant N)

> Yes, I get help from my church each time they have big services. I get a food parcel and my pastor's wife always ask me how we are coping. She helps us with cooked meals and clothes also. The other congregants also help us. (Participant Q)

Churches have a role to play in looking after orphans and therefore should create a supportive environment where children in CHHs feel accepted and supported (Ntangeni,

2005; Maqoko & Dreyer, 2007). Pastoral care and counselling are crucial to alleviate hunger, provide care and protect children in CHHs. Maqoko and Dreyer (2007) state that pastoral care involves pastors functioning as caregivers to vulnerable people, especially CHHs. However, most participants did not get any support from the church in their community. The support that was received by some, played a significant role in their lives as they could get food amongst other material things from the church members. Although the church helps children in CHHs, it has been silent in caring and supporting CHHs.

Support from school

Most participants (eighteen) said that they were beneficiaries of the National Schools Nutrition Programme (NSNP). They stated that they ate a full, healthy meal and a fruit at school every day except on weekends and holidays. Sometimes they were given leftovers to take home and assisted with school uniforms and food parcels by their teachers.

> We eat a nutritious meal at school every day except on weekends and holidays. I no longer buy school uniform; we get uniforms at the beginning of each and every year now from our school. Teachers give children from CHHs leftovers including fruits and at the end of each term, if there is food left, they make food parcels for us. Even vegetables from our school garden, they give us. My class teacher even gives me money to buy bread sometimes. (Participant H)

> My siblings and I eat at school every school day and if there are leftovers my teacher gives me and we eat that for supper, so we don't have to cook. (Participant Q)

This finding concurs with reports that a large proportion of children attending school in South Africa receive a nutritious meal (Department of Education 2016; Kelly & GroundUp Staff 2016; NSNP 2017). However, two participants reported not receiving any support from school. For one participant, it was by choice because he did not want to eat from the NSNP. The other one stated that she receives no help from school as she was currently at home on maternity leave. She said:

> I'm currently not getting any help from my school because I'm not attending school. I just gave birth and will only go back to school next year. But my siblings eat at school. (Participant N)

> I choose not to eat at school because I don't like the food they cook at my school. The aunties cook rice and fish, cabbage and beans with mealie pap. That is the food I always eat here at home and it's too much for me to eat it over and over. (Participant A)

Blaauw et al. (2014) concurs with the above sentiments in their study on CHHs in Gauteng where they found that children's meals lacked diversity of food groups. Although the food was nutritious, in some instances it was boring and not appealing to the children as they ate the same food almost every day. According to the KZN Department of Education (2017) learners were not being given proper food in some KZN schools due to corruption by some service providers.

Conclusions

This study investigated the experiences and challenges of child-headed households regarding food insecurity in Ingwavuma. Most children relied on social grants (foster care grant [FCG] and child support grant [CSG]) to provide for their basic needs. Support from relatives, neighbours, school, church and friends helped ease their need for food. However, such support appears haphazard and infrequent. Nevertheless, the church and school seem to be the most reliable sources of support in alleviating hunger, and should therefore be strengthened in their efforts to meet the basic needs of CHHs.

The Children's Act (38 of 2005) ensures that children that are orphaned, living on the streets, or not safe at home or in their communities can be placed in alternative care. Although it is regarded as the last option, Child and Youth Care Centres (CYCCs) play a significant role in accommodating these children who need care and protection (UNICEF, 2014). CYCCs address diverse issues facing children as a result of the breakdown of the family system either due to death of parents, divorce, abandonment or abuse. It is through these CYCCs that such children are accommodated and cared for in a homelike environment (Blaauw et al., 2008). Children in CYCCs in South Africa are offered

recreational, developmental and therapeutic programmes (Children's Act, 2005). They are looked after by professionals, provided with a comfortable home, food and basic essentials (Kelly & GroundUp Staff, 2016). Moreover, CYCCs allow a cooling-off period for a child from a difficult home environment (UNICEF, 2014). The programmes are meant to enhance the wellbeing of the children so that when they go back to their communities they become functional again (Children's Act, 2005). Children in child-headed households are vulnerable to abuse, hunger and exploitation (Ndaleni, 2012). They do not have adults who can supervise and guide them and CYCCs can play the role of a parent or caregiver which is greatly needed for their survival and development. In CYCCs, the children's basic needs such as food or nutritious food are met and children are given the opportunity to be children and not adults before the right time.

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Assessing the Impact of the Transition Process on Care Leavers of Udayan *Ghars*

Kiran Modi, Gurneet Kalra, Leena Prasad and Najibullah Zadran Babrakzai

Abstract

As a provider of child and youth care over the last 27 years, Udayan Care has always reinforced its approach of providing a safe, nurturing and loving 'family' environment to children and youth without parental care, who get cared for under its Udayan Ghars ('Sunshine' group homes). While all children attaining 18 years of age are continued to be supported under our Aftercare programme, our relationship and attachment with them does not end even after they exit this phase, as they become independent and mainstreamed in society. Largely known as "care leavers", there is enough evidence that shows that they need continued support and platforms that keep them connected as members of a larger ecosystem of a family and community around them.

As evidenced from various studies on care leaving, the pathways of care leavers are full of challenges as they are one of the most vulnerable groups in society (Höjer & Sjöblom, 2014). The present study aims to understand and assess the situation of care leavers, who are now alumni of Udayan Care, who had completed their transition process with or without a supportive service in the form of Aftercare and later support provisions as alumni as well, and also seeks to understand the impact of COVID-19 on their well-being. It records their experiences around well-being in their own words, as also an assessment of services made to them and their impact on their present life, as well as what could be the possible ways of improving their life situations through further continued interventions and processes. The collective pathways of alumni care leavers also provide deep insights for developing the current Aftercare programme.

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Introduction

Parents shape the lives of their young ones. Children learn to love, care, think, make decisions, and live fearlessly thanks to their guidance. Unfortunately, currently 140 million orphans reside in different corners of the world, many more with families not fit to care and protect their children: countless unimaginable issues plaguing them, preventing proper growth and progress of these children (UNCRC). The United Nations Convention on the Rights of the Child, (UNCRC), comprising of 54 articles, prescribes certain guidelines to be followed when children are no longer safe or cannot be accommodated in their birth families. Article 27 states that the state governments must take such matters into their own hands and provide them with alternatives for necessary shelter, food and safety as well as a supervised, holistic upbringing, by providing them with alternative care options that are necessary and suitable to them. The two most common forms of alternative care for children in out-of-home-care (OHC) children include residential care in children's homes or child care institutions (CCIs) and foster care (Kalisch et al., 2017).

In the absence of support from their birth families, various vulnerabilities of children under alternative care persist even after they enter this new phase of life. In India, children who have spent some or most of their childhood time in CCIs are entitled to receive aftercare services after leaving the institutions, on turning 18 years of age once they leave the CCIs. These young persons are popularly known as aftercare youth or care leavers. The Juvenile Justice (Care and Protection of Children) Act, 2015, including their Model Rules 2016 along with the Central Government's Child Protection Scheme (CPS) provide the legislative and policy framework for 'Children in Need of Care and Protection' (CNCP) and care leavers. The law defines aftercare as "making provision of support, financial or otherwise, to persons, who have completed the age of eighteen years but have not completed the age of twenty-one years, and have left any institutional care to join the mainstream of the society" (The Juvenile Justice Care and Protection of Children Act, 2015) and that any child leaving a CCI on completion of 18 years of age may be provided with financial and other kind of support in order to facilitate the child's re-integration into the mainstream of society.

The process of transition to adulthood involves varied experiences for different people differently, based on the starting points, accessibility to resources, approaches employed, and other aspects required to divulge the process (Storø, 2017). Care leavers need to make this transition much earlier in life and also in shorter duration as compared to the other young people (Morgan & Lindsay, 2012; Stein, 2014). The transition from adolescence to adulthood, in general, takes place within "cultural schedules" that indicate that people are supposed to follow a path (Hagestad, 1990), for example, "the big five – graduating from school, finding a job, moving out from home, finding a spouse and starting a family" (Settersten, Ottusch, & Schneider, 2015). Studies indicate that children coming out of CCIs feel unprepared to leave their childcare setting and struggle in various domains of independent living. They face several challenges and instability such as physical and mental illness, inadequate life skills, lack of economic independence, high risk of unemployment, homelessness (Chopra, 2015; Courtney et al., 2011; Gypen et al., 2017; Modi, Sachdev & Prasad, 2016; Vinnerljung & Hjern, 2018). Studies also report the differences in the transition to adulthood of care leavers based on the inequalities in access to resources and inequalities of support services which either compress or accelerate the transition process (Storø, 2017). Aftercare programs are thus allied with rehabilitation and social reintegration of this vulnerable section of youth who cannot be left uncared for even after they leave care homes. Any Aftercare support is supposed to target providing solutions to the challenges faced by the young care leavers.

Globally, many studies describe the challenges of children in institutions, the struggles of transition to independent life, and the transition's impact on care leavers (Akister et al., 2010; Meade & Mendes, 2014). Unfortunately, in India, one cannot find much empirical evidence regarding those challenges and struggles. Only a few standalone studies, from districts, states, and facilities, have been conducted, most of them are qualitative in nature; furthermore, most studies do not explore the multiple dimensions of aftercare. Therefore, a study titled, "A Study of Aftercare Practices in Five States of India – Beyond 18" (2019)", was conducted by Udayan Care with other partners that aimed to build empirical evidence with a view to influencing the practice of aftercare and improve outcomes of care leavers in India. The study, covering 450 youth, from five

states of India, found that around 44% of the care leavers were not able to pursue higher education while about 50% of them failed to generate employment opportunity for themselves, most of them could not arrange safe, secure or adequate living arrangements for themselves. Most of them also experienced emotional trauma, lack of trust and attachment and were also lacking skills that could help them towards independent living. This study helped us to develop a framework, called the "Sphere of Aftercare' for approaching aftercare in a comprehensive manner, to which our practice-based understanding, a review of the secondary literature on successful aftercare practices across countries, and the participatory surveys of young people and practitioners and functionaries contributed. This Sphere represents the ideology of rehabilitative services and support essential for care leavers, who are transitioning out of care. The 'Sphere of Aftercare' framework divides the scope of aftercare support/services into eight distinct but interdependent domains that are essential for care leavers' mainstreaming, as they transition out of care. These domains are: housing, physical health, independent living skills, social support and interpersonal skills, emotional well-being, educational and vocational skills, financial independence and career, identity and legal awareness (Beyond 18, 2019).

This study also brought forth the need for the 'Continuum of Care approach' and support necessary for such young persons, throughout their transitory stage. The study was an eye-opener for many, including us as practitioners, bringing forth the need to go back to our alumni care leavers and listen to them, do a reality check on their wellbeing, especially in the COVID era, as well as understand what other protective factors were needed, when they were growing up, and bring these into our current practices.

The Udayan Care Child and Youth Care Model

A sustainable continuum of care approach providing family-like environment to such children and young people

Udayan Care, a non-profit NGO in India, has the vision of "regenerating the rhythm of life of the disadvantaged" for 27 years. Contrasting to other large residential care

institutions prevalent in India, Udayan Care has developed 17 group homes, called Udayan *Ghar*s (Sunshine Homes, hereinafter referred to as 'homes') based on a unique L.I.F.E. model (Living in Family Environment) which delivers care and protection to a maximum of 12 children per home as a unit, and in some larger spaces, two units of children are accommodated. Children are positioned in these gendered separated homes through orders from the statutory body, Child Welfare Committee (CWC), provisioned under the Juvenile Justice Law. At present, there are 17 homes across four states of India. Each home has a carer team, including a group of 2-5 long-term volunteers called Mentor Parents, at least three full-time residential caregivers, a social worker, a part time mental health professional team, comprising of a child and adolescent psychiatrist, psychologist and counsellor, and a shared managerial, supervisory staff at the Head Office. Situated in middle class neighborhoods, all homes draw the support and strength of local communities, leading to positive impact, where full-time staff work centrally with the aim to provide financial, psychological, education and legal support and training to children (Modi & Hai, 2018).

Udayan Care also carries out an aftercare programme which bridges the gap for young adults aged 18 to 21 that are just leaving their Udayan *Ghar*s, by providing continued rehabilitative services combined with community, group or scattered housing along with empowering these youths to complete their education, become job ready and well prepared for independent living. Apart from board and lodging, the aftercare programme covers other expenses ranging from cost of commuting and clothing to medical facilities and help for them to grow stable roots through jobs, learn to save money, acquire the skills to sustain themselves without support and finally move out to live on their own as self-assured adults. They are also encouraged to acquire necessary life skills essential for leading an independent life by managing an independent kitchen, taking up part time jobs, etc. This aftercare program also facilitates and empowers them for their need-based interactions with various stakeholders including educational institutions, service providers and employers, which expand their societal space. Aftercare support for care leavers is thus meant to address their challenges along with

enabling them to identify their dormant talents and thereby reconnoiter opportunities available to them.

Scope of the research

As it has been stated in various studies on care leavers that the pathways of care leavers must be monitored as they need extra support for being the most vulnerable group in the prevalent society (Höjer & Sjöblom, 2014). As evident by the "Beyond 18" study, it was imperative that the voices of care leavers should be heard in a systematic manner, along with making them a part of the process to improve the practice of child and youth care. This study is informed by this need and thus aims to understand and assess the transition process, supportive services in aftercare, later as alumni, and record experiences and well-being of care leavers, who left Udayan *Ghars* and Udayan Aftercare Homes and have made the transition to adulthood, in their own words. As Udayan Care focuses on a continuum of care approach with children, even after they leave the child care setting, and is always working on improving its interventions and processes, this study aims to capture their current realities, with their reflections on the collective pathways of transition, and in the process learn the gaps that may have existed, so that informed decisions can be taken for furthering the programme to a new level. This post transition reality check will help Udayan Care to understand the un-addressed issues and develop better transition programmes to ensure support to the new care leavers, coming out into the larger world, so that their transition becomes more meaningful and impactful.

In the wake of COVID-19, there has been a growing concern that care leavers faced greater challenges across a range of sectors including lack of financial security, housing, education, jobs and career setbacks, psycho-social support, physical health and lack of policy reforms in keeping with the times. The situation of care leavers became more critical during these times and has impacted them adversely. This study also captures the impact of COVID on the wellbeing of alumni care leavers.

Methodology

A mixed methodology approach was used in this study as it involves the use of both quantitative and qualitative methods of data collection and analysis with a descriptive research design.

Universe and Sampling

The universe of the project comprised all the care leavers who have transitioned out of Udayan *Ghar*s at 18 years of age, either immediately, or were given aftercare support and then they transitioned out. The sample included care leavers, based on their availability and consent. Snowball sampling and convenient sampling techniques, under non-probability sampling techniques, were used for collecting data from the sample based on the availability of the respondents and the data was collected through Google forms. Based on the objectives of this study, the form included questions related to their demographic profiling; history related to leaving care homes; their current status of education, vocational skills, career development; transition pathways; their social relationships; emotional and mental health concerns; COVID impact; knowledge about identity documents and financial management, and their recommendations.

Ethical Considerations

Data was collected from the care leavers on a voluntary basis with their consent. Maintenance of confidentiality of the responses and the respondents was strictly followed.

Demographic Profiling

Amongst the 50 care leavers, who gave their consent to be a part of this study, and who completed the google form, 40% were males and 60% were females; 14% were married while the remaining were single; 16% were above 30 years of age while 14% of them were between 20-21 years. The data described that 18% of the care leavers, amongst the total sample, were restored back to their families, while 82% of them were on their own, after leaving Udayan *Ghar*s.

Analysis and Discussion

Transition Phase

This phase reflects the duration in care homes where children were prepared for leaving care homes towards independent living, where they were provided with relevant skills, opportunities, resources, workshops keeping in mind the Sphere of Aftercare, so that they were able to sustain and excel in the outside world. Aftercare lodging facilities were provided to the Care Leavers who were not ready and couldn't find a safe and secure accommodation, and needed support for further education, skilling and counselling. As mentioned in Figure 1, 38% of the respondents left Udayan *Ghar*s at the age of 18 years, 46% of them availed Aftercare facilities and transitioned at the age of 19-21 years while 16% of them left Aftercare homes at the age of 22 years. The data clearly states that a large percentage of youth were either enrolled in a professional or a vocational course at the time of exiting from Udayan *Ghar*s and had completed their education. As stated by the Care Leavers and shown in Figure 2, 62% respondents were graduates or had completed vocational training when they left Udayan *Ghar*s, while 30% of them completed senior secondary, and 8% of them had completed their class 10th only. Sixty eight percent of the respondents pursued their higher education after leaving Udayan *Ghar*s, while 42% stated that they needed further support from Udayan Care for their higher studies

During the transition phase, Udayan Care catered to the respondents with adequate help as mentioned by 2/3rd of the respondents, while 34% said they did not get any support from Udayan Care. As mentioned in Figure 3, 74% of the Care Leavers believed that they were able to fulfill their career aspirations while 26% of them felt the opposite. The data states that support to Care Leavers at the time of leaving care was provided in various forms, which included, aid in terms of emotional, mental and moral support (14%), financial support (12%), aid in finding them a job (4%), guidance in further education (10%), helping them find accommodation (8%), healthcare facilities (4%). The data reveals that certain youth did not feel supported and so demands an enquiry and self-reflection of its practices.

Figure 1: Age when Alumni left Care homes

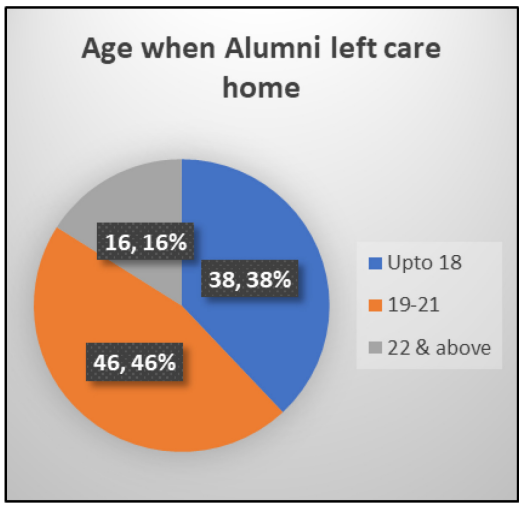


Figure 2: Educational Level at time of leaving care homes

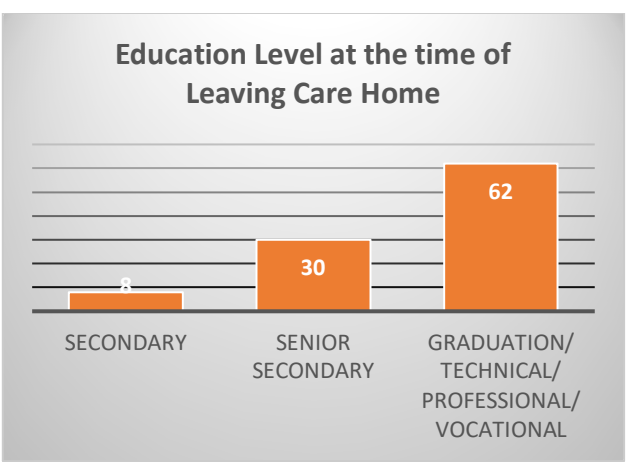
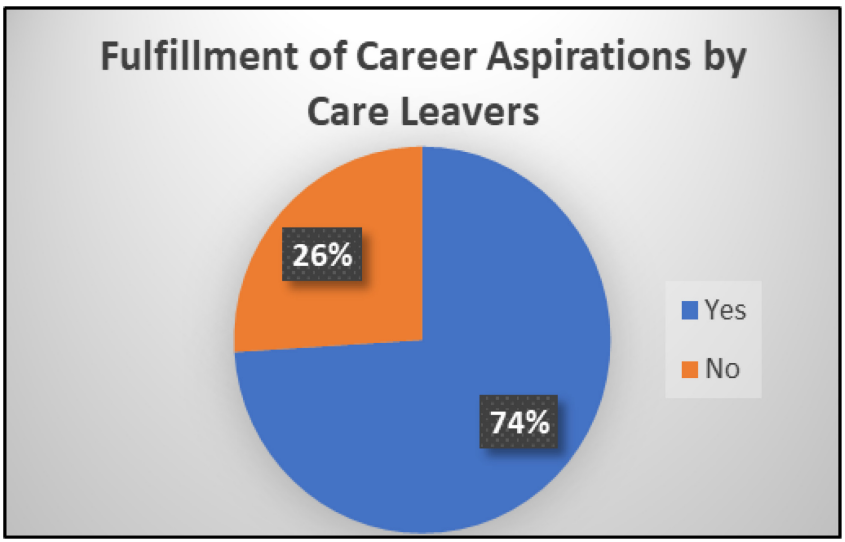


Figure 3: Fulfillment of Career Aspirations by Care Leavers



Care Leavers were provided with guidance, mentoring and support throughout their stay at care homes to cater to their overall mental health, planning for future, and developing communication skills etc. Keeping in mind the Sphere of Aftercare, other domains including financial management guidance, was also provided, as stated by 50% of the Care Leavers where they were taught about how to manage household finances as an independent adult while. While being at care homes, most of the youth felt the desire to be independent at the earliest, without any restrictions or supervision. Therefore, we tried to understand Care Leavers thoughts regarding independence post leaving care. There was a mixed reaction regarding whether independence had brought hope or uncertainty to their lives as 48% of the Care Leavers stated that they treated leaving care as independence, 14% of them didn't share their views, and 16% of them were still uncertain.

> "I was a fresher when I transitioned from Udayan *Ghar*. I was in a hurry to find my own feet in the world and so opted to be on my own, and not avail Aftercare facilities. Started with a job, referred by them, but soon realized my folly."
>
> Another youth opined, "I could continue to study and gain my bachelors' which in consultation with them, brought me good job prospects."

In the transition phase, most of the Care Leavers felt that they were provided with proper guidance, support, and resources in order to prepare them for independence. The Sphere of Aftercare was the focus of all interventions carried out at Udayan Care in order to support their youth leaving care.

Post Transition and Extended Support

Udayan Care has continued to support and fund their alumni's education beyond their stay as was stated by 48% of the Care Leavers, while another 48% of them self-funded their studies and 4% of them received some form of monetary support from family and friends. Around 54% of the Care Leavers stated that Udayan Care also supported them in preparing for job market amongst which 32% stated of having received their first job with help from Udayan Care. Respondents have also mentioned about important life skills training that Udayan Care had provided them such as financial literacy, higher education, soft skills, communication technique, sports and computer application, personality development, extra-curricular activities etc.

Even after leaving Udayan *Ghars*, as mentioned in Figure 4, 4% claimed that Udayan care helped them in handling their personal issues, 12% of them believed that they were provided guidance and support in various areas, 4% of them received support in higher education, while 8% of them received financial support while others claimed at receiving support in terms of training on various skills etc.

Figure 4: Ways in which Alumni were supported

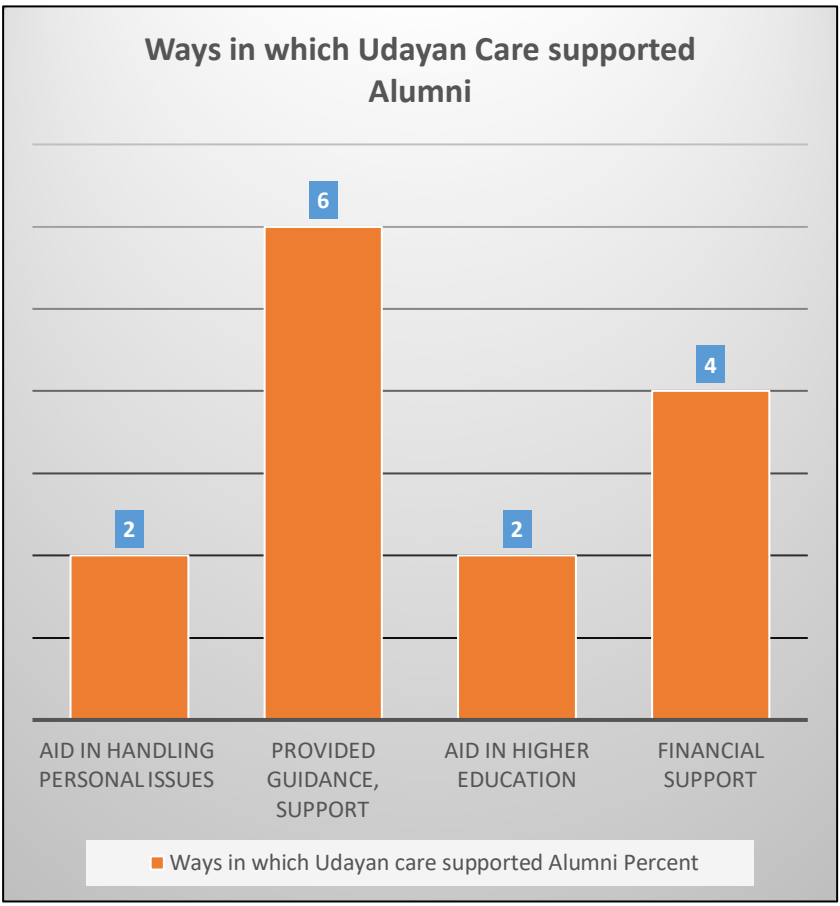
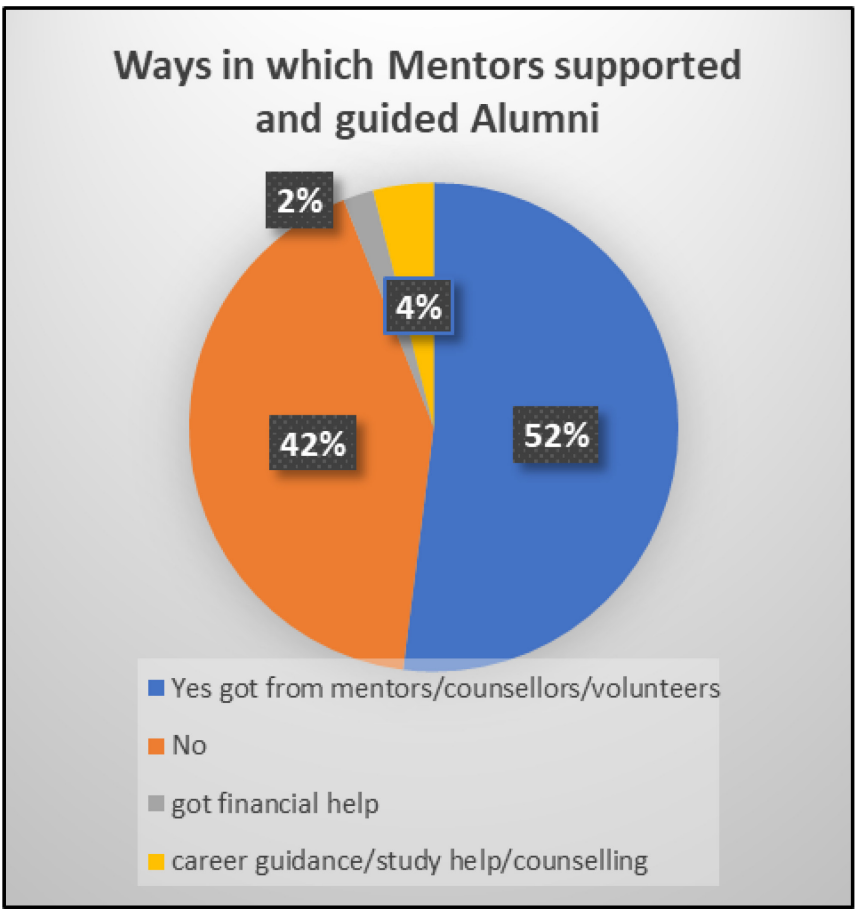


Figure 5: Ways in which Mentors supported and guided Alumni



Further applying the motto of Udayan *Ghar*'s LIFE (Living in Family Environment) model and continuing the sense of community belonging, Udayan Care provided Care Leavers with mentoring and guidance post leaving care as well. This was corroborated by the findings of the study as stated by 52% of the Care Leavers, while as stated by 42% of the Care Leavers, they did not remain connected with Udayan Care for mentoring and counselling support, 2% stated that they got guidance related to financial management, and 4% of them got guidance related to carrier and studies, as indicated in Figure 5.

Figure 6: Support for Job by Udayan Care

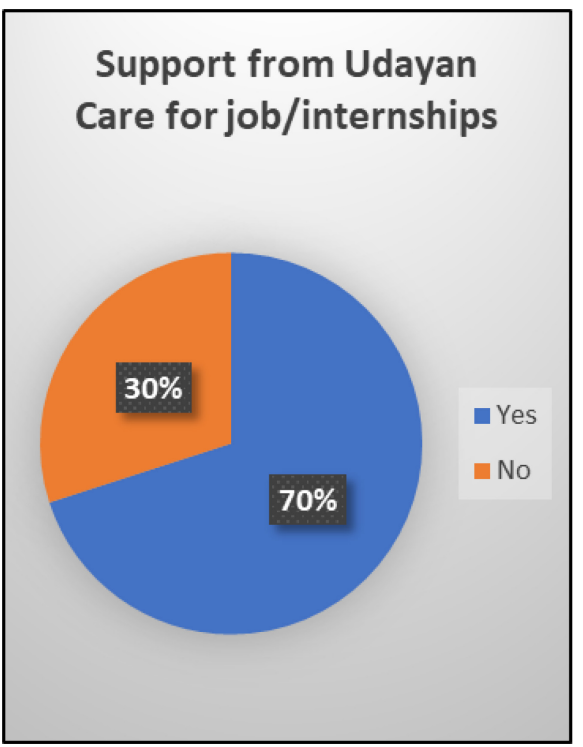
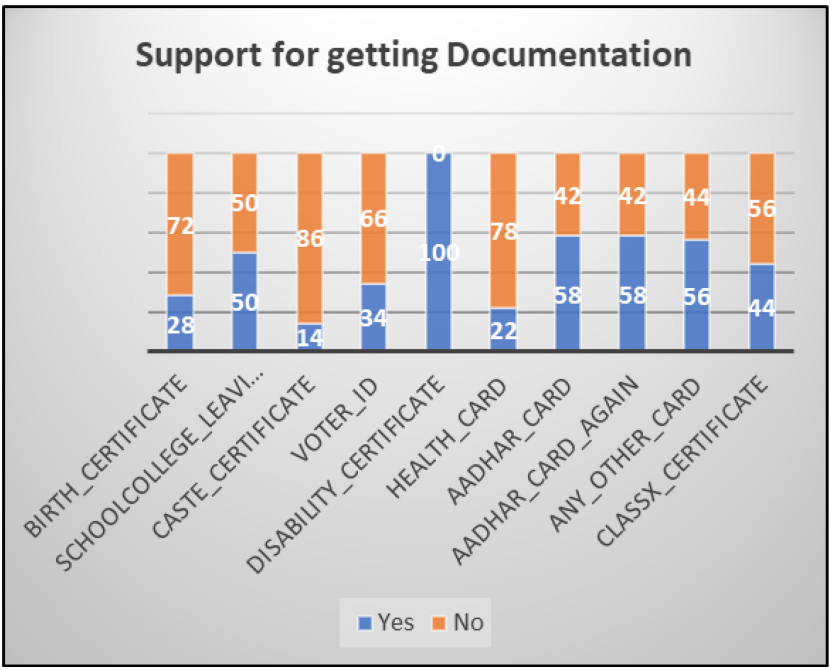


Figure 7: Support for getting Documentation



As indicated in Figure 6, 70% of the Care Leavers believed that, post transition, Udayan Care has helped them provide opportunities related to job or internships in various ways including helping them connect with relevant stakeholders, upgrading their skills relevant to their profession etc. As indicated in the Figure 7, support was also provided to Care Leavers in getting their relevant documents, including birth certificate (28%), school leaving certificate (50%), caste certificate (14%), voter id (34%), health card (22%), Aadhar card (58%) etc. By facilitating their systematic, focused and need-based interaction with stakeholders in the larger societal environment which include, inter alia, institutions of higher and technical education, employers, service providers and the civil

society in general, Udayan Care aims to allow their alumni youth to continuously expand their societal space leading to their independence.

Current Situation and Wellbeing

As the earlier section describes various ways in which support was provided by Udayan Care during the transition process and immediately after leaving Care, this section provides an overview of the current situation and well-being of the Care Leavers, recent support provided by Udayan Care during COVID times, Care Leavers' current education, and job and accommodation status. The alumni were still provided with some support in various areas, including, education (42%), living expenses (20%), and housing (18%), as represented in Figure 8.

Figure 8: External Aftercare Support Provided

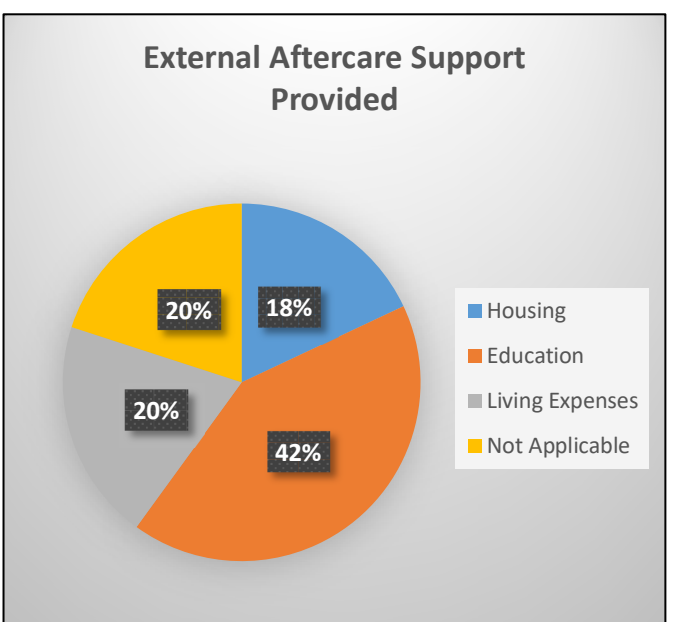
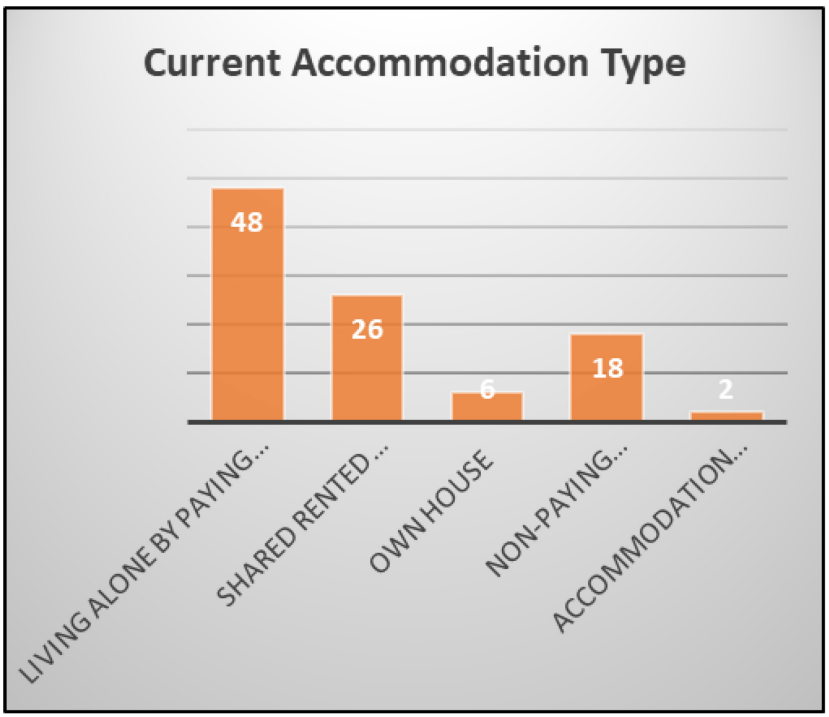


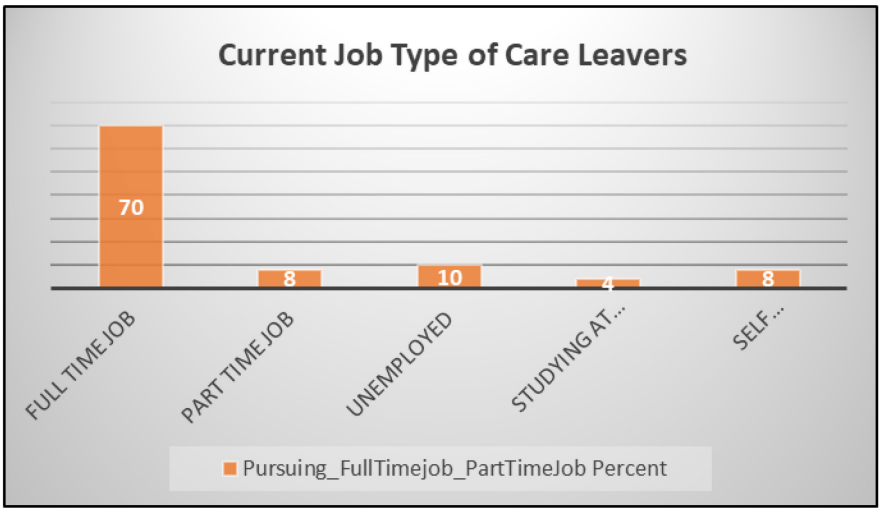
Figure 9: Current Accommodation Type



When asked about their accommodation type, as mentioned in Figure 9, 48% of the Care Leavers were living alone in a rented accommodation, 26% of them were sharing a rented accommodation, 6% of them had their own house, 18% of them stayed with their families or relatives, 2% of them were being provided accommodation support by Aftercare programme.

The current education status of the Care Leavers described that 50% of the Care Leavers were graduates, 12% postgraduates, 4% were pursuing professional courses, 8% of them were pursuing vocational courses and 26% of them had completed their 12th standard.

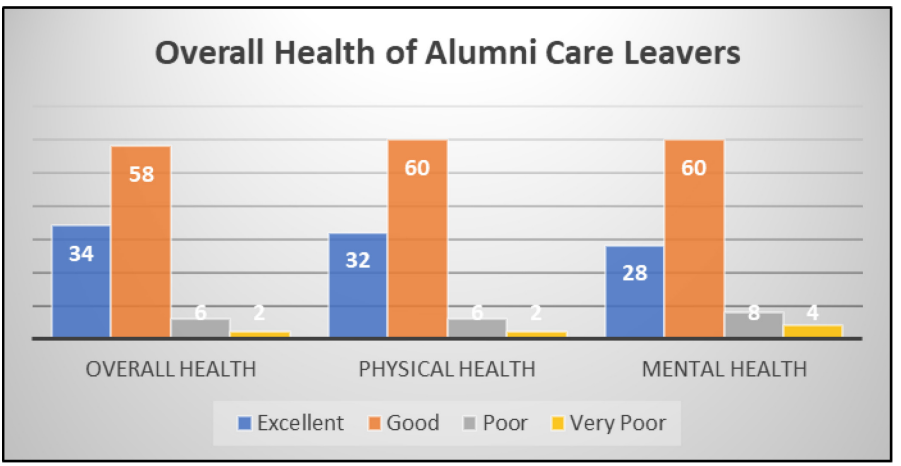
Figure 10: Current Job Type of Care Leavers



As mentioned in Figure 10, out of 50 Care Leavers, 70% were into full time job while 8% into part time jobs, 10% were unemployed, 8% were into self-employment and 4% of them were pursuing higher studies. About 20% of the Care Leavers believed that their present income is not covering their cost of living and they require more support from Udayan Care.

Below Figure 11, provides a description of the overall health of Care Leavers at the time of data collection which showcased mixed responses in terms of health. Fifty-eight percent of the Care Leavers felt that their overall health was good, 34% felt it to be excellent and 6% felt it to be poor followed by 2% felt it to be very poor. A similar trend was also observed in cases of physical and mental health. The data indicates that even though support and resources were provided to Care Leavers, especially in the times of COVID 19 more provisions are required to help them sustain and excel in life.

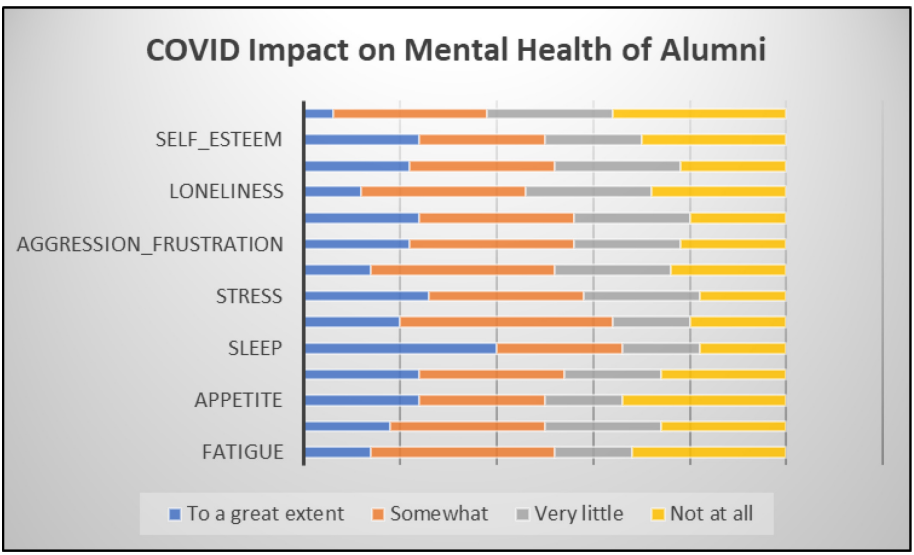
Figure 11: Overall health of Alumni Care Leavers



Impact of COVID 19 on mental health and emotional well-being

COVID-19 has impacted every sector of the society and Care Leavers are no different. The overall mental health was recorded as poor, as stated by 8% of the Care Leavers, whereas 4% of them stated it to be very poor. Thirty six percent of the Care Leavers also expressed the need for counselling and therapy for the impact of COVID situation in their lives and especially mental health. Thirty four percent of the Care Leavers also stated that they felt lonely most of the times and missed their time and peers at Udayan *Ghar*s Fourteen percent of them felt lonely sometimes and 6% of them felt socially isolated due to the entire pandemic situation. Figure 12 describes the impact of COVID on emotional health of the Care Leavers. Care Leavers stated having faced anger issues, dealing with the impact of death in a family, breakup in relationships, stress due to loss of jobs, financial issues, etc.

Figure 12: COVID Impact of Mental Health of Alumni



> "In the past few months I had faced depression, and many times I used to get negative thoughts about myself. I used to spend a lot of time sitting alone staring at the wall of my house. I often used to get very confused doing work at home. Then I joined a Care Leaver's group, encouraged and supported by Udayan Care, and they have helped me connect, we meet sometimes and share our issues."

However, 28% of the Care Leavers stated that they did not feel like sharing their problems with their friends and relatives, and 42% of them did not often engage in social activities with their peer groups. Other indicators that showed that mental health issues were prevailing among the respondents included the fact that 28% of the Care Leavers felt worthless and hopeless. Seventy-eight percent of them felt the need to give themselves self-affirmations as they struggled with the current pandemic. Amongst 50

Care Leavers, 30% stated that they received help from Udayan Care in solving emotional health issues during COVID times while 8% of them also stated that Udayan Care helped them connect with counsellors. Fifty percent of the Care Leavers also felt disconnected from their work and life. COVID has impacted Care Leavers' financial situation as well, as 52% of the Care Leavers had faced financial crisis.

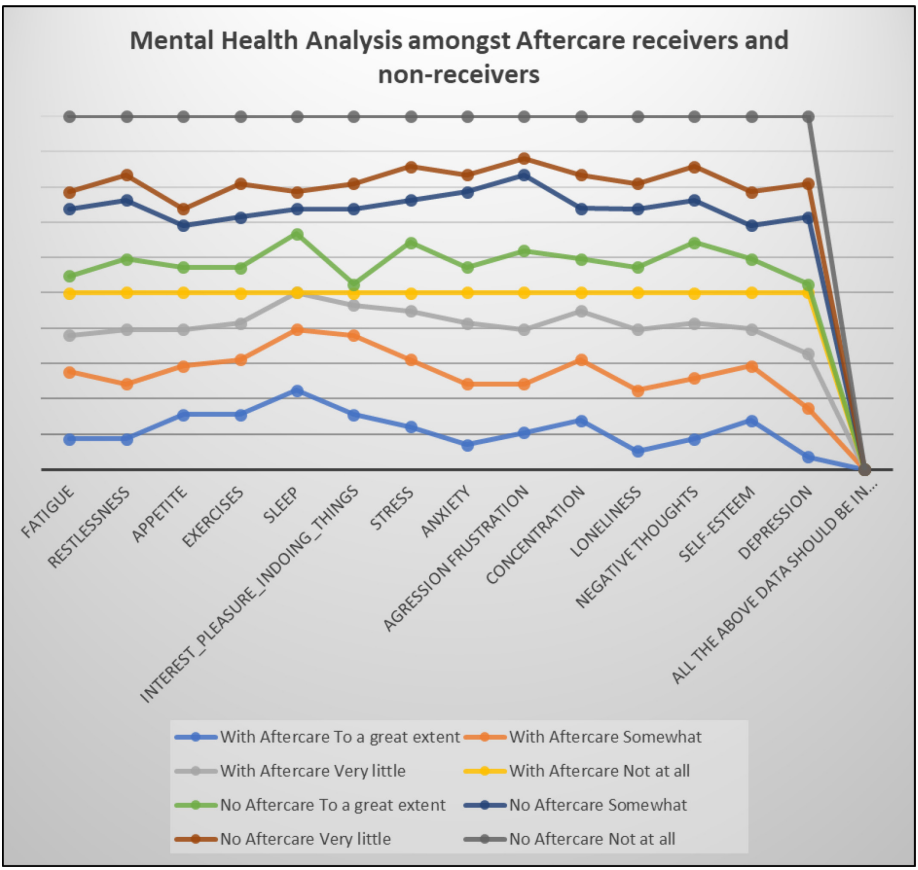
Figure 13 provides a description of mental health analysis amongst the Care Leavers who received Aftercare with those who did not receive Aftercare provisions. The trend clearly indicates that mental health situation of the Aftercare receivers is better as compared to the ones who left care homes at the age of 18.

Voices of Care Leavers suggesting improvement areas

Amongst 50 Care Leavers, 26% of them stated that they are yet to fulfill their career aspirations and amongst them the respondents expressed the need for more support in form of guidance (6%), higher education opportunities (2%), financial support (4%) and help to overcome personal issues (2%). Eighteen percent of them implied that some trainings that they would have benefited more were missing during their stay at Udayan *Ghar*s as few of them required more job market exposure, capacity building guidance, financial management support.

The findings of the research highlight the importance of the living environment, skills etc. provided at Udayan Care, and the kind of aftercare intervention provided, namely, mentor parents as lifetime volunteers, long term attachment and emotional bonding with mentors and other residents, the importance of exposure to the outside world, and transition preparedness. It is suggested that all of this, plus the continuum of care contribute to the social reintegration and relationship with youth when they start living independently on their own.

Figure 13: Mental Health Analysis amongst Aftercare receivers and non-receivers



Conclusion and Way Forward

At Udayan Care, children and Care Leavers are supported in the continuum of care approach and are forever members of the larger family. Even as they have settled in life, they are always welcomed back to seek any further guidance or support, celebrate festivals and give back in different ways. Many of them have become donors too. Individual planning and execution in terms of care for every child is done at Udayan *Ghar* level to ensure smooth transitioning of Care Leavers along with providing them opportunities and support for independent living. The data from this study shows Udayan Care's connect and concerns for their wellbeing, understand their needs, listen to them and provide them with suitable opportunities to share their opinions that can help improve the care practice at Udayan *Ghars*. It is important Care Leavers seek out a place of permanency in the world, not a transient aegis to take care of immediate needs, excel in all domains, according to the Sphere of Aftercare.

Interventional support, free counselling support and guidance, crisis management support and psychological assessment services from mental health professionals is required for a successful transition, as young adults raised in various alternative care spaces had faced trauma during their early childhood which needs to be addressed by providing continuous out of home care support (Meade & Mendes, 2014). Being a dynamic process, it is not uncommon to see challenges in administering child and youth care programmes. The needs of children and youth change often, and the system has to be responsive to such changing needs. While this is understandable given the past traumatic and negative experiences they have had in their early years as children, these findings of research offer an opportunity to the organisation to further work on these issues and address the challenges for the improvement of existing children's lives as they move into adulthood. Thus, the effort to continuously review and keep updating the knowledge on concepts and techniques of mental health care continue as a priority in the organisation. The ultimate objectives of any Aftercare program need to be to equip Care Leavers with the required skill, confidence building, imparting education, developing management abilities as well as self-defense mechanisms, and ensuring identity. Proper pathway planning, review and progression to be made possible that enables individual, tailored support to all Care Leavers, responsive to their practical, employment, educational,

relational, emotional and financial needs. Professional efforts should be ensured to maintain communication with young people to prevent isolation and boredom, as well as ensure access to resources. All practices on Care Leaving must focus on the 8 domains of interventions, being housing, education, employment, life skills, financial and legal literacy, physical and mental health care and social relationships. Buddy systems can be used to help each other out while dealing with isolation during difficult times of life. This way they can think beyond the period of crisis afflicting them in the present. All Care leavers must partner with each other, develop their own networks to ensure support to each other; Care Leavers Networks are the way forward. There are many such networks already existing in several countries, including India, but perhaps there is a long way to go in ensuring Care Leavers have a supportive ecosystem around them that supports them for life like a family.

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Embracing Interdependence: A Community Approach to Development for Adults Emerging from Care

Gabriel Dennis

Abstract

Despite strong evidence in favour of it, emerging adulthood has never truly been established in public consciousness in the same way other stages, such as infancy and childhood, have. Instead, there has been a tug-of-war between ideological stances on the subject. Some researchers have begun to question why opportunities to assist emerging adults, like the ones presented here, and especially for those who are aging out of care, are not more numerous. In this author's opinion, emerging adulthood should be fully recognized as a stage of development and considered in further policy changes for youth aging out of care. Agencies serving youth and young adults emerging from care can play a key role in in promoting interdependence and a sense of community belonging. This can be made possible by providing family like environments for emerging adults where they can try, fail, succeed, reflect, reference, and regroup all while allowing for positive thinking about the future.

Key words

emerging adulthood, aging out of care, interdependence, child and youth care, youth development

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A recent article I read in *Popular Mechanics* featured a young man in his early twenties who is paralyzed who competes nationally in events that include tasks such as walking, stepping over stones, and climbing stairs (Brant, 2020). He does this all with the use of a prototype biomechanical suit attached to him called an *exoskeleton* (Brant, 2020). From a youth development standpoint, this story fascinated me for two reasons. First, I could not help but see this impressive metal exoskeleton as a physical metaphor for what Vygotsky calls *scaffolding*, the structured nature of cognitive supports, social supports, and gradual instruction that adults can provide to younger people as they develop (as cited in Kranzler et al., 2019; Steinberg 2020). The second was the story's insistence that the reason the young man, Mark Daniel, both survived the trauma of his accident *and* became the perfect candidate for the experimental exoskeleton program was because he was in peak physical condition, somewhat naïve, hopeful about the future, self-focused, and a little fearless. In other words: he was the perfect candidate because he was an *emerging adult* (Arnett, 2006; Arnett, 2007; Berzin, Singer, & Hokanson, 2014).

Psychologist Jeffrey Arnett first proposed the term *emerging adulthood* in 2000 and has been developing theory to support it ever since (Arnett, 2006; Arnett, 2007; Berzin, Singer, & Hokanson, 2014; Steinberg, 2020). Arnett argues that, especially in industrialized societies, emerging adulthood is a distinct developmental stage between adolescence and adulthood, roughly the ages 18-25 (Arnett, 2006; Arnett, 2007; Berzin, Singer, & Hokanson, 2014; Steinberg, 2020). It can be defined by key features including identity exploration, risk-taking, instability, self-focus, feelings of being in-between, and a strong sense of possibility and optimism (Arnett, 2006; Arnett, 2007).

When we consider Mark's story as a case study and within the context of emerging adulthood, it is a good example of the concept at work in everyday life. Mark is lucky. After surviving a car accident at age 18 he went through a brief period of self-pity (Brant, 2020). However, he says his parents consistently inspired him to stay hopeful and to keep working. Mark has now become a key component of a research and development project that is hopeful for the future and needed someone just like him (Brant, 2020).

As an emerging adult, Mark is fiercely forward-thinking, and self-focused. For example, wearing the experimental exoskeleton requires a high level of conditioning and

requires the pilot to be focused on maintaining physique. When we consider the intersections of the social and biological domains of development, emerging adulthood comes at a time of peak image control and increased physical fitness (Steinberg, 2020). Mark, who is now in his early twenties, was already used to doing the kind of self-focused physical conditioning required for the work of controlling the exoskeleton. As a risk taker, he also never hesitated to undergo the surgery to implant the necessary biomechanical devices (that allow him to command the exoskeleton) under his skin.

Mark is employed and supported by a team who are older and who, as scientists, have ample experience in setbacks and resilience. They act as a support system for him not just in his work, but life in general. In a way, the community of researchers on the exoskeleton team also act as his scaffolding (Kranzler et al., 2019; Steinberg, 2020). However, even though Mark is intensely self-focused he sees his work as not just important for him, but for the future of the entire disabled community (Brant, 2020). This kind of developing conscientiousness can be seen as sign that he is indeed emerging as an adult.

I have found the theory of emerging adulthood fascinating, essentially ever since I stopped being one. Mark comes from a supportive family and has found belonging in a new group that, without even knowing it, is helping him develop into an adult. His emerging adulthood mirrors my own in some ways, and I am grateful I had similar kinds of community based, manageable opportunities and support. It shaped who I am today. Now, as a child and youth care practitioner, I have begun to question why more opportunities to assist emerging adults, (like the one in this example) do not exist, and especially for those who are aging out of care.

It was just a coincidence that I was reading this story at the same time as I was researching emerging adulthood. While gaining in popularity and reputation, the concept is still somewhat neglected (Côté, 2014; Hendry & Kloep, 2010). It was a combination of this and a consideration of emerging adulthood in child and youth care (specifically for young people aging out of care) that made me hypothesize that emerging adulthood should be fully recognized as a stage of development and that this should be considered in further policy changes for youth aging out of care.

Emerging adulthood was a term Arnett proposed in 2000 and it became so popular so quickly that even Arnett himself questioned why this was (Arnett, 2006; Arnett, 2007). Arnett hypothesizes that part of the reason is, at the time, developmental science was already in need of a way to clearly define a stage which almost everyone had already been observing in industrialized societies. The term emerging adulthood contrasted with both what Erikson called *young adulthood* (late teens to 40 years old), and biosocial theories which state that teens in industrialized nations are aging faster (Arnett, 2007).

Arnett's theory began with asking the question: what defines *adulthood?* Arnett states that adulthood can be characterized by evidence of accepting responsibility for oneself, making financial decisions, and financial independence. Previously, society used a much more direct determinant if a person was an adult: if they owned property or not (Arnett, 2007). Socially, from a western colonial and industrialized perspective, this just does not fit anymore. For these reasons, Arnett began developing the theory of emerging adulthood (Arnett, 2006; Arnett, 2007). Some question Arnett's reluctance to define emerging adulthood as simply a transition between, and overlapping with, adolescence and adulthood (Côté, 2014; Hendry & Kloep, 2010). However, Arnett asserts that emerging adulthood should be recognized as a distinct stage because it lasts at least as long as some developmental stages, and even *longer* than others such as infancy (Arnett, 2007).

Arnett also makes a point that depressive symptoms appear to decline after adolescence and into emerging adulthood (Arnett, 2006; Arnett, 2007). Part of the reason could be the newfound optimism and hopefulness that comes with possibilities and growing opportunities for experiences that can present during this stage. I do not believe this point can be understated. There are myths that emerging adults are suffering and slackers. However, Arnett believes emerging adulthood can be good for society because of the increased hopefulness that comes with it. For example, to the earlier point that depressive symptoms in adolescence appear to decline in emerging adulthood, this can be a time of increased optimism. Many emerging adults not only want to have a job, but an occupation that is a reflection of their developing skills and their personal sense of themselves. This can create a drive to focus and better oneself, which in turn can benefit society (Arnett, 2006; Arnett 2007).

Despite its popularity in mainstream media, emerging adulthood is still treated as either a new undeveloped concept or simply as a general way to describe a transitional stage between adolescence and adulthood. In my own experience as a child and youth care practitioner it is interesting to note that up until very recently, even within my professional network of teachers, social workers, community workers, nurses, and counsellors, emerging adulthood is still treated in this way. In child and youth care, we know that practice can often take time to catch up to theory. I noticed that it was only after I began integrating the term emerging adulthood in the field that my colleagues have begun using it too. It is also only very recently that have I seen consideration of emerging adulthood appear in policies and decisions concerning aging out of care.

Côté takes umbrage with Arnett's theory on two fronts. The first is as a critique of emerging adulthood as good theory, especially Arnett's assertion that the stage affects young people across the social classes (Côté, 2014). The second is in the potentially damaging applications of the theory in society. Côté asserts that for Arnett's theory (he instead refers to it as more of a hypothesis) to be accepted as universal, it will need rigorous empirical testing. He feels that Arnett is really only observing that youth are taking longer to transition to the responsibilities of adulthood. For example, when Côté pointed out that a certain young mother Arnett had interviewed would not have the luxury of experiencing an emerging adulthood, Arnett noted that despite the challenges of raising a young child, the mother still looked forward to becoming a teacher and had optimism about future possibilities (Côté, 2014). These types of indicators are especially important to remember when we consider emerging adulthood in the context of our work as child and youth care practitioners, and with vulnerable young people both in and emerging from care, and across economic class.

Côté acknowledges that young adults can often experience a period of what Erikson and Marcia label *identity moratorium* (as cited in Côté, 2014) but points out that neither researcher ever asserted that all young adults face this crisis. Côté warns that employers and economic policy makers may also misconstrue the growing prominence and narrative of emerging adulthood to avoid taking risks hiring young workers, deny them opportunities, and devalue their contributions (Côté, 2014). He is also concerned that the

establishment of emerging adulthood as a normative stage of development, and not just a general term, will further erode the motivation of young people and lead them to delay, or even deny, adulthood. However, research has shown that the ambivalence emerging adults feel towards the responsibilities of adulthood are normative and not a sign of laziness or selfishness, citing that that almost all emerging adults show evidence of taking on full adult responsibilities by age 30 (Arnett, 2006; Arnett, 2007). I often see this in my own relational child and youth care work.

Côté does state that he is willing to accept Arnett's term, emerging adulthood, as a loose concept and a way of defining the somewhat discontinuous transition into adulthood (Côté, 2014). However, he is concerned that firmly establishing emerging adulthood as a stage of development in the same way we do other stages such as infancy, childhood, and adulthood might cause young people, and especially vulnerable young people, to *expect* to experience self-blame for failures, and to prolong, or put off chances to develop into adults. Côté also argues that an over-emphasis on emerging adulthood as a distinct developmental stage could delay the formation of *vocational identity* (Côté, 2014). Yet, emerging adults have shown to spend a considerable amount of time focused on vocational identity, often tying it to their personal identity (Arnett, 2006; Arnett, 2007). I do, however, agree with both Côté and Arnett that before recognizing emerging adulthood as truly universal we will need further study of cultures around the globe to see if a stage comparable to emerging adulthood exists (Arnett 2007; Côté, 2014; Steinberg, 2020).

Hendry & Kloep also provide a critical antithesis to Arnett (2010). One of the key points of their argument against the universal adoption of emerging adulthood as a formal stage of development is that they caution strongly against creating another stratification stage with limits and boundaries (Hendry & Kloep, 2010). According to Hendry and Kloep, young people do not need another label placed upon them by the establishment. They make a case for taking much more of a lifespan view and seeing the period of between adolescence and adulthood recognized as more fluid and with careful consideration applied to supporting individual development. This was an interesting perspective for me to consider and makes me question my biases. In my own training and

experience this is usually the child and youth care (CYC) approach. Normally, I would agree that young people do not need yet another label and further stratification forced upon them. However, I have simply found the case for emerging adulthood as a distinct developmental stage too strong to ignore (Arnett, 2006; Arnett, 2007; Berzin et al., 2014; Gomez et al., 2015; Hokanson et al., 2019). More formal recognition of emerging adulthood could lead to practical application of techniques, techniques that could shape a brighter future for young people aging out of care.

Critics also argue that emerging adulthood does not stand up as good theory (Côté, 2014; Hendry & Kloep, 2010). However, Arnett argues that criticisms such as these are themselves indicators that it is standing up as good theory and invites further dialogue (Arnett, 2007). Another critique is that contemporary popular media has fueled a culture of emerging adulthood (Côté, 2014).

Anthropologists such as Margaret Mead have shown that traditional societies nurture child and youth development in a way that can be defined as *continuous* (as cited in Steinberg, 2020). Conversely, Arnett makes a convincing argument that, according to his research, our contemporary western and industrialized societies have in many ways helped to make development into adulthood particularly *discontinuous* (Arnett, 2007; Steinberg, 2020). For example, in industrialized societies, popular culture and the collective consciousness appear to continue to focus on the clear and brief transition into adulthood that many baby boomers faced during the 1950s and expect that it is normative (Steinberg, 2020). However, it is important to keep in mind that a form of emerging adulthood existed long before the common reference point of the 1950s (Steinberg, 2020).

In another article, the authors collected the stories of emerging adults who were aging out of care and their perceptions of learned helplessness (Gomez et al. 2015). They use a mixed-methods approach, and the centrepiece of the research is the interviews with emerging adults themselves who have aged out of care. This kind of participatory action research also advocates for the cause to these youth. The interviews reveal a theme: not only do many youths aging out of care not feel prepared for adulthood, they often do not feel their experience has even prepared them for a positive emerging adulthood (Gomez

et al. 2015). Despite this, most of the interviews reveal that these young people are still optimistic, they often just feel *in-between* something they cannot quite articulate. Rather than focusing on making specific recommendations for systemic changes (though it does make some good suggestions) the research shines a light on the voices of emerging adults who have aged out of care. The authors argue for increased support in helping them to achieve autonomy, to practice perseverance, and to integrate into their communities (Gomez et al. 2015). I believe it is integration that might be the key.

Gomez et al. find that the foster care experience for adolescents often falls short of providing the kinds of opportunities to be prepared for emerging adulthood (Gomez et al., 2015). These missed opportunities can include activities that provide scaffolding such as college campus visits. I have seen this in my own experience. Often, I have seen workers simply provide emerging adults with addresses, phone numbers, brochures, and websites and think this is enough assistance. I don't believe this goes far enough in facilitating the future independence of emerging adults. Especially for those who have aged out of care, this can be akin to helping push them off a cliff. We should be walking alongside and facilitating emerging adults in gaining self-efficacy, not expecting it to just appear once they have aged out (Gomez et al., 2015).

As a child and youth care practitioner, I cannot avoid (nor would I want to avoid) attempting to argue a concept from an unashamed CYC point of view. Perhaps we can conceptualize, apply, put into practice, and evaluate supports and policies that include the voices of youth, especially vulnerable youth (Gomez et al., 2015). Emerging adulthood should be fully recognized as a normative stage of development, and with particular consideration to those youth aging out of care. Many emerging adults in contemporary culture are afforded the space to learn and practice the responsibility and accountability that will define their future adulthood. Emerging adults can often experience this through trial, error, and scaffolding (Kranzler et al, 2019). Through supports and resources they can begin to understand the importance of nuanced civic engagement and accountability to the community. They can also be afforded the chance to experience identity moratorium, self-focus, *feeling in-between,* and optimism: all through the process of trial and error and the scaffolding provided by their parent(s) or other older family members,

from a secure home base (Arnett, 2006; Arnett, 2007; Berzin et al., 2014; Gomez et al., 2015; Kranzler et al., 2019).

A good example is living through a failure with the support of adults, who can help give these failures scale and place them in the greater context. This experience is a given for most emerging adults. Emerging adults who are aging out of foster care and group homes should have the same, if not more of the same, latitude to experience the safe base of an adult-led, home-like setting they can return to when needed. They can use this setting to contemplate, regroup, and have opportunities to experience informed, caring conversations, and helpful information and attention from adults that are invested in not just their development into adults, but who also recognize them as beautiful humans (Brokenleg, 2012).

Hokanson et al. (2019) explain that emerging adults aging out of care strive to gain independence, but they often do not feel independent enough (Hokanson et al. 2019). This can often be a result of repeatedly being let down by family and/or others in their lives (Berzin et al., 2014; Hokanson et al. 2019). As a result, many of these youth yearn to be emancipated from care and never look back (Berzin et al., 2014; Gomez et al., 2015; Hokanson et al. 2019). Often these instances lead to some form of young adult agreement including independent living (Berzin et al., 2014; Gomez et al., 2015; Hokanson et al. 2019). This can create a sense of independence but also one of isolation (Berzin et al., 2014; Hokanson et al. 2019). Perhaps independence is not the goal we should be looking for. Instead, we should be working to create *interdependence* (Hokanson et al., 2019).

We should be open to learning from Indigenous perspectives like the *circle of courage model* (Brokenleg, 2012). For example, the circle of courage *does* include an emphasis on independence, but independence is only one of the four components, or quadrants, of the model along with equal measures of belonging, generosity, and mastery (Brokenleg, 2012). It takes the courage of a whole community as well as the developing individual to create interdependence. It is important to demonstrate this community connectedness, especially for adolescents and emerging adults who, often because of past experiences, understandably feel that their independence includes not having to trust anyone (Berzin et al., 2014; Hokanson et al. 2019). In a healthy community, by contrast, dependence and

independence converge at points of interdependence; this is vital for young people to learn as they become adults (Berzin et al., 2014; Brokenleg, 2012; Hokanson et al. 2019).

There has been some positive progress in this direction as of late. We are beginning to see some additional supports for emerging adults aging out of care such as college tuition waivers and circles of supportive adults and elders (Gomez et al. 2015). These are good steps. Instead of creating learned helplessness, the system should help prepare emerging adults by recognizing, acknowledging, and normalizing the developmental stage of emerging adulthood, and continue to assist youth aging out of care to navigate through it (Arnett, 2006; Arnett, 2007; Gomez et al. 2015). Some developing strategies to support emerging adults include developing initiatives that help them become accountable to community. Examples include programs that allow emerging adults to directly see the outcomes of their actions, such as regularly helping others (Gomez et al. 2015). These kinds of interventions can occur while recognizing that, at the same time, most young people will remain self-focused for much of their emerging adulthood (Gomez et al. 2015).

Through this writing process my thoughts keep coming back to generating a child and youth care response to this issue. As is often the case, the truth lies somewhere in the middle between the arguments; it is my hope that I have begun to synthesize them into a new direction. Such reforms could also help youth development in industrialized societies, such as ours, to become more continuous, and not such a jarring experience for emerging adults who have aged out of care. Instead of thrusting independence on them before they are developmentally ready, we can create more interdependence. We could be relying on and learning from emerging adults at the same time they are relying on and learning from us.

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Co-adventuring for change: A solution-focused framework for 'unspoken' therapy outdoors

Stephan Natynczuk

Occasionally when returning a young person to their home after a day of adventure therapy, a curious parent will want to compare notes, and while looking for advice on how to manage their child's behaviour, might ask "How did you cope with anger, anxiety, and frustrations?" I answer that, most times, I rarely see such behaviour. I ask myself why I would design an outdoor therapy that provoked such behaviour when the aim is to return a young person feeling better about themselves and prepared to take on the challenges of life through improved self-efficacy?

In this brief paper, I examine my work with youth in or at the edge of crisis; work that could be considered post-therapeutic, that is therapy is not done to someone as a treatment in response to a diagnosed medical condition, but the participant is active in their own therapy, as a co-adventurer, on a journey of change (Natynczuk 2014). I provide adventure therapy services, which Mitten (2004) defined to fit within a concept of healing with purposeful use of natural environments and outdoor activities to increase well-being. Fernee *et al*. (2021) have shown that *Friluftsterapi,* Norwegian for therapy in the open air, can have long term effects with improving mood and emotional regulation leading to increased socialisation and greater agency. Adventure, as an approach to therapy outdoors, has existed for perhaps the best part of a century. There are many types of adventure and therapies to choose from (Gass, Gillis, & Russell, 2020; Harper & Dobud, 2021; Harper, Rose, & Segal, 2019). Some rely on nature as a co-therapist; others on

experiential learning. Some utilise talking therapy and others successfully blend each of these with an adventurous journey. Some, on the surface, seem to be the equivalent of park and play with high and low ropes courses and team-building type exercises. With over 600 talking therapies to choose from (Meichenbaum & Lilienfeld, 2018), there are plenty of options to help find solutions to a person's difficulties.

I strive to be a curious and reflective practitioner. Is simply deciding to be active outdoors enough? Why employ a therapist to take you outdoors when you can do that by yourself; or with friends and family? For many years, I have been intrigued with how a therapeutic framework can inform and structure an outdoor activity session beyond a baseline of character education (Baehr, 2017) so that something therapeutic occurs, even with minimal talking therapy. Taking this further has been a long-term project of mine. I ask myself how I can offer an adventure therapy in which experiential learning outdoors, talking therapy, and adventure leadership are aligned within a simple model (Natynczuk, 2019). If there is little talking therapy, can the strengths of the other components compensate and still provide an experience in which participants can feel better within and about themselves, improve their self-efficacy, and acquire some sense of being able to deal with challenges in their lives more effectively than before? In short, this is arguably the purpose of any therapy, which, as Dobud and Harper (2018) demonstrated, are equally as efficacious at making a difference within an adventure therapy context. We should also consider the characteristics of the Child and Youth Care (CYC) approach, which Garfat and Fulcher (2012) summarise – the following are of particular interest in this paper as they are clearly at work: Participating with People as They Live their Lives, Meeting Where They Are At, Connection and Engagement, Being in Relationship, Using Daily Life Events to Facilitate Change, Examining Context, Intentionality, Hanging Out, Doing 'With', not 'For' or 'To', A Needs-Based Focus, Working in the Now, Flexibility and Individuality, Meaning-Making, Reflection, Purposeful Use of Activities, Counselling on the Go, and Strengths-Based and Resiliency Focus.

Within the range of adventure therapy practitioners, there is a lore that *nature heals*. Indeed, nature can be a useful co-therapist especially if we are alert to opportunities that align with the CYC approach to meaning making, for the super abundance of available

metaphors and opportunities for mindful experiences, such as quietly watching animals in their natural habitat. When alert to sounds, signs, tracks, and physical changes, we can get closer to nature and can feel better in ourselves for the experience (Harper *et al.*, 2019). While there seems to be truth in this, nature is ambivalent to our presence. It can help us feel good in the sunshine or with a warm breeze, or drop a rock or a tree on us, strike us with lightening, freeze, or dehydrate us. Thus, we have strict safety protocols and risk assessments for outdoor and adventure activities. Nevertheless, a deliberate and thoughtful choice of outdoor venue can offer a useful, meaningful, therapeutic session, such as a tranquil canoe journey, time building a shelter, cooking on an open fire, a forest or beach walk, and so on.

I am an accredited counsellor, though there is evidence that being a professional counsellor is not necessarily a good correlation for good outcomes (Burman & Norton, 1985; Durlak, 1979; Hattie, Sharpley & Rogers, 1984; Karlsruher, 1974). Egan (2002) identified several professions, such as teachers and social workers, who often deal with people in crisis and distress, and who are well placed to offer help through talking. I shall add outdoor education practitioners to the list. It seems that adhering to Rogerian core-conditions of empathy, confidentiality, unconditional positive regard, trusting the participant as the expert on their lives, and being non-judgmental (Rogers, 1958) is sufficient as a baseline for building a useful therapeutic alliance. Additionally, I have found training in active or constructive listening makes a good foundation for helpful therapeutic practice (Ratner, George, & Iveson, 2012). Then there is the ability to engage, and to be engaged, to be sure of maximising the likelihood of a good outcome for the work (Bowen et al 2016, Raine, 2018).

Talk-therapists often work to co-facilitate change: a solution focused practitioner works with deliberate pragmatic determination to help someone get to a future where, whatever brought them to therapy either no longer exists or can be coped with (Shennan, 2019). Solution-focused practice for therapy, and as a leadership model (Natynczuk, 2019), demonstrates it is possible to work as a co-adventurer for change, especially when adventurous journeys are chosen such as by a river, hiking, or mountain bike. The choice of adventure is the participant's, and I am qualified to be able to offer a wide

range of possibilities. This seems to help ensure maximum engagement, reducing resistance, and increasing the quality of participation, which adventure therapy practitioners can do very well.

Co-adventuring might start with the initial agreement to attend outdoor sessions. Pre-session change, "One of the great secrets of brief therapy" (Ratner, George, & Iveson 2012) cannot be ignored due to its association with a good prognosis for the therapy (Weiner-Davis *et al.* 1987). For me, co-adventuring starts with a contracting conversation that extends to agreeing expectations for the adventure therapy. We acknowledge that we are all in these adventures together. We will depend on each other for our collective safety, and as far as the adventure goes, we are equal in our responsibility to each other. Levelling of responsibility for group safety and planning our day seems to be an empowering act for a young person able to take this seriously and to appreciate reframing power relationships in a teamwork context. Initial conversations avoid problem talk. We explore what our participant is good at, and what they enjoy. In this way, we start to build a new climate of competence (Natynczuk 2014) in which successes, strengths, talents, and exceptions to problems are acknowledged as already existing.

Co-dependence, mutual respect, and co-endeavour are essential for co-adventuring. Honest and clear communication and trust tend to develop and are essential for a good therapeutic alliance as well as good adventure-team work. We agree on the activities for the next session at the end of each day so I can prepare equipment. We review risk assessments together as we go along. The shared adventure is important to this level of co-adventuring: it is not the practitioner's adventure, or solely the responsibility of the practitioner to provide an adventure. Agreement on what we plan together is essential. It is the participant's new experience, and we must remember and honour this so as not to detract from their ownership of exploration and the perceived risk important to their sense of adventure. However, there is an art to managing perceived risk and a person's autonomy for adventure without overwhelming them with rules, instructions, and advice. While any member of the group is involved as much as possible in any choice we make, the practitioner is ultimately responsible for monitoring the safety and the welfare of others.

Tenets from solution focused practice (Hogg & Wheeler, 2004; Iveson & McKergow, 2016) come into play so that change and being at one's best become lived, shared, and witnessed experiences. The tools and language of solution focused practice can be used for coaching (Iveson, George, & Ratner 2012) and so it is adaptable to adventure sport performance, for example "What will you notice about yourself as you paddle down that rapid or reach for that handhold?" and so become familiar questions when used therapeutically. Care is taken not to become solution-forced (Thomas, 2007), that is working for our own best interests, or those of a third party above those of our co-adventurers. Together, we experience exceptions to whatever lead to their referral. For example, authenticity within the experience, mastery of technique, undertaking something for enjoyment, being at one's best for hours through positive engagement, quiet acknowledgment of success, the intrinsic therapy of playing with curiosity, the intrinsic reward of learning through doing, and experimenting with leadership and responsibility. We can add the tranquillity of wild places and the 'natural mindfulness' of watching wildlife or concentrating on a task, uninterrupted reflection time, and the experience of flow during an activity that demands nothing less than full concentration (Russell, Gillis, & Kivlighan, 2017). We can sense participants moving towards having more self-efficacy as the adventure therapy experience becomes a lived glimpse of a different way of being, highlighting, through experience, a path forward. At times it seems more pragmatic for some co-adventurers to live 'at your best' rather than to describe in words what they notice when they are at their best, especially for participants who might struggle to find adequate words to describe what it means to be at their best. The idea is to spend less time talking and more time experiencing competence and enjoying it. The pace of anything we do is deliberately slow. We want time to enjoy what we are doing and reflect, without enforced deadlines and the rush from packing too much into the day. Practitioners who try too hard are likely to be disappointed. Sometimes, outdoor activities are crammed with events, much like a competition with higher, faster, deeper, wetter, further, stronger among the primary motivations. This contrasts with the talking and reflection time that co-adventurers, commissioning headteachers, parents, and social workers tell me they value most.

I strive to make the connection between adventure-based learning and therapeutic conversation seamless. For quality experiential learning, context makes everything we talk about relevant and meaningful. With such new experiences, perspectives and behaviour can change without much conversation about change. We quietly expect the best from our co-adventurers and largely see it in the exchange: an instance of the 'unspoken' solution focused framework working. Underground exploration provides a practical illustration. A cave environment is initially unfamiliar. The light is different, the smells and ambient temperatures are different, every surface feels unfamiliar, sound behaves strangely, the passage of time is difficult to guess, direction can be confusing: every sense works differently. Movement can, at times, be likened to extreme yoga in constricted spaces, which also demands an obvious amount of teamwork for passing group gear along and protecting each other on short climbs. Cooperative behaviour in this context, becomes an expected norm, very few complaints or refusals to help are heard, and we have not had one preachy conversation about the need to be helpful. Everyone's help is needed for the success of the adventure, and it seems to come organically, aligning strongly with Activity Programming in CYC (Garfat & Fulcher, 2012, p.15).

We can monitor how well we are working on behalf of our co-adventurers by using feedback informed treatment (Dobud, 2017) and routine outcome monitoring (Dobud, Cavanaugh, & Harper, 2020). This is how we know co-adventurers are getting what they need from the work and that practitioners are doing a good job on their behalf. We privilege our co-adventurers' perceptions of the care and adventures we facilitate. If something needs to change, we change it.

Participants have taught me, through feedback, that less is more, that time and space to relax, talk, be in the moment, and to enjoy just being are significantly therapeutic. I am reminded of an old military adage, perhaps attributable to Napoleon, to not interrupt your enemy when they are making a mistake. The therapeutic reciprocal of this is to not interrupt co-adventurers when they are doing the work themselves. Knowing when to not say anything, knowing when a participant is in a moment of revelation, and knowing when not to kill that moment, is an art informed by paying close attention to what any participant needs from our work together. Certainly, note the moment and save

it for later. My priority is to build engagement through quality adventure experiences that bring out the best in others. Engagement is a fundamental component of good outcomes in therapy (Dixon et al. 2016) and as Krueger (2011) reminds us Youth Work is primarily a process of human interaction. Should a meaningful conversation be necessary it is often participants who will initiate it when the moment feels right for them. Hence, the best conversations have seemed spontaneous, organic, and occur in the most unlikely places.

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combines solution-focused practice with adventure activities and loves every minute of it. Stephan began his postdoctoral career in experiential education in 1988 and has continued to work outdoors mostly with young people in and out of school. Stephan is a Hon. Senior Lecturer at the University of Worcester, has written about SFP Outdoors, Adventure Therapy, and Host Leadership, and enjoys speaking and training aspirant practitioners internationally. Stephan is an accredited Member of the National Counselling Society, is currently co-chair of the International Adventure Therapy Committee, and has been in private practice since 1993.

Suicidality Within Residential Care

Sharina Zurcher

Abstract

Suicidality is complex and in exploring it, there are many aspects that must be discussed to gain more understanding. Some of these aspects include terms that are commonly used, frequency, demographics impacted, and risk factors. These will all be examined in this paper. Additionally, important perspectives regarding how suicidality can come about and how they play a role will be covered, such as practical, developmental, historical, and sociocultural perspectives. Impacts of suicidality and how they affect families and communities will be considered. Lastly, a specific case will be described, as well as two potential interventions that might be used by a frontline practitioner in a residential care setting will be offered.

Key words

suicide, suicidality, residential care, youth, adolescents, frontline, interventions

Suicide

There is an almost palpable feeling of heaviness and grief that follows all discussions surrounding the topic of suicide and suicidality. Being a leading cause of death all around the world across all age groups, it is a necessary subject to pay attention to in order to pursue prevention, intervention, and to spread awareness (Cha et al., 2018, p. 460). More specifically, suicide is an even more apparent concern among children and youth, as it is the second leading cause of death amongst the younger population, as compared

to the tenth leading cause of death among all other age groups (Cha et al., 2018, p. 460). Therefore, the need to understand suicide within the context of children and youth is both pressing and necessary, as well as knowing and being prepared with the appropriate intervention methods that could be used. This information also leads to the fact that children and adolescents present a key timing for prevention, and thus highlights the importance for those who works as frontline practitioners with this age group to ensure that they are well educated on this topic (Cha et al., 2018, p.460). This paper will explore the concepts that suicide often entails, the differing perspectives that are key and should be considered when talking about suicide, and the impacts of suicide, particularly within residential care. Lastly, some possible interventions will be discussed that could be used by front-line practitioners, as well as some of the collaborative partners and resources that might be accessed in order to further help the affected individual.

Understanding Suicide

This portion of the text will be a review of the common terms that are used when discussing suicide that will also be used throughout this paper, a general description of the frequency and the common demographics of suicide, as well as the risk factors associated with this mental health complexity. Considering this paper is largely concentrated on suicide within a residential care setting, it is fitting to also define this. Residential care, which include both treatment centres and group homes, are places in which children and youth are directed to live when they are no longer able to live in their own homes. These children and youth are sent to these places by various government services (Pritchard, 2018, p. 154).

Suicide Terms

To accurately examine suicide, there are a few definitions and descriptions of terms that must be clarified. The term suicidality is often an encompassing term, which refers to suicidal thoughts, ideation, and suicide death (Espinet et al., 2019, p. 3). Next, is deliberate self-harm, which is the act of an individual intentionally inflicting pain on themselves (Cha et al., 2018, p. 461). Suicidal ideation is when an individual considers or

desires to end their life. If an individual attempts to or does an action that is intended to end their life, it is considered a suicide attempt. Lastly, suicide death refers to when an attempt is fatal, and someone has deliberately ended their own life (Cha et al., 2018, p. 461).

Frequency and Demographics

Suicidal ideation has a higher prevalence than actual suicide attempts, averaging between 19.8% and 24.0% among youth worldwide (Cha et al., 2018, p. 461). Before the age of 10, suicidal ideation is quite rare, but increases between the ages of 12 and 17. Although suicidal ideation does not necessarily indicate that a suicide attempt is definite, the likelihood of attempt increases as suicide ideation becomes more frequent and serious. For child and youth practitioners, who work closely with this age range, this means it is incredibly important to be aware of suicidal ideation, as this aids in the prevention of suicide. Being able to recognize when children and youth in residential care experience suicidal ideation could prevent a suicide attempt. A suicide attempt often occurs 1-2 years after the onset of suicidal ideation, pointing to the fact that attempts are more common after the age of 12. This means that older adolescents are more likely to die from suicide compared to younger children (Cha et al., 2018, pp. 461-462).

As far as race and ethnicity, suicide rates are highest amongst Indigenous youth, and this is particularly true in Canada (Barker et al., 2017, p. 208). A loss of culture and identity, intergenerational trauma, and poverty act as risk factors with the Indigenous population for suicide rates (Cha et al., 2018, p. 463). In addition to this, suicidal ideation and suicide attempts have a higher prevalence in youth that are a part of the lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) community (Cha et al., 2018, 463).

Risk Factors

While there is often not one single cause or motivation for suicide for most individuals, there are usually a few factors that seem to commonly be present between individuals who experience suicidal ideation or that have attempted suicide. These are considered to be risk factors. For youth, the factors that tend to be more age-specific

include restricted educational achievement, family history of suicidal behaviour, and parental separation, divorce, or death (Hawton et al., 2012, p. 2377). In addition to this, there are connections to youth who have difficulty or negative tendencies in their affective, social, and cognitive processing to correspondingly have more suicidal ideation and suicide attempts (Cha et al., 2018, pp. 468). These are all connected to overall psychological functioning, which may include different co-existing mental illnesses, but does not mean that youth have to be diagnosed with a mental illness in order to recognize that their psychological functioning might be a risk factor. Across all ages, risk factors include childhood maltreatment, being bullied, peer influence, and media influence (Cha et al., 2018, pp. 464-465). It is said that individual factors- with a specific focus on psychiatric disorders- tend to have the greatest effect on suicide rates throughout a lifetime. Some mental illnesses are known to increase the risk of a completed suicide by a factor of more than three, such as depression, bipolar disorder, substance abuse disorders, and some others (Seena & Bo, 2020, p. 267). These mental illnesses are likely to impact affective, social, and cognitive processing, therefore increasing the risk of a completed suicide, which then correspondingly may increase suicidal ideation, and suicidal attempt. Lastly, some other risk factors that can act as triggers are stressful life events, relationship stressors, natural disasters, and previous traumas (Seena & Bo, 2020, p.268).

Perspectives on Suicide

Now that there is an informational basis of the factors that frequently impact suicidal ideation and suicide attempts, it is important to discuss the perspectives these factors fall under and analyze how and why they might present themselves as important in preventing, assessing, and intervening within suicidality.

Basic health and survival perspectives

It seems that some of the most important practical perspectives that can influence risk of suicidality would include co-existing mental health complexities as well as some of the basic social determinants of health in Canada, such as general stress and

unwellness, as well as food and housing insecurity (Mikkonen & Raphael, 2010, p. 9). When it comes to the social determinant of health that is stress, bodies, and illness, it is discussed that people who are living in adverse social and material situations, such as food and housing insecurities, often experience high levels of stress, both psychological and physiological (Mikkonen & Raphael, 2010, p. 10). Commonly, these situations can create feelings of shame, hopelessness, worthlessness, and high anxiety (Mikkonen & Raphael, 2010, p. 10) some of which strong evidence supports as contributing to suicidal thoughts and behaviours in youth (Cha et al., 2018, p. 466). As far as co-existing mental illnesses, it is shown that the odds increase up to three and a half times as much for major depression being reported from people who are experiencing food insecurity (Mikkonen & Raphael, 2010, p. 28). From this, it is plausible to recognize that practical and environmental perspectives, like stress, housing insecurity, and food insecurity, are deeply interwoven with mental health and wellness. Subsequently, if one mental health complexity is present from these considerations, it is common for another to co-exist. When reflecting on these perspectives, it would seem almost senseless to not evaluate these concerns when regarding cases of suicidal ideation or suicidal attempts for children and youth in residential care. Once evaluated, they should also be considered in creating a solution towards mental wellness in order have a truly holistic assessment and intervention. Lastly, knowledge of these factors can have a powerful role in prevention of suicide, as these are practical needs that can be tended to and advocated for by many frontline workers, such as those in residential settings.

Developmental

One of the largest risk factors when considering development amongst children and youth and how it impacts their mental health is childhood maltreatment. This includes various types of abuse, with all types having strong evidence for prediction of suicidal ideation and suicidal attempts in youth. However, it is shown that sexual abuse in particular has a unique effect on suicide attempts in youth (Cha et al., 2018, p. 464). Under the social determinants of health, early childhood development is considered to be important because of the long-lasting effects that childhood experiences can have

throughout lifetimes, which is true when looking at the connections between abuse and predictions of mental health, even just in later childhood and adolescence (Mikkonen & Raphael, 2010, p. 23). It seems that childhood developmental experiences are more regularly considered when assessing suicidal ideation and suicidal attempts for youth, as past experiences are more commonly connected to mental health. Nonetheless, developmental perspectives are significant to address in assessment and intervention, as differing childhood experiences shape the mental health of children and youth and in order for children and youth to express these experiences, various interventions are likely needed to holistically approach mental health.

Historical

As mentioned in the risk factors, and for youth more specifically, a family history of suicidal behaviour, would be a historical perspective. This is especially notable because suicidal behaviour can aggregate in families, meaning that even when other significant factors, such as co-existing mental illnesses, are controlled, suicidal behaviour within families still can accumulate, seemingly through genetics (Hawton et al., 2012, p. 2377). In addition to this, there are other potential genetic correlations that are being studied. Within youth, it seems that the most common genetic markers for suicidality are associated with serotonin levels. Where there is serotonin dysfunction, there are links to suicidal thoughts and behaviours (Cha et al., 2018, p. 469).

Lastly, some historical perspective considerations might overlap with developmental considerations, like traumas, such as abuse, and the correlations present among abuse and suicidal ideation and suicide attempts in youth (Cha et al., 2018, p. 464). This perspective is important for the assessing and intervening process, as it gives context for understanding the child or youth experiences. It allows the intervention process to potentially include a space for speaking of previous traumas. While not every child or youth will know about their genetics or family history, it can still help in the cases when there is knowledge around these topics, even in prevention.

Sociocultural

Within sociocultural perspectives, some of the largest considerations within suicide would be race, ethnicity, and gender. When it comes to gender, suicidality does not seem to differ largely. The most notable difference between males and females when it comes to suicidality is that while more females experience suicidal thoughts and attempts, males are more likely to die by suicide. Additionally, the onset differs, with females tending to have higher suicidal ideation rates at a younger age, whereas males have a higher rate of attempts at an earlier age (Cha et al., 2018, p. 462). However, where gender does affect suicidality is within the LGBTQ community, where it is known that there is an increased risk of suicide in Canada (Ferlatte et al., 2020, para. 1). This is important to acknowledge in assessment and intervention, as this can act as a barrier for youth that are trying to access mental health services, as well as play a role in the type of intervention with which a child or youth might feel most comfortable. As for race and ethnicity, it is known that Indigenous youth are highest risk for suicide in Canada (Barker et al., 2017, p. 208). Knowledge of how race and ethnicity, and culture, can impact assessment and intervention is a huge need for frontline workers, as so many prevention and intervention programs have Western approaches that are discordant with Indigenous approaches, which can cause more harm than good (Barker et al., 2017, p. 209). This is also true for various cultures outside of the Indigenous population. Barker et al. (2017) even suggested culture as treatment for Indigenous youth in the recognition of such high suicide rates, which involves cultural reclamation in order for there to be social change (p. 209). Considering this, ignoring sociocultural perspectives in prevention, assessment, and intervention within suicide could contribute to the harm that vulnerable and minority populations already face in society.

Impacts of Suicide

Another important aspect of suicidality to discuss is the effect it has on the family of the child or youth, as well as how they interact in the community. Evidently, suicidal ideation and attempts would have a very different impact compared to a suicide death. Therefore, both will be discussed within this section.

Impact on Family

When it comes to family members who experience a loss through suicide, they are sometimes referred to as suicide survivors (Cerel et al., 2008, p. 38). These survivors, understandably, will not be affected in a uniform manner, as the process of grief will not be linear for the various family relationships; these are merely some of the more common effects. For parents who experience a loss of a child to suicide, their emotional functioning often will lessen to their other children at home (Cerel et al., 2008, p. 38). In addition to this, parents are often seen as the people to blame for the suicide within the community, whether it is overtly or covertly. This can often cause a strain on the family cohesiveness (Cerel et al., 2008, p. 39). Blame is also taken on by the family survivors, often being very aware of their shortcomings in the relationship with the family member who died from suicide. It is also common for immediate family members to maintain some secrecy about the cause of death, even from relatives, or sometimes from their younger children, which can also be a source of tension within the family system (Cerel et al., 2008, p. 39).

When it comes to caring for a suicidal family member McLaughlin et al., (2014) stated that there are four major themes that they experience: family burden, competing pressures, secrecy and shame, and helplessness and guilt (p. 238). Family burden included how family members took responsibility for the safety of the suicidal family member, and how it affected their other life activities, causing long-term worry and stress. Often, carers of the suicidal family member are in danger of neglecting their own mental health needs, which can lead to them experiencing mental illness as well. These other life activities also acted as competing pressures- causing great amounts of fear and anxiety while completing daily life-tasks due to the uncertainty of what they might encounter at home. As for the secrecy and shame, often the suicidal family member might ask their family to keep it a secret, causing the family to feel shame in sharing any thoughts or fears of the suicidal ideation. Lastly, many family members feel a sense of helplessness, not knowing how to truly be of support (McLaughlin et al., 2014, pp. 238-239).

Impact on Community Interactions

Considering that suicide is often a very complex and poorly understood death, it can also have complex impacts within the community. Community members often feel a need to attach blame to the death, with an especially negative opinion being placed on the parent(s) of the child or youth who died. As aforementioned, this blame can be both overt and covert, sometimes communicated through non-verbal cues or social withdrawal in the community (Cerel et al., 2008, p. 39). When discussing suicidal ideation, it seems that community interactions might include less care or focus at work from family members, due to the stress felt at home in caring for a suicidal family member. Additionally, there is a stigma associated when discussing suicidal ideation, and it often brings shame, and therefore it is possible that family members might tend to retract from as much community interaction and want to avoid relationships when they otherwise might discuss the well-being of their family members (McLaughlin et al., 2014, p. 239).

For the child or youth who is experiencing suicidal ideation, it is plausible to say that the stigmatization around suicide could cause them to want to keep these thoughts or desires a secret. In order to keep it a secret, it is likely that they, too, would withdraw from social relationships, and other community interactions, such as not attending sports commitments, church/spiritual gatherings, and others. Additionally, depending on their circumstances and other risk factors that were previously mentioned, such as being part of a minority population, it might cause them to not want to access care for their mental health, for fear of the judgement they might receive. Although, in an effort to keep their suicidal ideation a secret, some youth and children can be very discreet about it, not changing anything about their regular community interactions (Pritchard, 2018, p. 164).

Child or Youth within a Residential Setting

To understand how suicidality might impact family and community interactions, Pritchard (2018) gives an example of a youth experiencing suicidal ideation within a residential care setting (p. 164). A pseudonym is used in order to protect the privacy of this youth. This is the case of a youth named Derek, who was doing well in school, had friends, and did not display any behavioural issues. His mother has a mental illness and

was hospitalized, so he was placed in care. Yet, when he was asked at his quarterly assessment about having any thoughts of harming or killing himself, he answered yes. After this, he disclosed his experience of being sexually abused when he was younger, feeling both violated but also felt pleasure, and therefore felt shame, which eventually led to thoughts about suicide (Pritchard, 2018, p. 164). Although in this case there is not large amounts of information on Derek's family and the impact it could have had on his family, it is likely that he either would have kept the sexual abuse secret from even his family or would have asked his family to keep his suicidal ideation a secret, had he told them. This could create the feelings of secrecy and shame for the family, as mentioned in the precious sections.

Residential Setting

Understanding the setting in which children or youth are receiving care can help to understand what interventions and treatment might be best, and when looking at Derek's case, it is important to understand residential settings. Since these settings offer care 24/7 for children and youth, the frontline practitioners take on the role of caring for the basic needs of clients, such as providing meals, ensuring hygiene, and similar day to day activities. As for the children and youth in these homes, they have often come from a home environment that is unhealthy, putting them at risk of various mental health concerns. Additionally, there is often an over-representation of Indigenous youth, alongside other at-risk populations that might require specific care due to differing experiences such as refugees and immigrants, and members of the LGBTQ+ community (Pritchard, 2018, p. 156).

Interventions

Since the details of Derek's case have now been described, and the foundation of understanding suicidality is laid out, it is important to present some interventions that could be used by frontline workers in order to actively help Derek. This section will discuss a few potential interventions and important considerations in these interventions. What might be noticed about these interventions is that they are *life space* interventions,

which are often used by child and youth care practitioners. Life space interventions are essentially making daily life events and settings within residential settings therapeutic. Rather than the child or youth in care having to change their spaces to have a therapeutic environment, life space interventions allow for the settings and events that they are already participants of to become therapeutic (Graham, 2003, p. 34). Ideally, this would result in children and youth in care being able to transfer these activities that have become therapeutic into independent living, giving them control over their environments, and lifelong skills (Graham, 2003, p. 34).

Intervention One

Considering that Derek is within a residential care setting, the interventions would take place in day-to-day activities, with intentionality. It seems that Derek needs a space to be able to talk about his suicidal thoughts, and the internalized emotions, as he was willing to disclose it along with more of his traumatic history, but he needed someone to directly ask him. Therefore, as a frontline practitioner, one intervention that could be used to give space for Derek to dialogue, would be to find an interest of his, such as basketball or a type of art form, which would include an intentional discussion around how he is doing. For example, if it was basketball, a front-line practitioner could try to set-up a time twice a week to play basketball with Derek. There could be a few direct questions that the practitioner could ask while playing basketball, such as if Derek has had suicidal thoughts within the past week, and if he noticed that these thoughts were attached to any other thoughts, such as his previous trauma. These would be low-pressure conversations, when Derek could tell the practitioner as much or as little as he would like. It would be while doing something he enjoys, and it would allow for privacy that would not indicate anything suspicious to the other clients in residential care bearing in mind that he had kept it a secret previously, and it would keep him moving his body to regulate the heavy emotions while talking. Physical activity has shown to alleviate depressive symptoms, which are common symptoms for those experiencing suicidal ideation (Pritchard, 2018, p. 171). It also would not put the practitioner in a position of power where they are staring directly at Derek while asking questions. Additionally, each basketball session could end with a

practice of an activity that is helpful for emotional processing and regulation. For example, a breathing exercise where Derek could take three deep breaths, imagining a release of a negative thought with each breath out. Since Derek is a teenage boy, and might not appreciate these activities, they could also finish off with a basketball drill of passing the ball back and forth in a repetitive motion, regulating Derek's body. This could help provide Derek with a few different activities that he could use when he is experiencing suicidal thoughts or just challenging thoughts overall and does not have someone with him.

Intervention Two

Another intervention that could be used is leading the entire group of residential care clients through a six to eight-week mindfulness/emotional regulation session. Once a week, a practitioner could set-up a time that works with all the residents, and then use that time each week to practice a mindfulness activity. It is the practice of being attentive and aware to what is happening in the present moment, with no judgement (Pritchard, 2018, p. 171). Since Derek had been feeling shame about his past, mindfulness would be a great practice for allowing himself to think and feel whatever he might need to, with no judgement. It has also been shown to be very effective with depression, stress, and anxiety, all of which are very likely for Derek to be experiencing alongside his suicidal thoughts, or at least some symptoms of these other mental health complexities (Pritchard, 2018, p. 171).

Having the whole group do these practices would be intentional in keeping any confidentiality that Derek might want, provide space for relationships to grow, as well as be beneficial for not just Derek, but the entire group of residents. Additionally, it provides Derek with a toolkit that he can use on his own time when any difficult thoughts or emotions show up. These could include a simple breathing exercise, or an activity like giving each resident a piece of chocolate and taking note of every texture they see, feel, and taste. This can be very simple, and low pressure. While a group of teenage boys might find it funny to do this as a sort of exercise, it is unlikely that any of them would

deny a piece of chocolate, it can be fun for everyone, all while practicing and learning mindfulness.

Collaboration of Resources

While a frontline practitioner can use some day-to-day interventions like the ones aforementioned, the use of other resources can help to create an even more holistic approach. If Derek is Indigenous or an ethnic minority, there might be some interventions that would be far more culturally appropriate. For example, the File Hills Qu'Appelle Tribal Council in Saskatchewan, Canada offers workshops and cultural camps for youth that are theatre and art-based practices that can help youth explore and re-create their Indigenous identities. This is done while addressing youth mental health and suicide through decolonization (Barker et al., 2017, p. 209). If Derek is Indigenous and interested in this, it could be a great resource that would help Derek be more connected with his cultural identity and help his healing process in a way that would not simply be a Western approach.

Another resource to consider for Derek would be for him to attend counselling, with a potential trauma focus. While the residential care environment might be trauma aware, going to counselling that would be fully trauma informed would likely aid Derek in healing from his past abuse. Lastly, depending on how often Derek is having these thoughts and if he has made any plans, it would be smart to communicate or collaborate with a school counsellor, or a teacher to whom Derek is connected. This would help to make sure that Derek is physically safe, as well as having safe people in the places he attends often to be aware of what is going on and prepared to take action, or to simply check in on him, and even to communicate any notable behaviours to his frontline workers.

Additionally, depending on the severity of Derek's suicidal ideation, which this information would likely be gathered in an assessment, a connection with a local medical team or a suicide hotline member would be beneficial. If Derek were to have had a plan laid out for a suicide attempt, it would be important to ensure that there is someone he can be with during these times and being admitted into a hospital to have around the clock safety ensured could be a part of this plan. If Derek does not have a plan, but a

frontline practitioner knows that his suicidal ideation is persistent, connecting with a suicide hotline for Derek to have a professional to talk with at any time and could help to ensure his physical safety.

Conclusion

Considering all of this it can be noted that suicidality is truly a complex topic that must be handled with intentionality, care, and sensitivity. There is not one, undeviating, cause for this mental health complexity, but rather, there are many risk factors and perspectives that can play a role. These include some more observable and typically considered factors, such as already existent mental illnesses, or a historical perspective, such as past traumas. However, there are also practical considerations, such as food and housing security, which might not be as typical to consider when assessing a case of suicidality. With this knowledge, it is plausible to say that in order to successfully assess and intervene within suicidality, there is a need for a holistic approach that is considerate of many factors, including the individual. There is not a one-size fits all approach for front-line practitioners, aside from the approach of simply caring with intentionality.

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Vulnerable Little Hearts and the Impact of Adverse Childhood Experiences

Sukhdeep Kaur Chohan

Abstract

The complexity of our lives is embroidered with varying colourful threads that interweave as our stories unfold. In a seemingly "sane" culture, it is optimal to raise healthy, self-aware, compassionate, and resilient children who are open to experience, comfortable with themselves, and have a profound sense of deep connection with others. Unfortunately, far too often, their basic needs for feeling loved, authentic connection, validation, belonging, and safety are trampled upon. My intent in this paper is to remind readers that we share a collective responsibility towards children to mitigate toxic stresses and adverse childhood experiences. The paper provides a window into the impact trauma can have upon a child's overall well-being and quality of life, sheds light upon steps that can be taken to create healthier environments for all children and invites meaningful conversations within your homes.

Keywords

Childhood trauma, Adverse childhood experiences

Snuggle with your children a little longer. Cherish their cute smiles and sweet laughter. Listen attentively and patiently as they share their stories, opinions, heartaches, and dreams. Be emotionally available and remind them often, that they are dearly loved and their voices matter. Provide them with a nurturing home where they

know they are safe, valued, trusted, and always have you by their side. Hold them close in your protective embrace as they build resilience in the face of challenges and strengthen faith in themselves. Create an intentionally inviting environment that conveys messages of acceptance, understanding, compassion, fairness, social justice, and mutual respect. By doing so, children are provided with ongoing opportunities to draw upon and share their natural ways of being loving, sensitive, and empathetic in their daily lives.

Shattering the Innocent Lens

Children are precious blessings. Their delicate and tender hearts are filled with boundless love and compassion. Although parents may take all possible measures to protect their children from harm, circumstances may arise that prevent them from always being present to shield them from those who may hurt them. It is a heart-breaking truth that in every community, there are manipulative, aggressive, deceptive, and cruel-hearted individuals who assert their control over defenceless and vulnerable children. Preying upon their innocence, they destroy their sweet and endearing smiles, and shatter the bubble of warmth and comfort that cushioned them against the thorns of harmful experiences. Within seconds, they alter the lens through which they once perceived and understood their familiar world, and force them into the depths of confusion, uncertainty, and despair.

Enduring Adverse Childhood Experiences

How children feel about themselves rests upon how their minds filter and interpret everyday experiences (Csikszentmihaly, 1990). Trauma comes from the Greek word for wound. Childhood trauma can take place when a child witnesses or is subjected to overwhelming negative experiences or events that are emotionally painful, distressful, threatening, and/or harmful (The National Institute of Mental Health, USA). The harsh reality is that children may even endure pervasive suffering, loss, betrayal, violence, abuse, and neglect by those charged with their care or who are in a position of power over them. According to Dr. Gabor Maté, trauma is a wound upon our psyche and in our body that leads to a disconnect within ourselves. He states, “Trauma isn’t what happened to you, it’s what happened inside you” [as a result of what happened to you] (Healing the wounds of trauma, 2020, p. 29).

Trauma is that you were "wounded during your development because you were not seen for who you are, you weren't understood, you weren't held when you needed to be held" (p. 29). As a result, you lose the connection with your authentic self.

Adverse childhood experiences are threats that are so pervasive, that they profoundly affect the physiological, neurological, and psychological functioning of children, and can have long term ramifications upon their behaviour and overall health and well-being. Exposure to adversity and toxic stress at a young age also affects the structure of a child's brain, their physical development, and immune system. Leaving deep rooted imprints of unhealed wounds, invisible scars, heart-wrenching pain, and unshakeable fear, many traumatic experiences may be folded away in a child's subconscious mind due to not being understood at the time they have taken place, or because they lack the language necessary to be able to verbalize what has been endured. Excessive fear may interfere with a child's ability to process what is happening, leaving him/her struggling to try and make sense of it using the emotional maturity available at the time.

Living with the Effects of Childhood Trauma

For healthy development, children need sanctuaries with relationships where they feel connected and safe, a strong sense of togetherness, and an attachment that is not threatened (Neufeld and Maté, 2013). Childhood trauma can have long-lasting, detrimental, and debilitating effects. It filters into a child's everyday life, changes their relationship with the world, and influences their ability to trust. According to the National child traumatic stress network (2021),

> Through relationships with important attachment figures, children learn to trust others, regulate their emotions, and interact with the world; they develop a sense of the world as safe or unsafe, and come to understand their own value as individuals.

Using disassociation as a defence reaction while the trauma takes place, some children may even develop a dissociative disorder when faced with severe isolated or repeated traumas (Diseth, 2005; van der Kolk, 2014).

Traumatic experiences “leave traces on our mind and emotions, on our capacity for joy and intimacy, and even on our biology and immune systems (van der Kolk, 2014, p. 1). Survivors of adverse childhood experiences often re-live their terrifying experiences in their minds and battle against daily triggers that remind them of the injustice(s) they have faced. Suffocating with fear of being blamed for having done something "wrong," or being held responsible for not being able to walk/run away, they often silence their own voices, internalize feelings of overwhelming guilt, shame, and self-doubt, and sadly begin to believe that they are unworthy of being loved. Consciously, they may distance themselves from their loved ones, emotionally if not physically, believing that they are no longer "good enough" or "worthy" of being treated well. Endless nights consumed with horrifying nightmares are endured with tears filled with pain, pillows coated with sweat, and deafening cries held within. Replaying the traumatic experiences in their mind while helplessly trying to alter the outcome, fearing seeing the perpetrator(s) again, losing hope of being able to escape the inner-turmoil, and praying to be released from the clutches of darkness, survivors of trauma crumble inside with excruciating emotional pain while fighting to maintain a strong composure when interacting with others. Although physical wounds may heal over time, the imprint of the harm endured remains fresh in the psyche of a child's mind.

Every Child’s Voice Matters

Young children’s internal dialogue is influenced by the “experiences woven in everyday life, concealed in everyday occurrences [and] hidden in deep communications of unspoken feelings (Purkey, 2000, p. 48). Verbal and non-verbal messages a child receives from influential individuals in their life can be filtered through invitational propositions that “proclaim that the child is able, valuable, and responsible or unable, worthless, and irresponsible” (p. 54).

When a child draws enough courage to share his/her frightening experience, and feels safe in being able to so, by no means should he or she be dismissed, or the trauma be downplayed in any manner. Each uttered word needs to be listened to and believed. The pain must be acknowledged and respected. No child should ever have to live in fear or feel alone.

It is crucial from a very young age, that children learn to value their voice, trust themselves, understand that they can reach out, and know that if something doesn't feel right – it's not right. By stressing the importance of speaking up when mistreated, not accepting and internalizing self-blame, understanding they are not responsible for their circumstances, and reaching out to appropriate individuals when necessary, children begin to understand that they are not alone, build inner-strength and courage that empowers them, and develop a protective shield that hinders the continuation of harm being inflicted upon them.

Breaking the Silence

Internal imprints of trauma keep a person imprisoned. Healing begins with restoring broken relationships, including within ourselves. In a sense, it is an internal journey to find wholeness from a place of brokenness. Reflection on experience can be perceived as a springboard for action and in turn transformation (Dyke, 2006). Vowing to never allow themselves to be vulnerable, helpless, and taken advantage of again, some childhood trauma survivors proceed to take active steps to empower themselves when they become adults, demonstrate courage by sharing their stories, and inspire others to cultivate courage to speak up. Using the influential ink behind the pen and voices to stand up to those who thrive on and assert their authority, they break the silence that enables the perpetuation of immoral, hurtful, and atrocious behaviours.

Collective Efforts of Resistance

Through unwavering commitment and strong conviction to protect the health and overall well-being of children, collective efforts of resistance must be put forth, alongside strong advocation for fundamental changes to how childhood traumas are perceived and addressed. Opportunities must be created to actively encourage community healing and meaningful conversations to take place that not only open the doors to comprehend the factors that give rise to these traumas, but also nurture the potential for reorientation and transformation of societies around the world (Van der Kolk, 2014; National child traumatic stress network, 2021). Trauma-informed communal rhythms of healing invite

reconnection with the authentic self which has been buried beneath layers of pain. To bring paramount changes in the power dynamics that give rise to human rights violations of children in all communities, it is vital that progressive steps be taken that challenge assumptions, question societal norms, and hold those accountable that turn a blind eye, despite strong evidence of harm taking place.

By creating nurturing environments that cultivate healthy relationships, resolve conflict in a respectful manner, encourage dialogue and mindfulness (Ortiz & Sibinga, 2017), and provide support when facing times of hardship, the fabric of every community across the globe has the potential to bathe itself in a conscious effort to diminish the variables that give rise to all forms of harm and injustices inflicted upon young children.

Mindful Meditation and the Blanket of Healing

Living in a global village with a multitude of faiths, religious practices, and holy scriptures, transpersonal and contemplative practices like meditation and focus upon *Vaheguru ji*, the universal soul, should be encouraged. Meditation (Cotto, 2020) gives birth to paramount personal, psychological, and health benefits that when combined with proper sleep, self-care, and nutrition, can contribute towards peace, harmony, and healthy environments for children to be raised in. Immersing ourselves in the ocean of spiritual wisdom filled with waves of faith, dedication towards serving humanity, mindful meditation, and inward reflection, we are able to connect with our inner strength and courage, fearlessly stand up against those who cause harm, wrap ourselves and others in the warm blanket of healing, and put on spiritual armour necessary to forge forward and transform lives. Carrying the torch of change in our hands to dispel the darkness of ignorance, each of us have a warrior spirit within us that can infuse love, compassion, unity, righteousness, and social justice in all communities. We are interconnected with the whole, the ever-present loving energy that pulsates throughout the universe. By cultivating gratitude, selflessness, humility, and love for the *Divine*, together we can create a ripple of change that will embrace the world and make it a safer place for all children.

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Dancing in the Reign – Staying Relational during a Global Pandemic

Lee Loynes

Abstract

The Covid-19 reign of terror was an experience of many ironies. On the one hand, there was the threat of imposing a non-relational way of being that involved socially sanitizing, isolation, quarantine, and social distancing with masks. This transformed into meaningful, conscious relational practice that offered accessible belonging and attachment, transformative awareness of responsibility, and generosity of spirit through the shared crisis. Four days' notice that all is to change is crisis enough for children in residential settings, their families, and the workers who care for and heal them. However, challenges to relational child and youth care philosophies and then multiple interpretations of the National Lockdown requirements by provincial authorities presented another whole layer of challenges to staying relational during a world pandemic.

The South African Covid-19 Context

The South African Government declared a State of Disaster and implemented Covid-19 Virus Level 5 lockdown as of midnight 26 March 2020. Overnight, the country was brought to a standstill with a stalling of essentially all economic and social activities. The South African population, other than essential services staff, were only to leave their homes to purchase essential foods, household, and medical supplies – and this within

curfew times, with no social or familial visiting, leisure travel – even within a Province or exercising outside of one's home. Alert Level 4 was implemented from 1 to 31 May 2020 with very few shifts from Level 5, other than a slight opening of the economy in areas identified as essential and the opportunity to exercise within 5km of one's home – between the hours of 6 and 9am. Schools remained closed. Alert Level 3 was introduced on 1 June 2020 seeing a further small opening of the economy in certain sectors, but still no cross provincial travel, social or familial gatherings or events, and the opening of schools was to have been phased in across grades but was then essentially again brought to a halt. And there were declarations made as greater 'freedoms' were introduced which, in many instances, were immediately reversed – adding to management and practice challenges and frustrations.

The Child and Youth Care Covid-19 Impact

The resulting impact on the Child Care sector staff teams, children placed in residential care, their families and fundraising efforts was profound – especially so for organisations working on a national level where the interpretation of the legislated restrictions across the different provinces varied significantly as they were translated into the child and youth care practice environments.

The Girls and Boys Town South Africa (GBTSA) Experience

Think of a national organisation operating since 1958 to support ten child and youth care residential programmes in three[1] of the nine South African provinces, the core focus being therapeutic residential child and youth care. Four larger Youth Development residential programmes are located in countryside settings just outside the main cities, offering residence for up to sixty girls and boys each, and 6 Family Homes in the Community with residential capacity for 10 girls and boys in each Family Home. Three of these six family homes are located on the Youth Development campuses – and 3 operate within residential areas and suburbs of the provinces. At the beginning of what became a

[1] KwaZulu-Natal, Gauteng and Western Cape.

transformational journey, we needed to remain relational in a Covid-19 environment that demanded non-relational child and youth care practices and behaviours, including lockdowns, social distancing, no physical contact, mask-wearing, constant sanitisation and prolonged separations from and between family members.

Policy Development

Although national policy seemed clear as each new alert level was declared (albeit draconian on many levels), and the State summary flow diagrams that followed seemed even clearer, the lack of consistency when interpreting policy into practice across provinces was confusing for child care administrators, staff, youths and then their families. The State declared that place of domicile was to be established by midnight 26 March 2020 and maintained through to the end of Alert Level 5 lockdown. The GBTSA national management team held an emergency meeting to identify how to comply with State Covid-19 response management, whilst still meeting the needs of the youth in our care and identified caring, responsible and safe processes and procedures in balancing and meeting all needs – and then updated each province of the plans.

On the day of lockdown, Provincial authorities each responded. The first Province stated that youths and families were able to declare their domicile for the duration of Level 5 lockdown to be their 'biological' family home if they so wished, but required that very high-risk youths return to their legal residential child care environments. A second Province declared that all youths were to return to their residential child care environments in time for lockdown Level 5. The third Province left it to families and residential centres to make the decision and declared that the authorities would not be held responsible should there be any complications or problems arising from those decisions. Thus, policy development across the national child care platform was difficult and fraught with ongoing adaptations and challenges.

The Covid-19 Reign and The Transformational Dance

The initial adjustment experience of all in the team was that Covid-19 had resulted in another whole layer of administration and practice. However, having made the critical and

essential adjustments, reflections began to present real opportunities and benefits over the six-month period. The ironies were that although potentially life threatening, the Covid-19 lockdown had also enabled an environment for and of real relational life-space opportunities – a forced experiential learning platform for great relational child and youth care practice. Finding the relational in the new non-relational Covid-19 world required the reviewing and revamping of all that we did in order to maintain all that we knew to be necessary for good child care practice.

Each practice area was reviewed, guided by the need to keep within the boundaries and principles of good child and youth care. A challenge was to ensure that philosophy continues to underpin the new thinking and design of both the care environments that we offer our young people and the adaptation of practices to meet the needs of young people and their families. The outcome sought involved the need to adjust to practices that 'created caring barriers' with terminology that described the antitheses of all of the terminology with which we found comfort in 'the old world'.

From Crisis to Opportunity

The figure alongside reflects the processes from an initial experience of crisis with "Covid-19, the non-relational child and youth care environment" – to an emerging experience of real and positive movement towards "a meaningful, intentional relational child and youth care environment".

Shifting/Securing Strategy

The initial months of caring during the 'hard lockdown' required an adjustment to working within an environment that required responsiveness to the need for a continuously 'shifting strategy'. The goal on a strategic and practice level was to keep all staff and young people as safe as humanly possible, and to ensure that our child and youth care environments remained contained and free from rampant infections that could spread and disable the care environments. Care and safety policies were implemented but required consistent updating and reviewing as the science and knowledge regarding the behaviour of the virus unfolded, almost on a daily basis. The strategic principle applied always was underpinned by 'err on the side of caution' and so often resulted in our assuming measures beyond those required at the differing lockdown levels.

A case in point was the State recommended reduction of quarantine time from 14 to 10-days. We retained the 14-day quarantine and isolation guidelines for any staff member or youth who might have, in any way, been exposed to potential infection or who was showing two or more symptoms as the science and evidence was being clarified frequently to guarantee a depth of understanding about the impact of the virus at that point. A practice tension persisted around the ways in which layers of administration were distracting from our primary focus on care strategies for young people. As the months unfolded and adherence to policy was understood to be a matter of safety and potential 'life or death' for some, policy was followed earnestly and absolutely by teams – and by the youths – as a whole community. A wonderfully beneficial irony was that experiential needs during this time of crisis began unfolding as a disciplined practice in line with organisational intent, actually *securing, rather than shifting, the discipline required for securing strategic implementation*.

Sanitised Yet Supportive Management

We learned quickly to address the need for regular debriefing and processing of challenges across all levels of the organisation. This was to manage anxieties and resulting stressors and to ensure real and meaningful support throughout the structures

of the organisation – keeping thinking, emotions, and responses in continuous check and sanitised. The goal was to achieve 'known', approved, and understood processes as much as was possible – within an environment where so much about the Covid-19 experience remained unknown and unpredictable. The practice stress was that, with the lack of opportunity for face-to-face meetings and contact management, processes would be less effective and 'sanitised'. Initially many of the team members reported finding virtual meetings and contacts exhausting and limiting.

The resulting irony was that rather than being 'sanitised', management contact evolved into more frequent, focused, and supportive-style contacts, which bore more richness of development and co-collaborative outcomes than previously. The forced crisis transformed what was always intended to be a supportive style of supervision and consultation to a lived experience of truly supportive and collaborative management implementation. National management meetings were held weekly using virtual means where Covid-19 related updates, challenges, practice adjustments and management applications were considered. Operational decisions were reviewed and adapted where required. Such meetings and information updates, along with continuous learning and education flowed down through the structures of the organisation.

There were regional differences in the national responses taken to try and manage the disaster. Different lockdown level requirements applied across different residential campuses. Because the agency was dealing with different Covid-19s related infection risks, so the transfer of learning and practice applications from different parts of the country were beneficial for the wider national team. Management teams reported on how, when faced with what otherwise might have been a stressful and overwhelming new development, they were immediately able to draw on the previously shared practice process from an event managed from a different campus in a different region. In essence, the processes allowed for a sense of real management control, flow, and responsiveness, even while dealing with a viral impact, where still so much remained 'unknown'. The flow grew into collaborative and authentic shared contributions to team development, growth, and ownership of individual members, reinforcing organisational intent and meaningful leadership. We learned yet again that an organisation is only as

good as its staff team members' capacity to transform opportunities through shared crises and lived experiences.

Masked and Meaningful Communication

Through the Covid-19 crisis, medical 'stay safe' guidelines required the non-negotiable wearing of multi-layered masks, social distancing of two meters, constant sanitising, and the limiting of human-to-human exposure times of no more than fifteen minutes at a time. If necessary, then extended human-to-human exposure may happen in well ventilated areas with small groups involving essential membership only. These guidelines are virtually the antithesis of what is required for relational child and youth care practices that are therapeutically healing.

Initial implementation and practice challenges included concerns around educating youths in care to use their masks, washing them daily, keeping them accessible at all times, managing their proximity to others and so on, all with immediate effect. Such expectations would be very challenging considering youths' history of behavioural challenges and low responsiveness to learning new and adapted ways of being and behaving. Concerns also related to the many elements essential to reading and decoding within the relational child and youth care environment. Closer observation of non-verbal expressions, behaviours and/or communication opportunities, might be obstructed or 'masked'. Ironically, rather than obstructed, limited and 'masked', the reality was that the process of communication offered more meaningful experiences, with richer relational expressions and acts of appreciation, and thus outcomes between staff, between youths, and between staff and youths.

With 'masks' restricting accessibility and communication processes, so it was that all were encouraged to give more intensive attention towards non-verbal communications, with opportunities for more 'meaningful' and relational communication styles. In practice, staff interventions with young people, around the need for changed behaviours to protect themselves and others, saw positive and unexpectedly swift responses by youths. Youths took personal responsibility for their safety, the safety of others, and even held others accountable when they were less responsive. Such responses came from youths who had

– until the crisis – paid little heed to interventions regarding their safety and the need for changed behaviours – such as drug experimentation, absences without leave and so on – to keep themselves safe.

Isolated Yet Significant Stimulation

What started as a two-week Alert Level 5 lockdown was extended across a 6-month period with de-escalating lockdown levels, where staff teams and youths were bound together, living and sharing their life-spaces on a 24-hour,seven-day basis. Community-based schools were closed, places of residence had to remain unchanged, and outings and/or gatherings were not allowed. As a means of controlling the virus through 'flattening the curve' of infections, staff who could work from home were required to do so, and only essential service workers were required to interface with other humans.

This practice stress meant that our therapeutic residential campus staff, along with our youths, were 'isolated' and secured – almost from the outside world – for months on end. Schooling, caring, nurturing, connecting with friends and other such human survival needs were met, day after day for months, within this closed circle involving the same staff members and youths. Staff schedules were stretched, and a tedium of routine and activity threatened the healthy rhythm and energised developmental activities so critical to meaningful relational child and youth care and the required outcomes.

Although the need to ensure 'significant stimulation' (vs 'isolated stimulation') for the staff teams and youth was identified and addressed through a reprioritisation of budget to line items and an individualised 'Covid-19 joy list' was enabled, the irony was that this forced, closed environment facilitated relational child and youth care – through meaningful presence, activity, and connectedness. In practice, this crisis afforded staff and youth a unique and intensive opportunity to truly relate and get to know one another – relational connections were healing and healed. Under the circumstances, such unexpected, yet strategically plans for outcomes, were recognised over the ensuing months. One such example was that national reports highlighted that negative youth incidents had dropped by significant percentages. Another occurred when staff members were offering numerous examples during virtual treatment planning sessions of

transformed youth behaviours. One senior staff team supervisor began such a planning session with “I never thought I’d hear myself say this, but yay for Covid-19 …”.

Remote and Connected Belonging

The implications of the Covid-19 lockdown were that youths, families and significant others were prevented from physical access, as also applied to our live-in staff team members and their immediate family members living on-campus. There were some youths and families who had had no physical contact for seven or more months. The concerns and stressors related to the relational aspects of care, belonging and attachment influences – and the potential for escalating youth behaviours born of frustration and sadness at the distancing from familial contact.

Although youths continued with regular ‘remote’ telephone contact with families between approved weekend and holiday visits, this form of contact alone was assessed to be insufficient. A further practice concern and challenge required our review of how to ensure ongoing family strengthening interventions using only remote means – as access to other environments was restricted and not allowed during the various Covid-19 lockdown Alert Levels. This threatened relational support and much-needed interventions during these threatening times for families of youths in our care. Our concern was that personal developmental work, and life, could not simply be put on hold. Youths needed to ‘see’ their families.

Teams were resourced to enable connectedness via virtual communications with families – and between families and children on a weekly basis. Ironically, had it not been for the lockdown and the threat of ‘remote belonging’, we may never have reached geographically distant families and significant others. This involved the resourcing of teams, refinements to GBTSA Family Strengthening practices, and developing worker skills that enabled youths to stay connected using a virtual medium. Thus, the threat of ‘remote belonging’ allowed for the beginning of a journey to adapt to ‘connected belonging’ strategies and practices.

New Lessons and Learning

Crises can indeed facilitate opportunities for renewed thinking, learning, and innovation. This assumes that threats are recognised and responded to with energy and consideration, but deliberations are most fruitful when they draw on solutions within the philosophy of intended practice and outcomes. Threats and crises are real at the time of experiencing and being in those moments. However, very real, productive, and meaningful practices can emerge from what seems, at the time, to be real adversity. Relational practice can occur in less than perfect environments or under less than perfect conditions or circumstances. Meaning is given to lived experiences, even under the most adverse of circumstances, offering opportunity moments for transformative learning. Where were you during the Covid-19 Lockdown?

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Reducing Recidivism

Kelsey Hagen

Abstract

A traditional justice system approach to youth offences does not reduce crime. Youth often end up reoffending and become stuck in a cycle of criminal activity. This article takes a critical look at various programs designed as an alternative to the traditional justice system for youth offenders. Programs are evaluated based on their ability to reduce recidivism in youth long-term. Characteristics of the successful programs are then analyzed. Based on the review of the literature and the author's experience in the field, suggestions of how to improve the youth justice system are given. There needs to be better programs for youth, as well as a better system to evaluate their effectiveness.

Introduction

There is a problem where youth who become involved in the justice system reoffend, leading to an ongoing involvement. A number of youth who become involved with the justice system are arrested on multiple occasions (Kubik & Boxer, 2020) and they may continue to be involved as adults. As said by Quinn & Van Dyke, "There is a continuing need for effective interventions with juvenile delinquents" (2004, p 178). There is a need to implement intensive and holistic programs to prevent recidivism, as "The most cited recidivism rate among juveniles involved in the system is 60% by the time they turn 18 years of age." (Menon & Cheung, 2018, p 460).

We need to challenge the traditional ways of dealing with juvenile delinquency. It has been noted that "probation has not been demonstrated adequately as a viable response to delinquency to curb recidivism," (Quinn & Van Dyke, 2004, p 178). If society wants to

reduce the rates of recidivism, there needs to be holistic services that do more than punish criminal behaviour.

Throughout this literature a variety of programs were reviewed. The end goal of all these programs was desistance, which is when a youth stops committing crimes. Each program tackled the problem of recidivism in a different manner. Before examining the programs aimed at desistance, I examine the many layers that accompany youth committing crimes, in addition to potential risk factors. Then the various programs and measurements of success are examined in the sections below.

Youth crime – a complex issue

There are many factors that contribute to a youth committing a crime. Risk factors include poor mental health and poverty (Kubik & Boxer, 2020). Family involvement in the youth's life and/or involvement in crime are also factors that influences repeat offending. If the family is involved in the youth's life in a positive way, then the youth are less likely to commit crimes, while the opposite is true if family members are involved in crime themselves (Kubik & Boxer, 2020).

A lot of the youth involved in the justice system are vulnerable youth. Research has found that "The majority of youth involved with the juvenile justice system report significant mental health and/or substance issues" (Kretschmar, Tossone, Butcher, & Marsh, 2018, p 168). The rate of youth in the justice system reporting a minimum of one mental health or substance use disorder is between 65% and 75% (Kretschmar et al., 2018).

In addition to mental health, addition, and trauma, "It has been repeatedly demonstrated that a substantial number of offenders are likely to be or have been victimized at some time in their lives" (McKillop, Brown, Johnson, Smallbone, & Ogilvie, 2016, p 41). Youth involved in the justice system are more likely than other youth to experience victimization (Kretschmar et al., 2018). Victimization takes many forms, including being the victim of a crime, abuse, or neglect (McKillop et al., 2016). The risk factors for those who commit crimes overlap with the risk factors of being victimized (McKillop et al., 2017).

Types of programs

There is no clear answer as to which type of treatment program is the best for youth offenders. Overall, the studies show that the traditional justice system is not effective. Something needs to change. Collaboration was shown to be effective in creating change and presents as a way to transition the youth at the end of treatment (McKillop et al., 2017).

Various types of programs that aimed to reduce recidivism were examined. Menon & Cheung completed a review of multiple programs, while Kubik & Boxer focused on one program called COPY (Call Out Program for Youth) in their research (2018; 2020). Some of the programs included one type of treatment, while others included a multidisciplinary approach. In the sections below I examine the programs that have been proven effective in reducing recidivism and the programs that are not effective when compared to the traditional justice system.

To prevent youth from reoffending, there are many programs that have been implemented. Menon & Cheung completed a review of twelve studies completed between 2007 and 2017 to see what characteristics of programs were most effective in reducing recidivism (2018). Menon & Cheung refer to a 40-asset development model to determine if the programs are successful (2018). They take the position that the more assets that are included in the implementation of the program, the more likely the program is to be effective in reducing recidivism (Menon & Cheung, 2018). The assets were focused on "the essential factors for healthy youth development." (Menon & Cheung, 2018, p 460). Working with youth as a child and youth care practitioner, I recognize that these assets can be invaluable in providing the best care for the youth. The assets look at identifying which protective factors and risk factors impact a youth's risk of reoffending (Menon & Cheung, 2018). Some of the assets listed included external assets such as boundaries and expectations, empowerment, and support (Menon & Cheung, 2018). These assets can be implemented through things as simple as conversations and programming with youth. As someone who cares for young people, I recognize the crucial role I play in developing these external assets. It should be noted that Menon & Cheung did not research whether youth in various programs reoffended, they merely looked

hypothetically at whether or not a program could be successful (2018). This makes the programs analyzed by Menon & Cheung and the assets-based model used unable to be categorized as effective or not, as there was no clear answer provided in the literature.

Effective programs

Effective programs had some common characteristics. Family and community involvement showed promising results in reducing recidivism (Flash, 2003; Kretschmar et al., 2018; Quinn & Van Dyke, 2004). It is also important the any treatment implemented meets the youth's individualized needs. It is also crucial that the treatment be representative of where the youth is at in life.

Quinn & Van Dyke evaluated a multiple-family group-intervention program (2004). This type of program is a form of group therapy that involves the family as well as the youth. Families had the opportunity to support each and relate to each other on a level that a professional could not (Quinn & Van Dyke, 2004). This helped create a sense of community for the youth and their families. All the sessions were facilitated by thoroughly trained facilitators (Quinn & Van Dyke, 2004). The program was shown as successful in reducing rates of recidivism (Quinn & Van Dyke, 2004). Even youth who started but did not complete the program were more successful at desistance than those who were not referred to the program (Quinn & Van Dyke, 2004).

Having treatment take place in the young person's home community has shown greater results in reducing future offences (McKillop et al., 2017; Kretschmar et al., 2018). The Griffith Youth Forensic Service is a treatment program that goes to the youth (McKillop et al., 2017). This means that the treatment takes place in the youth's community and home environment. In South Africa the Isibindi program trains people in local communities to become child and youth care workers (CYCWs) (Visser, Zungu, & Ndala-Magoro, 2015). This not only allows the youth to stay in their home community but also allows the children to work with community members who are familiar to them. Displacing youth during treatment could cause additional stressors. Taking a youth out of their normal environment for treatment then placing them back after treatment is something I have seen through my practice as ineffective.

A systems-focused program in Australia was created to provide individualized treatment in an offender's home environment (McKillop et al., 2017). The focus of the treatment program was to look at "changing lifestyles and activities within the youths' natural social ecosystems that increase the risk of offending" (McKillop et al., 2017, p 48). This was done by addressing risk factors associated with committing crimes, particularly violent and sexual crimes (McKillop et al., 2017). "There is also some evidence to suggest that the trauma associated with these victimization experiences influences both initial involvement in offending and re-offense risk" (McKillop et al., 2017, p 41). The results showed that youth who completed the program were less likely to be victimized or commit another crime (McKillop et al., 2017).

Another program that showed promising results in community-based treatment took place in Ohio (Kretschmar et al., 2018). Functional Family Therapy is a treatment method that takes a strengths-based and family approach. Youth and their families complete sessions focused on five components: "engagement, motivation, relational assessment, behavior change, and generalization" (Kretschmar et al., 2018, p 176). The process takes place close to the young person's residence, which makes attending the treatment more accessible (Kretschmar et al., 2018). Individualized treatment is tailored to both the youth and their family (Kretschmar et al., 2018). Multiple professionals are involved and meet on a bi-weekly basis to discuss the treatment plan (Kretschmar et al., 2018). This program is successful in part because after the treatment from a professional is completed, the support system still exists for the youth, as the family remains intact (Kretschmar et al., 2018). Youth from the program not only had a lower rate of reoffending, but they also received less charges on average than those who were not involved in the program (Kretschmar et al., 2018).

The final effective program was one that focused on "cross-over" youth. "Cross-over" youth are young people who are dually involved in the child welfare system and the justice system (Haight, Bidwell, Choi, & Cho, 2016). Haight et al., examined a type of treatment that focused on cross-over youth, called the Crossover Youth Practice Model (2016). The treatment is strengths-based, multidisciplinary, and looks for increased family involvement (Haight et al., 2016). It was deemed effective in reducing recidivism

and "disrupting negative development of trajectories that could eventually lead to involvement in the adult criminal justice system" (Haight et al., 2016, p 83).

Programs with less long-term effectiveness

Not all alternative treatment types are better than the traditional justice system. Some of the programs analyzed were not effective in reducing rates of recidivism. Carney & Buttell looked at a wraparound services program (2003). The services focused on a strengths-based approach, which included family involvement, educational outcomes, and peer relationships (Carney & Buttell, 2003). The program was successful, according to parents, in reducing delinquent behaviours, but did not reduce the rate of recidivism compared to the traditional justice system (Carney & Buttell, 2003). They believe that the lack of success is due to various treatments that were provided by volunteers, who had little to no professional training (Carney & Buttell, 2003). While involving the community and family as supports, it is crucial to have professionals facilitate the service.

Boot camps, also known as shock incarceration, have not shown to be effective for youth (Flash, 2003). Structured like the military, boot camps focus on instilling structure into a youth's life (Flash, 2003). At the boot camps there are varying degrees of "job-training or educational opportunities, health or mental health care, and community service requirements" (Flash, 2003, p. 516). While there was no clear treatment or post-intervention treatment model, the results from research into several boot camps were the same. There is usually a change in attitudes surrounding multiple things, such as life, crime, the justice system, rehabilitation, and hope about the future (Flash, 2003). Recidivism rates did not drop when youth went to a boot camp compared to a traditional correctional facility (Flash, 2003). In fact, one study saw youth who attended the boot camp reoffend faster than those who were incarcerated (Flash, 2003). If boot camps are to be effective, it is recommended to provide additional treatment within the boot camps and examine which offences are most likely to benefit from the structure boot camps provide (Flash, 2003).

One form of treatment is a mediation/Victim Offender Reconciliation Program (VORP). Flash conducted a literature review focusing solely on recidivism rates for youth who took

part in a VORP (2003). Overall, the results showed only slight decreases in recidivism rates for youth who took part in mediation programs (Flash, 2003). Flash believed that this was in part due to mediation being a voluntary process for both the victim and perpetrator (2003). There is a mediation program for youth in care in Nova Scotia called restorative justice. The process follows mediation and there is always work for the youth to complete as their sentence. This provides youth the opportunity to keep a clean criminal record, which can eliminate the barrier of a limitation in possible jobs and careers. However, this often results in youth feeling as if they have "gotten away" with the crime. Youth who have participated in the restorative justice program also tend to have multiple encounters with restorative justice and the criminal system. Kubik and Boxer echo the sentiment that mediation is not the best option to reduce recidivism in youth (2020). Restorative justice does not always deal with the underlying conditions that may have contributed to the youth committing the crime. In New Zealand a form of restorative justice for youth was created using Maori principles (Maxwell & Morris, 2006). While nearly half of the youth had rehabilitative elements in their restorative justice plans, more than half did not (Maxwell & Morris, 2006). While this may have been due to a lack of services available, it is still unacceptable (Maxwell & Morris, 2006). A mediation or restorative justice has to be more than showing remorse and doing an act of kindness for the community of harm. There needs to be appropriate services in place that work on helping the youth keep from reoffending.

Kubik & Boxer examine a program called COPY (Call Out Program for Youth) and see if it is effective in reducing recidivism in youth (2020). Kubik & Boxer performed a study where they looked at "the impact of referral to and engagement in a voluntary diversion program on recidivism outcomes after a first arrest for a serious offence." (2020, p. 288). There is ample short-term evidence that shows the success of the program. According to the data collected, "youth in the referred group had a decrease in odds of re-arrest within 3 months by 72.7%." (Kubik & Boxer, 2020). The results were not promising when it came to long-term desistance and did not show significant results in desistance rates after a three-month period (Kubik & Boxer, 2020). There needs to be a long-term solution to the problem, not a short-term one. A factor that may have impacted this is the lack of

wraparound services (Kubik & Boxer, 2020). There was also a lack of data surrounding factors that contributed to youth reoffending (Kubik & Boxer, 2020).

Evaluation

The current youth justice system presents with many problems. In my practice I see a lack of referral to services as a key factor in recidivism. Many of the youth I work with have a criminal record. The youth with more serious offences, such as breaking, entering or assault, are often given lengthy sentences without a referral to any sources. Without proper services in place, some "youth simply slip through the cracks" and never receive the help they desperately need (Carney & Buttell, 2003, p. 553). As stated by Kubik & Boxer, there are often underlying mental health conditions that are untreated in the youth (2020). As a child and youth practitioner I see the lack of referrals to services provided to these youth. Underlying causes of criminal activity often include drug addiction and poor mental health as key factors. The youth themselves recognize that they are stuck in a cycle of poor mental health and/or drug addiction and committing crimes.

In addition to a lack of referrals to appropriate services for underlying conditions, there is a lack of holistic programs that focus on reducing recidivism. There are lots of programs and services that focus on one aspect of what is causing the youth to commit crimes. Youth can participate in therapy, employment programs, intensive treatment through the IWK Children's Hospital, and drug treatment, such as rehabilitation. Oftentimes the youth I work with need multiple services in order to stop committing crimes but are not being referred to all the necessary services. Menon & Cheung echo this need for intensive and holistic services, citing that "young offenders must attend a rigorous curriculum with quality…" (2018, p 473). There are numerous benefits to holistic and collaborative approaches as stated in some of the programs above. As stated by Quinn & Van Dyke, "The focus of human service must be expanded to include the level of the family, school, and community in order to break the cycle of criminal behavior effectively." (2020, p 195). It cannot be one service provided by one profession that stops a youth's cycle of criminal activity. It also cannot be the professional alone who is

involved in helping the youth. Family, important people in the youth's life and their community all have to be committed to change.

Having so many resources with targeted approaches presents its own set of issues. The youth are usually unwilling to engage in multiple services at any given time, with some citing it as overwhelming to be engaged in so many services. Another issue is the lack of proper communication between resources. As a provider of services to youth who have committed crimes, there have been times when the youth's probation order hasn't been sent, or appointments have been set up without communication between service providers and the youth misses the appointment. A lack of communication between resources can also be confusing for the youth. If each resource has its own goals and treatment plan for the youth, then the youth could end up with conflicting goals. A lack of communication between service providers negatively impacts the youth more than anyone else.

There are many benefits to having individualized treatment services for youth offenders. Providing individualized services are a way to ensure that youths receive the specialized help they need. Carney & Buttel state, "What is clear is that juvenile delinquent youth need to be connected to services that meet their individual needs" (2003, p 553). Each person is unique and should be treated as such. Traditional "one size fits all" methods to reducing recidivism have been proven ineffective (Carney & Buttel, 2003). Menon & Cheung cite that "Desistance-focused programs must take an individual focus …" (2018, p. 469).

While the goal of programs should be desistance, there are also cost savings for taxpayers. The fiscal benefit was noted for effective treatment programs (McKillop et al., 2017). The cost of youth continually going through the justice system was lower than the cost of the treatment program and collaborative care approaches (McKillop et al., 2017). If a program is effective in treating the underlying causes of committing crimes the first time, then youth do not re-enter the justice system, which saves the justice system money. Not only does the justice system save money, but potential victims also save money from the cost of repairing the harm caused by the crime (Quinn & Van Dyke, 2004).

When analyzing which programs in the literature were effective at reducing recidivism, I noticed that there was a lack of cultural considerations. Not every young person who commits a crime is of the same culture. North America is centered around a Eurocentric point of view. This view ignores minorities and their ways of being. If a young person's cultural needs are not taken into consideration when providing services, then how effective will the services be? Young people should not have to conform to the traditional Eurocentric way of being. Instead, services should adapt to the needs and culture of the youth whom they serve.

Conclusion

The literature shows mixed reviews regarding the success rate of alternatives to the traditional justice system. With so many types of potential services out there, "there must be follow-up evaluation of these efforts to ensure that both the public and today's youth receive the best care possible in our search for the prevention and treatment of juvenile delinquency" (Flash, 2003, p 525). Strong evidence of success from research will aid in the creation of future programs and future funding to said programs. As I found out through my research, "The field lacks evaluative literature of treatment programs" (Flash, 2003, p 523). If there is not evaluation of programs that demonstrate rates of desistance in youth, then how can a program be deemed effective?

Throughout this article I have looked at numerous programs that aim to reduce youth recidivism. Common themes of successful programs included multidisciplinary teams of professionals, a strength-based approach, family and community involvement, and having treatment available in the youth's home community. A lack of cultural considerations was evident in the literature examined. Youth need to be treated after committing a crime, not punished. Otherwise, there is a high chance that they will reoffend (Haight et al., 2016). With underlying conditions such as mental illness often accompanying youth in the criminal system, merely holding the youth accountable for the crime is not enough (Kubik & Boxer, 2020). It is an injustice that the children and youth are not being helped. As child and youth care practitioners we often look for the meaning behind the behaviour. Behaviour often serves a need. Providing services that address the needs of the youth

would likely reduce the rate of recidivism. We need to do better for our youth and give them the best chance possible at thriving by living crime free lives.

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Modelling Relational Practice through Learning Strategy Instruction in the Child and Youth Care Classroom

Chrissy Deckers

Abstract

The teaching of learning strategies by child and youth care professors offers a model of relational practice to students. Furthermore, embedding learning strategies into the curriculum supports first semester students with their transition into the postsecondary environment and demonstrates our commitment as professors to student wellbeing and success. A brief introduction to learning strategies is provided and parallels between the fields of learning strategies and child and youth care are articulated. The potential of learning strategy instruction to provide a model of relational practice is explored. Considerations for professors who wish to incorporate learning strategies into their classrooms are offered.

Key words

Learning strategies; Relational practice; Teaching; Higher education

As a child and youth care professor I aim to model core tenets of child and youth care practice in my teaching. This includes working from a strengths-based approach and supporting postsecondary students holistically through their academic journeys, which often include times of considerable transition. Having worked

in the college system as a part-time professor, learning strategist counsellor, and student success advisor, these multiple vantage points have provided me a unique perspective on the challenges first semester students experience and the potential of learning strategies to assist students in their transition. While supporting students in their transition, learning strategy instruction also provides an opportunity for professors to engage in relational practice with their students. Parallels will be drawn between the fields of learning strategies and child and youth care practice, prior to delving into select elements of relational practice to illustrate the potential of professors' purposeful use of learning strategies to enact relational practice. To conclude, practical considerations will be offered for those readers who have an interest in exploring the promise of learning strategies for themselves.

Hunter and Korpatnicki (2014) described the emotions students often experience as they enter postsecondary education and adjust to the demands of their new environment, explaining "stress and anxiety" (p. 1783) as common. I have made similar observations in my work over the years in the postsecondary environment both as a professor and practitioner supporting student success and wellbeing. Entrance into postsecondary studies constitutes a significant transition in a student's life (Chickering & Schlossberg, 2002). While a predictable life event, entry into postsecondary education can present other unanticipated transitions as well. For example, some students begin to struggle in their schoolwork despite excelling in secondary school or question their program choice. Steele and McDonald (2008) referred to such phenomena as "non-event transitions" (p. 158), which, while not tied to an event, nonetheless can provoke an experience of loss. During these times of transition, we can support students by further strengthening their academic and personal resilience through the introduction of learning strategies in the classroom. As defined by Unger (2006), resilience is the "capacity to overcome [...] adversity" (p. 3). Of note, Unger's (2020) work has demonstrated that individuals are more likely to demonstrate resilience when they have access to supportive resources.

Learning strategies encompass academic skills development. Skills include time management and organization, reading comprehension, notetaking, breaking down assignments, essay writing, presentation preparation, studying, and test taking. Simply

put, learning strategies are about helping students to "[learn] how to learn", an insightful term coined by Novak and Gowan (1984) in their book *Learning How to Learn*. Beyond academic skills, learning strategies can include other important life skills that impact academics, including goal setting, bouncing back from a set-back, self-advocacy, and stress management. Learning strategies are important to helping students succeed and reach their individualized academic goals. My use of the term 'success' is broad and inclusive, to reflect students' diverse academic goals and views of excellence (Dei, 2010, 2014). Indeed, Schreiner (2010a) explained that it is conducive to students' success when professors take the time to explain the usefulness of specific strategies within the classroom. As a result of the shift to remote learning prompted by the COVID-19 pandemic, learning strategies are a valuable resource to provide for a more accessible remote learning environment (Pichette & Rizk, 2020).

In alignment with child and youth care practice, learning strategies are strengths-based. They focus on the student's ability to persevere and overcome difficulty to achieve a higher level of independence. Philosophically, the teaching of learning strategies is grounded in a growth mindset. A growth mindset is the belief that new skills can be developed through effort and practice (Dweck, 2006). Being in the privileged position to hear students' stories day in and day out, has underscored for me the potential of learning strategies to support students through a myriad of expected and unexpected transitions and model relational practice. As a learning strategist counsellor, I worked one-on-one with students in confidential appointments to assess student need and collaboratively support students to build on their strengths and cultivate a growth mindset regarding areas of need. In classrooms, I spent considerable time embedding learning strategies into the curriculum as well as consulting with professors interested in doing the same. In my current role as student success advisor, I continue much of the formally described one-on-one work with students. The similarities, yet juxtaposition of my various roles in the postsecondary system have provided me with significant insights into the student experience. I have supported students who beyond the transitional experiences common to first semester students are pursuing their studies while experiencing homelessness, are grieving the loss of a loved one, are overcoming addiction, or are

receiving cancer treatment. These stories are shared with me in the security of a confidential student appointment in a private office, where my relationship with the student is foundational to the skill building that happens in this space. When I teach, I carry these stories with me. I remind myself that the students in my class arrive with their own unique experiences.

While the implementation of learning strategies is beneficial for all students, regardless of their program of study, I have a particular interest in how embedding learning strategies can further aid child and youth care students. As will be illustrated, beyond providing child and youth care students with additional 'tools' to add to their metaphorical 'toolbox', incorporating learning strategies provides a model of relational practice, as the teaching of learning strategies provides a means to cultivate and nurture relationships with students. In the field of child and youth care, our relationships are central to our work and support growth (Garfat, 2003; Garfat & Fulcher, 2012; Garfat et al., 2018). Indeed, Garfat et al. (2018) clearly stated that it is our relational approach to our work that unites us as child and youth care practitioners, whether working as professors or otherwise. As child and youth care professors, we attend to more than just a course's learning outcomes, we model relational practice. Embedding learning strategies into the curriculum is one way professors can demonstrate relational practice as described by Garfat and Fulcher (2012), including "meeting them where they are at" (p. 9), "responsive developmental practice" (p. 11), "connection and engagement" (p. 9), and "being in a relationship" (p. 9).

Supporting students in their academic and life skills development is about "meeting them where they are at" (Garfat & Fulcher, 2012, p. 9) and "responsive developmental practice" (Garfat & Fulcher, 2012, p. 11). These facets of child and youth care practice involve responding to an individual's needs. Moreover, the former necessitates validating their corresponding emotions (Garfat & Fulcher, 2012). Teaching learning strategies is not just about developing academic skills like note taking, studying, or essay writing, but rather validating and normalizing the emotions that accompany periods of transition as students adapt to the demands of postsecondary studies. As an example, perhaps the most significant adjustment for first semester students is time management, which can

be supported through various learning strategies. Many incoming students do not realize how much time they should be spending on a course outside of class time or what they should be doing outside of class and consequently do not spend enough time on their studies. As a result of lower-than-expected grades, these students may feel discouraged and at a loss as to how to bounce back. Conversely, other students may lose any semblance of balance in their days, quickly feeling overwhelmed by their studies. Meanwhile, a considerable number of our first semester students are trying to navigate these new expectations while living on their own for the first time and experiencing homesickness and new freedoms. Importantly then, when presenting learning strategies, these common first semester experiences and feelings are shared back to students while demonstrating empathy.

One example of a student who had his needs meet through this relational approach connected with me after our class. He shared that he struggled in high school, and despite being passionate about the program continued to struggle as he navigated the transition into college. He had received a lower-than-expected grade on his first assignment and reflected that had not been spending the needed time on his courses because of his employment. Addressing common first semester struggles in class encouraged this student to connect outside of class time and request additional support. Listening without judgment and normalizing the learning curve that is presented in first semester, supported this student to come to the realization that his studies would benefit from him reducing his hours at work, maintain his determination, and importantly treat himself with kindness. Yet another student was adjusting to the demands of first semester when her child became ill during the pandemic. Entry into postsecondary studies is a time of transition for all students; in addition, this student was balancing medical appointments and advocating for her child, while managing her own mental health during a challenging period. Often, students are coping with complex situations. This student reflected that this relational approach encouraged her to reach out for additional supports offered through the college.

As might be expected when acknowledging the empathetic approach to the presentation of learning strategies, learning strategies foster “connection and

engagement" (Garfat & Fulcher, 2012, p. 9) between the professor and students. As described by Garfat and Fulcher, it is the responsibility of the child and youth care practitioner to develop relationships. Building on the example of time management, a weekly plan is one tool to support students' skill building. However, more than skill building, learning strategies present an opportunity to gain a deeper appreciation of students' lives, including their many roles and responsibilities. Developing this weekly plan requires a student to schedule regular commitments like classes, which occur at the same time every week, followed by those activities that have more flexibility, including homework (The Learning Portal, 2020a). As part of this process, I prompt students to consider the commitments and activities they ought to capture in this plan through interactive activities, which allow me to get to know them, including learning about hobbies, family responsibilities, and employment. During the pandemic, one student shared that every week she was commuting to her older sibling's house located two hours away, to support her young niece and nephew with virtual learning while her sibling worked. This in-class activity opened up future one-on-one discussions about missed synchronous classes, as this student worked to find a balance between supporting her family during a time of need and working towards her own academic goals. Thus, this activity extends beyond skill building as it relates to managing class requirements and prioritization and can be facilitated in such a way that professors begin to build community.

Through the introduction of weekly plan and other learning strategies, a natural space is created for us as professors to "[be] in a relationship" (Garfat & Fulcher, 2012, p. 9). "Being in a relationship" (Garfat & Fulcher, 2012, p. 9) recognizes the significance of the relationship during times of challenge and being responsive. The semester plan is a learning strategy that provides an overview of all of the student's due dates for all courses they are enrolled in, including the percentage each item is worth (The Learning Portal, 2020b). Once students complete a semester plan, they can identify the busiest weeks of the semester and prioritize. Professors can begin modelling the mapping out of due dates for their course and then then provide an incentive for students to complete. Importantly, professors can refer back to this document to anticipate students' stress

levels and check in on students' wellbeing to support them through inevitable times of difficulty as they navigate the learning curve presented during their first semester, with the complexity of their unique circumstances in mind. Support may include bringing students' attention back to their weekly plans to ensure they are taking time for self-care, offering stress management strategies, or taking the time to support students through mindfulness activities (see Slavik, 2014; Ventrella, 2017).

Embedding learning strategies into the curriculum may seem onerous, but it does not need to be. Hunter and Korpatnicki (2014) provided an accessible explanation of possibilities for integrating the teaching, modeling, and practice of learning strategies into postsecondary curricula, using time management, reading, and note-taking learning strategies as concrete examples. Furthermore, many institutions employ learning strategist counsellors or related professionals whose regular responsibilities include consulting with professors to do exactly this. Online resources also exist that provide a menu of options for professors' consideration and corresponding templates, including the Ontario College Libraries' Learning Portal (see The Learning Portal, 2020c). In programs that have as part of their first semester curriculum a course with learning outcomes related to learning strategies, there is the unique opportunity to reinforce this learning in other first semester courses and to build on these foundations in the future to continue to scaffold the learning experience while modelling relational practice.

When embedding learning strategies into the curriculum, consider starting small. Focus on one or maybe two skills to initially support with "intentionality" (p. 11), which is yet another aspect of relational practice described by Garfat and Fulcher (2012). Reflect on prior teaching experiences and where students commonly struggle. Do students request extensions often? Do they perform poorly on tests despite sharing that they studied? Are they nervous about presentations? Do they feel overwhelmed by large assignments? Do their essays need work? For example, when teaching online I have generally focused on time management, appreciating that many students struggle with managing the self-directed nature of an online course. In the recent shift to remote learning this has continued to be a priority along with stress management, appreciating that an increased number of students are studying online out of necessity rather than

choice and are under additional stress because of the pandemic. With this realization in mind, I have started each synchronous class with a short mindfulness activity to encourage students to get comfortable in their space and (as their lives allow) center their attention on the present moment and task at hand. Drawing on Garfat's (2013) exploration of *the meaningful use of life events in child and youth care*, as a child and youth care practitioner the incorporation of mindfulness activities during class provides an opportunity to intentionally support students in their 'life-space' and have a shared experience to support relationship building. Indeed, Ventrella (2017) pointed to the connection between mindfulness in the child and youth care classroom and relational practice. Recently, when teaching a course on family dynamics and discussing the topic of roles in the family, I prompted students to reflect on their own family dynamics in light of the current public health crisis and associated restrictions and facilitated an activity inviting students to explore what was on their metaphorical plate, what had been pushed off, and what they felt they needed to bring greater balance to their daily lives. As a final illustration, when teaching a course heavy in theory I often focus on study strategies that help students to apply the material to ensure they are understanding the theories as opposed to simply memorizing them.

In conclusion, acknowledging that as professors we cannot do it all, I routinely encourage students who would benefit from individualized supports to seek out assistance offered through student services and help them to make this connection; when making this referral I frame this as a strength, highlighting their resourcefulness and commitment to their goals. Within the postsecondary environment, Schreiner (2010b) has emphasized the need for professors to normalise help seeking behaviour such as this. Beyond a commitment to relational practice and the possibilities learning strategies offer to model this core tenant of child and youth care practice in the classroom, educating on learning strategies fosters a growth mindset in students, supporting their academic success and ultimately their transition into the field.

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Time is a Concept in Being with the Work

Sherene Whyte

Abstract

A reflection on the concept of time within a Jamaican and Indigenous cultures and it's use in practice when working with children, youth and families

In my Jamaican culture, time is a concept that is circular; meaning that ones life is not based on a list of procedures or expectations but on family, community and relationships. Growing up there was a cultural understanding that when asked to attend an event there was the unspoken expectation that as a guest you may arrive at earliest an hour or two after the stimulated time on the invitation. This relaxation of not being on time has great significance within my culture and can impact work hours and expectations and even national functions. This innate concept of time can also be historical as I have a mix heritage of being an Indigenous African and East Indian.

According to Babalola & Alokan (2013), "Historically, Africans perceive the concept of time as a social cultural reality in the realm of how they are being with self and others philosophical scholarship". Babalola & Aloka (2003) further states for Africans "time is tied to events". These events can be seasonal and defines how specific tribes experience their cultural beliefs and carry out traditional practices. This concept of time is said to be a circular experience. A number of Indigenous people and non-Indigenous communities discern time as circular with the individual being the centre of time Janca & Bullen (2003).

In the Jamaican culture, time is centred around people and cultural events. It is important to Jamaicans to have the relaxation and ease in not being expected to be

punctual. This allows for time in preparing, traveling, and arriving at functions without anxiety. Thus, making the experience of the individual the centre of time. To further demonstrate our understanding of time within the culture there is a saying used of "soon come". Whenever a Jamaican says, "soon come" this could mean they will be with you within a minute or a day., A similar concept of the Jamaican saying "soon come" is also illustrated in the Aboriginal saying "It is not important when things happen it is important that they happen", (Janca & Bullen, 2003). When working in the North I am constantly reminded through self reflection and positive self talk to go with the flow and let go of my own personal inhibitions of how an event and or intervention should proceed based on a list or schedule. If you ever lived in the North of Canada you would know nothing normally goes as planned. There may be a sudden water shut down, a death, a snowstorm, or any number of unforeseen events. Thus, I have learnt to centre myself and how I practice around the needs of children, youth and families. By doing this I have learnt through my clients how to relax and be with the moment, taking me back to my roots and cultural understanding of self.

I believe this similar understanding of time between two cultures can help support our work with Indigenous Peoples. However, we must be mindful that our individual concept of Indigenous ways of being and doing is not necessarily true and indictive of each community or person we may build a relationship with. Within Indigenous community's time is viewed as moments for strengthening the bonds with family and community thus building relationships, (Janca & Bullen 2003). However, this can be personal and may become intrusive if not monitored and understood. It is therefore important to respect the lead of Elders and other community members. For example, when working with children, youth and families within communities, I have experienced firsthand that before an event can commence there has to be time given for various ceremonies such as prayer and smudging. This time must be respected and as a collaborator within the community I have to understand the need of such cultural practices.

The practice of Child and Youth Care work comes with power in knowing and being with others (White, 2007). As Blackstone (2009) indicates Indigenous Peoples of Canada have a tragic history of being in the moment and engaging with social workers. The same

is said for CYCWs. Even though there may be cultural similarities in how we are being with time, we are all being in the moment in different ways. We must be aware of the power of professional identity and how decisions both historically and present made by social workers and other human services professionals continues to impact the lives of Indigenous people. In my experience when working with Indigenous children and youth within schools, due to historical content of trauma, I have found that being trauma informed as a CYC helps in building relationships with Indigenous children. Therefore, there will be a need for continuous self-reflection and awareness of assumptions and biases (Thomas & Green, 2007). Continuous self-awareness of our own colonial historical content and trauma is vital. Individuals of black and brown identity will also have to be mindful of their own colonial history of trauma and how their body unconsciously may react to different events while engaging with communities.

When working with Indigenous children and youth, if individual practitioners such as teachers, social workers, and CYCWs are not open to a cultural understanding of time, being trauma informed and practicing self awareness, the act of building relationships and making connections with the children and youth will be hindered. An awareness of self within the moment, is of vital importance. This time of being is also private and personal and is a privilege if allowed to share. Accordingly, being mindful of the power of your position, the meaning of such power to the Indigenous community and resistance that may arise. Despite this, be aware of where you are and how you are being in the moment. Be cognizant that you may have to allow others to lead. In doing this, be humble and patient.

The Jamaican concept of time has grounded me in remembering that the individual and relationships are the centre of everything. In our practice as child and youth care workers the work should be about the client and not an accumulated set of notes that are to be jotted off. Time spent with a client should be valued beyond being punctual. Therefore, I would appeal to all my human services colleagues to challenge themselves to experience time as a gift, However, be mindful that we are living and working within a society that experiences time as linear. My challenge is to think through how we can stay true to ourselves and be in the moment with children and families as needed while also being accountable to our profession. In holding ourselves accountable I hope we reflect

on the following questions before engaging with children and families. Who am I in this moment? Why am I here? What are my intentions and or goals? Does this align with the client? How can I make this moment meaningful to the client?

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Information

Relational Child and Youth Care Practice (formerly *The Journal of Child & Youth Care*, established 1982) is committed to promoting and supporting the profession of Child and Youth Care through disseminating the knowledge and experience of individuals involved in the day-to-day lives of young people.

This commitment is founded upon the belief that all human issues, including personal growth and development, are essentially "relational".

Certain pieces in *RCYCP* have received peer review. However, we do not peer review all articles as we choose not to exclude those voices where peer review would be inappropriate or on request from writers.

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Relational Child and Youth Care Practice is committed to providing equitable and inclusive spaces that promote and support the global profession of Child and Youth Care through disseminating the knowledge and experience of individuals involved in the day-to-day lives of young people, families and communities. This commitment is founded upon the belief that all human issues, are essentially "relational".

Relational Child & Youth Care Practice welcomes submissions on all aspects relating to young people, families and communities. This includes material that explores the intersectionality of Child and Youth Care practice and the lived experiences of all who are engaged in Child and Youth Care practice. Considerations will also be given to interpersonal dynamics of professional practice and all submissions that assume a relational perspective. This might include topics such as cultural values, ethics, social policy, program design, supervision, education, training etc. Welcomed are also submissions that address advocacy, social justice and reconciliation practices within the diverse spaces and places of Child and Youth Care. Each issue may include refereed articles that comply with acceptable 'academic' standards; submissions contributed by regular and guest columnists; short pieces that describe particular relational experiences and reflections; poetry; artwork and photographs.

Material should be submitted by email to rcycp@press.cyc-net.org in standard word processing format (eg. .doc, .rtf). Formal articles should not exceed 6000 words in length (excluding references). Referencing should conform to either APA or Harvard format. Author-date citations should be used within the text and a double-spaced reference section should accompany each article. In all submissions, authorship details including an abstract of no more than 150 words should be included, as well as a short list of keywords at the beginning of the article, a headshot photo and a short author bio of about 100 words to publish with your article. Importantly, authors should also indicate whether a peer review is required (in addition to the standard editorial review).

Although no article or submission will be rejected purely for stylistic reasons, the editors reserve the right to return any manuscript for additional work. Authors requiring editorial assistance in this regard should indicate their request in a covering letter. Originality of material is the responsibility of the primary author. Previously published material must be identified as such and will be published only where the necessary permission has been granted from the original source.

Relational Child and Youth Care Practice may include Peer Reviewed contributions, stories, case studies, thought pieces, experiential descriptions and other forms of writing which will not be peer reviewed. In this way we aim to strike a balance between the values of Peer Reviewed articles and experiential voices from the field. This is a unique approach and one which we feel offers the best of both. Peer Review is available on request.

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