HEALING h+ MAGAZINE
2019 Vol. 24, No. 1

40 years of Foster Care

Plus:

- Perspectives from foster kids
- The Matrix Model for addictions treatment
- Gender diversity in schools

Visionary • Science Lover • Anxiety

It may not be obvious but mental health issues are as real as physical health issues. They can affect anyone. Even future astronauts.

HOPE. HELP. HEALING.

2019 • Vol. 24, No.1

Healing Magazine is a publication of:

KidsPeace
c/o Creative Services Department
4085 Independence Drive
Schnecksville, PA 18078-2574

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About KidsPeace
KidsPeace is a private charity dedicated to serving the behavioral and mental health needs of children, preadolescents and teens. Founded in 1882, KidsPeace provides a unique psychiatric hospital, a comprehensive range of residential treatment programs, accredited educational services and a variety of foster care and community programs to give hope, help and healing to children, adults and those who love them. Learn more at www.kidspeace.org.

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Providing practical, clinical information to families and children's professionals

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Are you interested in writing for *Healing Magazine*?

If you are a professional in the field of mental health, education or parenting, we welcome your submission. Healing articles should be about 1,200 words and consist of practical, clinical information about children's mental health that can be applied in the home, classroom, community and/or office setting.

Ideas for articles can be sent to healing@kidspeace.org. *Healing Magazine* reserves the right to edit all manuscripts.


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Dear Friends of KidsPeace,

In 1979 KidsPeace (then known as Wiley House) decided to enter into a new realm of caring for children, by launching its first-ever therapeutic foster care services in Bethlehem, PA. From that modest start, our foster care operations have grown in geographic reach (seven states) and in the types of targeted fostering programs we offer – therapeutic foster care, kinship care, respite care, adoption studies and support, and program extensions like the "Health Homes" initiative in New York. We've also grown in the number of families we support – serving more than 1,200 foster children in 2018.

To mark our 40th anniversary in foster care, we've dedicated the special section of this issue of *Healing Magazine* to examining foster care today and in the future from a variety of perspectives. We offer insight into what some might call "a typical day" in foster care *(spoiler alert: there's no such thing!)*, along with why someone might take the steps towards becoming a foster parent. We discuss where the field is headed from professional and public policy viewpoints. And we hear from perhaps the most important people in the whole issue – foster kids themselves, on what they'd change about the system and what they'd tell their younger selves about growing up inside it.

In this issue you'll also find our trademark range of important topics – from an advancement in treating both addiction and mental health issues, to the need for educators to learn about the impact of gender diversity on their students, to a new young-adult science fiction novel series with the goal of presenting mental health concerns in an engaging way (reviewed by someone in its target teen demographic). Providing this wide range of perspectives on topics of critical interest to parents, educators, and clinical professionals is how we work to achieve our goal with *Healing Magazine* – to provide practical, useful information about real solutions to the challenges our kids face today.

As always, YOUR perspectives are important to us. Please let us know what you think of the subjects we cover, or what subjects you think we should be covering, at healing@kidspeace.org. Don't forget – you can get electronic versions of this issue and back issues of the magazine, and subscribe to receive your own printed copy of future issues, at www.healingmagazine.org.

Here's to another forty years – and more - of KidsPeace helping foster families thrive, and thank you for your interest in *Healing Magazine*!

Michael Slack

Interim President/CEO

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In 2019 KidsPeace's Pennsylvania Community Programs launched a new service – an addiction treatment program known as "dual-diagnosis," meaning it was designed to serve those individuals struggling with both addiction and a mental health condition. The program utilizes an approach called The Matrix Model that provides the therapist the ability to address the various issues facing their client in a flexible and comprehensive way.

By Michelle Callahan, LPC

THE MATRIX MODEL:

An Integrative Evidence-Based Approach for Substance Use

BACKGROUND

The Matrix Model is a multi-element package of complementary therapeutic strategies that combine to produce an integrated outpatient treatment experience. That combination can be seen as a set of evidence-based practices intended to be delivered in a clinically coordinated manner as a program. The Matrix Model was developed by Richard A. Rawson, Ph.D and Michael McCann, M.A., as a result of their extensive research on addiction and based on a collaboration of studies focusing on brain imaging, clinical trials on pharmacological and psychosocial addiction treatments, and evidence-based behavioral interventions. Through their research, Rawson and McCann discovered ways to implement their research findings into clinical practice.

The Matrix Model was developed at the height of the cocaine epidemic in the 1980s. In urban areas of Los Angeles, cocaine and crack use was on the rise, resulting in users in need of treatment beginning to attend the Matrix Clinic for assistance with their substance use problems. The development of the Matrix Model was influenced by an ongoing interaction between clinicians working with clients and researchers collecting information. Through the information gathered and working with clinicians, materials were written to help guide the clinical staff with how to work collaboratively with their clients, as well as to teach Cognitive Behavioral strategies and basic brain research to clients and their families. In addition, the authors wrote manuals for clients that contained handouts for each session and included homework assignments to help them remain focused on their recovery outside of sessions.

THE MISSION AND GOALS OF THE MATRIX MODEL

The Mission of the Matrix Model is to "improve lives of individuals and families affected by alcohol and other drug use through treatment, education, training, and research by promoting a greater understanding to improve the quality and availability of addiction treatment services." Each session/group is specific, with its own topic, purpose, and goal, and is delivered best in sequence. The goal of the model is to provide stabilization, abstinence, maintenance, and relapse prevention. This is achieved by the use of their five core clinical areas:

- Individual/Conjoint sessions
- Early Recovery Skills Group
- Relapse Prevention Groups
- Family Education Group
- Social Support Group

The relationship between the therapist and the client is one of the primary treatment dynamics of the model, in which the therapist is a combination of teacher, coach, and concerned human being. With this approach, clients are able to build rapport with their primary therapist and have a safe place to discuss their addiction in a non-judgmental context. The individual sessions help the continuity of the primary treatment dyad, and therefore the retention of the client in the treatment process. The therapist approaches the clients from a strength-based perspective, focusing on the positive and reinforcing progress.

The Matrix Model also incorporates the collaboration of the client's family and loved ones as a part of their recovery process. Often, family members do not understand the disease of addiction; in response, the Family Education Group provides psychoeducation about addiction, recovery treatment, and the resulting interpersonal family dynamics. The group also provides a program component for clients and their families to participate in treatment together, as well as an opportunity to become comfortable with the treatment process.

Addiction is presented to the family as a chronic condition, which they can help to remediate by providing support for the client. Successfully engaging families in this component of treatment has shown to significantly improve the probability of retaining the client in treatment for the duration of the program.

INTEGRATIVE AND STRUCTURED APPROACH

Many of the treatment strategies that contribute to the success of the Matrix Model were derived from evidence-based practices like Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI). In addition, the model incorporated clinical research literature, research on relapse prevention, psychoeducational information, and 12-step program involvement.

Structure is also a critical element, as functioning within a structure can decrease stress and provide consistency and predictability – aspects that are incompatible with an addict's spontaneous, unplanned, and chaotic lifestyle. The program emphasizes the importance of attendance, participation in community self-help groups, and an individualized roadmap for recovery for each client. In addition, helping the clients to create a schedule assists them with the concept of proactive planning of work, treatment, recovery, family, recreational, and relaxation activities. Learning to schedule and create structure this way makes it possible to teach, the identification and avoidance of high-risk settings and people, as well as to promote engagement in new non-drug-related alternative behaviors.

Knowledge and skills that have been developed within the field of cognitive behavioral therapy (CBT) play a large role in the Matrix Model. Each of the Matrix groups are anchored with a specific CBT topic for each session. This approach teaches clients that drug use and relapse are not random events, and that they can learn skills that can be applied in daily life to promote abstinence and prevent relapse. Relapse Analysis is a specific exercise used when the client relapses unexpectedly or repeatedly and does not seem to understand the causes of the relapses. Through the use of CBT techniques, the therapist comes to understand the context of the relapse to help reframe the event for the client; the ultimate goal is the therapist and client understanding issues and events that preceded the relapse, in order to prevent future relapses. The Matrix Model also helps clients to shift their thinking from viewing relapse as a failure and rather looking at it as a need for adjustment in their treatment plan.

There is a substantial amount of research supporting the efficacy of the systematic use of reinforcement for meeting specific behavioral criteria in the treatment of addiction. Contingency management research with substance abuse problems usually has targeted drug-free urine results, attendance at treatment sessions, or achieving treatment goals as the basis for receiving incentives. The Matrix Model suggests a combination of contingency management and positive reinforcement, including abstinence, urine results, attendance, promptness, and behavior in group.

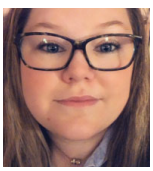
The Matrix Model can be easily adapted and integrated into treatment in an outpatient therapy setting, as it is highly structured and expectations are clear. Clinical staff usually have a basic understanding of how to use its evidence-based practices, making it easy to follow the model. Key supervisors who are familiar with the use of the model are able to offer basic training and support to counselors through the use of supervision.

CO-OCCURRING DISORDERS

The Matrix Model can focus on both mental health and substance use disorders simultaneously and concurrently. Structure is the treatment choice for mental health and substance use, and can be effective in reducing the use of non-prescribed drugs while tracking compliance with prescribed psychiatric medication. The Matrix Model also includes the use of Site Specific Groups to address special needs of the treatment site's particular client population. Topics may include trauma, anger management, mindfulness, parenting skills, depression, anxiety, and other common mental health disorders. This provides a platform for the clients to collaboratively receive psychoeducation about co-occurring mental health disorders and the role they play in their substance use.

SUMMARY

The Matrix Model is the only treatment program noted by the National Institute of Drug Abuse (NIDA) as a scientific-based approach. It is different from other models in that it draws from Cognitive Behavioral Technique concepts, imbued with a Motivational Interviewing style and supplemented with Contingency Management. The disease of addiction is explained to the client and their family in a way that they can understand and teaches how substance abuse has changed the addict's brain function. There is also research that supports clients attending more clinical sessions, staying in treatment longer, and have longer periods of abstinence with the use of the Matrix Model.



Michelle Callahan, LPC, is Site Supervisor overseeing KidsPeace's Mount Pocono (PA) outpatient program. Michelle earned a Bachelor's Degree in Psychology and Sociology with a minor in Women's Studies from Wilkes University, and a Master's Degree in Community Counseling from University of Scranton, after which she joined KidsPeace in the Diagnostic program at its Pennsylvania residential treatment facility. In 2014 she became a part of the KidsPeace Community Programs team - working as an Intensive Case Manager, Therapeutic Support Staff, and a counselor in drug and alcohol treatment. She is certified in Trauma Focused Cognitive Behavioral Therapy and serves as the Chair for the Appropriate Mental Health Appeals Board through the Bethlehem (PA) City Council.

References

Carroll, K.M. and L.S. Onken (2005). "Behavioral techniques for drug abuse." Am J Psychiatry

Rawson, R. A., M. J. McCann, et al. (2006). "A comparison of contingency management and cognitive-behavioral approaches for stimulant dependent individuals." Addiction 101

Rawson, R.A., Shoptaw, S.J., Obert, J.L., McCann, M.J. Hassson, A.L., Marinelli-Casey, P.J. Brethen, P.R. & Ling, W. (1995). "An intensive outpatient approach for cocaine abuse treatment: The Matrix Model. *Journal of Substance Abuse Treatment*

Rawson, R. A., McCann M.J., Obert, J.L. (2005) *The Matrix Model Handouts and Worksheets.*

SAMSHA (2006). *Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders.* Rockville, MD: US Department of Health and Human Services.

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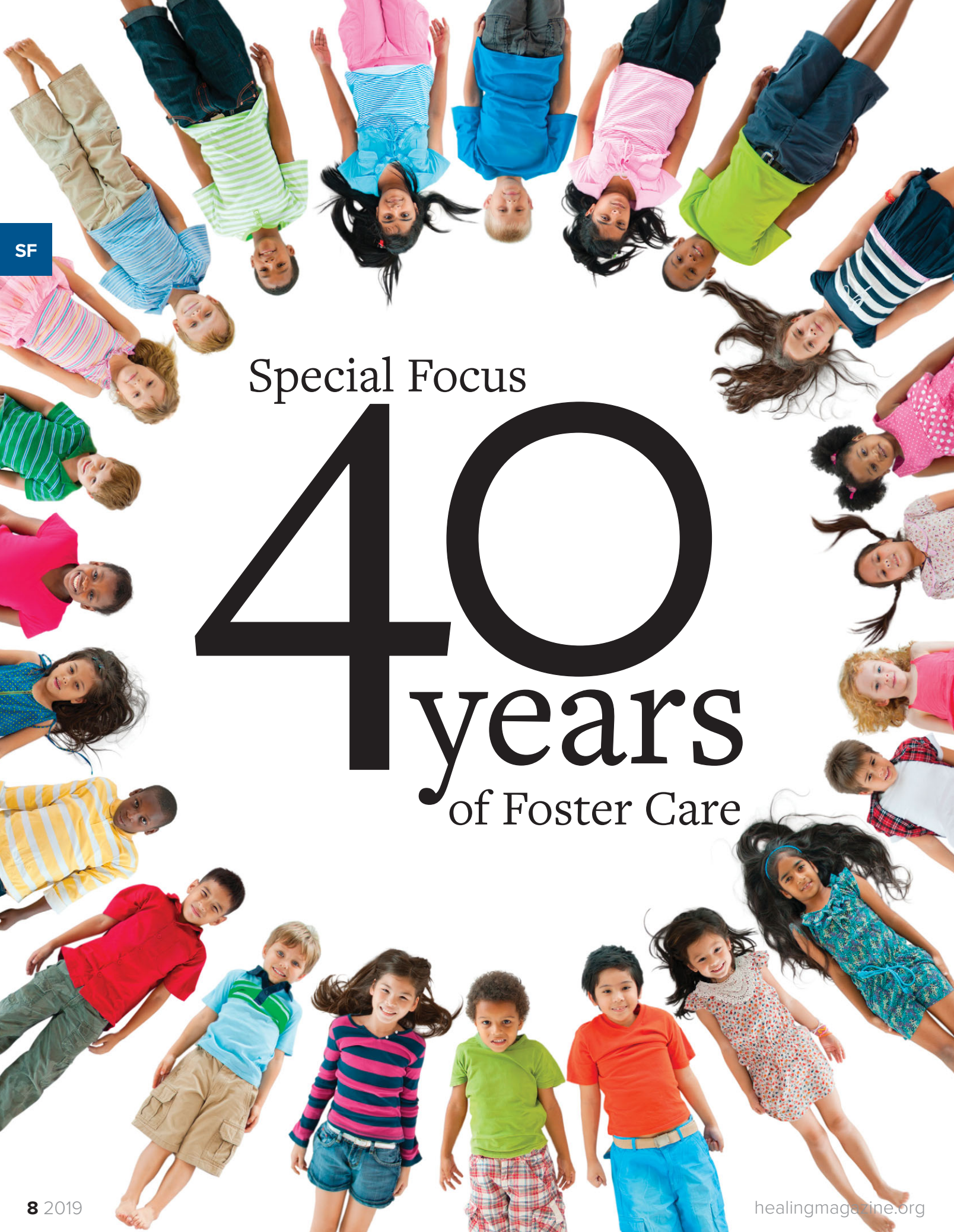
Special Focus

40 years of Foster Care



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KidsPeace Foster Care at 40:

A Historical Perspective

By Bryan Hoffstetter

In 1979, KidsPeace (then Wiley House) received its first license to begin providing foster care services to children at the Bethlehem, Pennsylvania office. It was during the 1970's when Wiley House expanded their continuum of services to include day treatment services, specialized preschool services, afternoon treatment programs, and foster care.

I have been privileged to work with the Foster Care and Community Program at KidsPeace for nearly thirty of its forty years. I can reflect on the many children, families, and associates who have been a part of the KidsPeace program during this time. It is in looking at the legislation and changes within the foster care and child welfare system that we see the progress from those early days in 1979 to the present.

"Progress is impossible without change, and those who cannot change their minds cannot change anything." - George Bernard Shaw

The stage for foster care was set with the passage of the **Child Abuse Prevention and Treatment Act (CAPTA) of 1974**. CAPTA provided minimum standards for defining physical abuse, neglect and sexual abuse. States increased programs for the prevention, assessment, investigation and treatment for children. With an increase in the number of child abuse and neglect reports, the needs for foster care programs grew as a means to provide a temporary service to children and families.

The **CAPTA Reform Act (1978)** continued to promote the development of children who would benefit from adoption, and extended and improved CAPTA. **The Adoption Assistance and Child Welfare Act (1980)** required states to make adoption assistance payments to families. It also required states to make "reasonable efforts" to prevent removal and to reunify families.

In the Wiley House Community Care Manual, the foster care program was designed to "build on the strength of the family model rather than the medical or social rehabilitation models in utilizing the strengths proven effective in our existing programs." A teamwork approach used professional staff of social workers, therapists, and clinicians to work closely with the foster parents in the development of therapeutic treatment goals. The program grew to include additional recruiters/trainers to prepare potential foster families.

During these years, the primary focus had been on family reunification. While reunification did occur for many children, some children continued to linger in foster care for longer periods of time. Other societal factors led to an increase of children at

risk of child abuse and neglect. Poverty, homelessness, substance abuse, declining informal and extended family supports put a strain on the ability of families to receive prevention and early intervention services along with needed treatment for mental health and substance abuse.

In 1997, the **Adoption and Safe Families Act (ASFA)** looked to restore some balance between the rights of parents with the safety of children. Safety of the child was a guiding principle in determining any decision to remove or return children with a family. ASFA looked to accelerate permanency for children. In most cases, court proceedings to free a child for adoption could occur for children who had been waiting in foster care for at least 15 of the most recent 22 months.

Concurrent planning was instituted to shorten the length of foster care placement. In addition to pursuing reunification with immediate birth family, the team began to explore other options, such as extended family (kin) and foster parents as a permanent resource to children.

Children benefitted from shorter stays in foster care and fewer moves. Foster families who had bonded with children became adoptive resources. Training for resource parents was expanded to include resiliency theory, attachment, and trauma-informed care.

Additional changes resulted with the **Fostering Connections to Success and Increasing Adoption Act (2008)**. The definition of kinship was expanded to include extended family and friends. The act required that extended family members be identified and questioned about their willingness to be a resource for children entering out-of-home placement. Kinship parents could be approved as resource families and receive the same subsidies as a foster parent. The act also required that agencies place siblings together unless specific concerns were identified. Other elements to foster connections are to keep children within their "home" school. A final part of the act addressed the needs of older youth. Extended benefits were given to teens beyond the age of 18. Youth could elect to remain in foster care until the age of 21 as long as they were in school or working.

With this Act, the children often experienced less trauma by remaining with siblings or family members. By staying in the home school, education disruption is avoided and better outcomes could be achieved. Resource parents have taken on new roles of being mentors to birth families which results in faster reunification.

Preventing Sex Trafficking and Strengthening Families Act (2014) brought further changes. This act looks to keep children from becoming victims of sex trafficking. It gives children age 14 and older authority to participate in the development of their own case plans. The act also looks to promote a sense of "normalcy" for children in out-of-home care. By defining a "reasonable and prudent parenting" standard, resource parents are trained and allowed to make decisions for opportunities for youth to engage in age- and developmentally appropriate activities.

As a result of the Prudent Parenting standard, many more foster children are easily engaged in activities like going on vacations, spending time in the community, participating in activities, working part-time jobs, and even obtaining a driver's license. Resource parents, after discussions with caseworkers, have clear guidelines in making decisions for children in care. The goal is to provide youth with necessary life skills and opportunities as they enter adulthood and independence.

What's next for foster care? **Family First Prevention Services Act (2018)** was signed into law last year, and state agencies are working on its implementation. Family First looks to balance the allocation of funds to child welfare programs. The first part looks to improve prevention services to keep at-risk youth from entering foster care. Prevention programs would be used for 12 months. The second part looks to limit the amount of time a child would be placed in congregate care, such as residential or rehabilitation placements. Guidelines are established for qualified residential treatment programs, and regular reviews are completed. The third part of the law looks at foster care and adoption. While prevention services may lower the number of children entering foster care, youth may be entering care because of shorter stays in residential care. The law says that individual states will have to look at their licensing

standards for programs. Increased family support services under the law will include the strengthening of foster and adoptive families. Foster home recruitment and retention will be critical to serve the needs of children who are unable to either live with immediate family or relatives or who do not qualify for extended congregate care.

The immediate future is moving to more outcomes-driven, family-focused care. Here in Pennsylvania, the Office of Children, Youth, and Families is targeting four areas. OCYF wants to safely reduce the entries of children into out-of-home placement. They also want to promote safe and stable reunifications for children and families. Third, they want to achieve timely permanence for children in out-of-home care. The last effort is to enhance prevention and stabilization services.

In 2018, KidsPeace Foster Care and Community Programs served 1,233 children across seven states. FCCP conducts standardized outcomes measurement using the Strengths and Difficulties Questionnaire. The SDQ is administered on intake and at discharge for youths. An outcomes report for 2018 showed 73% of children in foster care were discharged to equal or less restrictive placement, often reunification with birth family or kin. Another 13.6% of children achieved permanency through adoption. Other outcome studies have been tracking the educational outcomes for children in placement.

In our foster care programs, we also ask our clients, their families, and our staff to complete a survey called the Trauma-Informed Agency Assessment (TIAA). The TIAA was developed to measure the extent to which agencies employ trauma-informed approaches in meeting the needs of our clients and their families. With the insights we gain through the TIAA, we are able to develop actionable plans which help us to improve our responsiveness to trauma in our clients - trauma which can impact their physical, emotional, behavioral, and cognitive development.

Evidence-based training, policies and practices are already appearing in KidsPeace FCCP programs. *"Together Facing the Challenge"* (TFTC) is a training curriculum developed by faculty of Duke University's Services Effectiveness Research Program in the Department of Psychiatry and Behavioral Sciences. TFTC is one of only two therapeutic foster care programs in the nation that has received a rating of "Supported by Research Evidence" from the California Evidence-Based Clearinghouse for Child Welfare.

Utilizing research and data from observations studies of therapeutic foster care in the KidsPeace FCCP program in North Carolina, developers established a series of structured didactic and interactive training sessions for parents and program staff to provide them with the tools and skills necessary to improve outcomes for youth in care.

Three factors have led to TFTC's success in foster care:

- TFTC builds upon supportive and involved relationships between supervisors and foster parents.
- TFTC uses effective behavior management strategies by foster parents.
- Finally, TFTC uses supportive and involved relationships between foster parents and youth in their care.

By the end of 2019, KidsPeace FCCP offices in all states are aiming to be certified in TFTC. We have been training our resource parents and KidsPeace associates in TFTC practices, and feedback from parents has been positive. TFTC has provided parents with the tools to manage the therapeutic needs of children impacted by trauma. It also gives everyone on the treatment team a common language to discuss the goals and challenges. Ongoing communication and feedback between offices has been helpful in successfully implementing the program.

By using an evidence-based program, KidsPeace FCCP looks to achieve even higher outcomes for children in care. The laws and regulations of the past forty years have steered the direction of foster care services. As we look ahead, KidsPeace FCCP follows the KidsPeace Vision to help children and families transform their lives.

Bryan Hoffstetter has been a KidsPeace associate since 1985 and is currently a Family Resource Specialist in Bethlehem, Pennsylvania. He has worked with the Foster Care program since 1990 and has provided training to resource parents and KidsPeace FCCP associates across Pennsylvania. He is a long-time member of the Greater Lehigh Valley Foster Care Coalition, a group of foster care professionals including 17 public and private agencies.

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References:

KidsPeace® The First 125 Years: Giving Hope, Help and Healing to Children Facing Crisis

Wiley House Community Care Manual

Historical Child Welfare Information Gateway Timeline on Foster Care and Adoption https://www.childwelfare.gov/aboutus/cwig-timeline/

CliffsNotes on Family First Act, John Kelly, https://chronicleofsocialchange.org/finance-reform

Building a Child Welfare System for the 21st Century, Jennifer Jones & Theresa Covington, https://chronicleofsocialchange.org/finance-reform

Major Federal Legislation Concerned with Child Protection, Child Welfare, and Adoption https://www.childwelfare.gov/pubs/otherpubs/majorfedlegis/

Pennsylvania Council of Children, Youth and Family Services: Child and Family Service Review (CFSR) and Findings and Program Improvement Plan (PIP), March 18, 2018.

From Theory to Practice: One Agency's Experience with Implementing an Evidence-Based Model. Maureen Murray, Tom Culver, Betsy Farmer, Leslie Ann Jackson, and Brian Rixon. J Child Fam Stud. 2014 July; 23(5): 844-853.

KidsPeace Vision

To transform lives of individuals with emotional, mental, developmental, and behavioral disorders caused by trauma, abuse, neglect or other causes; by providing mental health care and educational services in a safe environment with teamwork, compassion and innovation.

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How Congress is Helping Parents

By U.S. Rep. Matt Cartwright

As a father of two, I've been blessed to experience the joys and challenges of parenthood. It has been the privilege of my life to watch my sons grow over the years. Becoming a father showed me a new way of looking at the world, and it has inspired my work to help others experience the bliss of starting a family.

On any given day, there are roughly 400,000 children in our country's foster care system. These are kids who want nothing more than a safe and loving home. Adoption has the potential to stabilize and forever change the course of these children's lives. And because families come in all shapes and sizes, we must work until every one of these kids has found a loving and responsible parent.

I have tremendous admiration for those who open their hearts to the children who need it most. In Congress, I've worked hard to ensure that we are funding programs to help every child in need. As a member of the Appropriations Committee, I supported $50 million in funding for the Adoption Opportunities program, to find permanent homes for children in foster care. The program helps make sure that all kids have an equal chance at being adopted by caring parents, regardless of their race, gender, or needs. I've also voted to support programs run by the Children's Bureau at the Department of Health and Human Services (HHS), which works to connect children with potential foster parents and families.

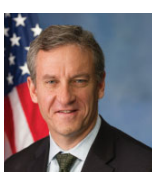
The Children's Bureau awards millions of dollars to state, local, and tribal partners that offer adoption opportunities, child-welfare training, and abandoned infant assistance. Every year, my colleagues on the Appropriations Committee and I do all we can to make sure the Children's Bureau receives the funding it needs. This year, we were proud to award the Children's Bureau $9.5 billion, an increase from 2018. This funding will allow the Bureau to serve families who make the selfless decision to adopt, especially in cases where the child has special needs. I will continue to use my position on the Appropriations Committee to help our government support foster care children and parents.

When it comes to direct federal assistance, taxpayers can receive a one-time tax credit of up to $13,810 on money spent on the adoption process. Expenses like adoption fees, court fees, attorney fees, and other costs directly related to adopting a child can all be applied for tax exemption, which can provide much-needed support for a family welcoming a child into their home. The state of Pennsylvania will also help families and individuals looking to adopt a child, with monthly stipends to help cover the cost of an added family member. I am proud that Pennsylvania has committed to making adopting a child as easy as possible.

As citizens, we can all do more to help children find homes across our nation. It is a cornerstone of our American identity, to come together and assist those who need it most. And helping children in the foster care system starts with being informed.

Despite the benefits that the foster care system adds to our society, there are many misperceptions that can turn potential parents away. For example, adoption has a reputation for being expensive, which might prevent working class families from considering it as an option. The fact is there are many federal and state programs available to help families who are looking to open their homes to these children. Another unfortunate misconception is that only families or married couples can adopt a child. That's far from the case. In all 50 states, single Americans can legally become foster parents. Anyone who can provide a welcoming environment for a child in need deserves the opportunity to do so.

As we look forward to the future of foster care in the U.S., the job of Congress is to support and empower the families who sent us here to represent them. I've worked with Members on both sides of the aisle to fund government programs that strengthen our ability to place foster care children with their forever families. We must also partner with private organizations to guarantee families face the fewest obstacles on their path to adopting. Every child deserves a safe and loving home. I will continue to work to make that a reality.



Congressman Matt Cartwright represents Pennsylvania's 8th District in the U.S. House of Representatives. He is a member of the bipartisan Congressional Caucus on Foster Youth, and also serves on the House Appropriations Committee and the Committee on Natural Resources. For more information, visit https://cartwright.house.gov.

Foster Parent Perspective: Learning from the Best

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By Betsy Farkas

I was a teenager when I first heard of the concept of fostering. My parents were well known for taking in people down on their luck: my best friend whose mother died of cancer and there was no father in the picture … a woman and her two children escaping a domestically violent life … my aunt and three cousins as they struggled through a financially devastating divorce. Funny thing is, our little three bedroom house never felt crowded. Plus, there was always someone around to play with!

After life settled down and my sisters and brothers and me began growing up, my mother starting feeling the "empty nest syndrome." (Why else would my mother want to complicate my parents' lives by taking in someone else's kids?) My mom and dad took the professional plunge into fostering when I was about 13. Our first newborn baby came straight from the hospital and stayed with us for three years. When she was finally adopted by a wonderful couple, I watched my mother's heart break as she let this little girl go to her forever family.

I thought my mother would be done with fostering at that point. But she did it again six more times over the course of ten years – each time loving these babies with all her heart and then letting them go with tears.

The last little girl was a "preemie" and came home to us wearing doll clothes. We would learn she had cerebral palsy and might have suffered brain damage during birth. It was suggested to my parents that they do the best they could and then start looking for a residential setting for her when she was older. But my mother and father were not going to even consider that for the baby whom we eventually adopted. Because of my parents' patience, tenacity and resilience, my youngest sister is now a well-known veterinarian with the only evidence of cerebral palsy being a slight limp after a twelve-hour shift at the vet clinic.

Fast forward thirty years to my own decision to become a foster parent. As a program manager for KidsPeace, I run across so many heartbreaking stories of children coming into foster care. The ones that really pulled at my heart strings are the stories of teenagers whose parents have neglected and abused them, the child welfare system tossing them around and the hopelessness they feel knowing there are few families who want to foster teenagers.

I met my first two foster kids, Terry, a 16 year old girl and her brother, Nick, age 12 when they entered my program and were placed into a temporary home. Terry came to me in tears and said she was unhappy at her current foster home and was frustrated because she hadn't done anything to deserve being put in foster care. It was her mother and step-father who had made so many bad choices. Because of the lack of foster homes, she was going to lose her friends, her senior year of high school and all that she loved about her home town. Her brother was a quiet little mouse, almost non-verbal, but with his own anger buried deep inside.

After speaking with my own two teenagers, we decided together to become a foster family. On August 5, 2010 we slowly starting adjusting to our new norm, found our comfort zones and settled in to what was going to turn into a lifelong adventure.

(Continued on page 17)

Tracking A Typical Day* in Foster Care

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Megan Craig

Heather Moore and Megan Craig are the minds and hearts behind the popular Foster Talk blog series on fostercare.com – offering real-world advice on foster parenting based on their experiences as foster parents and an agency caseworker.

When Healing Magazine asked them to map out "a typical day" in foster care, they quickly pointed out that a "typical day" doesn't exist; every day in foster care brings unique challenges and rewarding moments. So they agreed to present what's generally involved in a potential foster care placement situation from the agency and parent perspective...

Heather Moore

When you sign up to become a foster family, you quickly learn how a single phone call can change your life. Dramatics aside, quite literally answering a phone call at any point during your day can instantly take set plans, routines, and family dynamics and send them all for a spin.

Our day officially begins around 7 am. We kiss Daddy goodbye as he leaves for work, and I have breakfast together at the table with my two daughters, ages 3 and 6. Once my oldest is off to school, I get my youngest settled in with a craft and TV show and I start painting our front hallway...

7:00 AM

When I came into work today I had a lengthy "to do" list to tackle, because the foster kids on my caseload have visits with biological parents, aunts and uncles and grandparents which requires a lot of coordination. I knew that I had to supervise a visit at 1 pm, and was hoping to get some treatment plans written and get caught up on my case notes and phone calls.

Then, The Phone Rings....

9 am - I miss the original call while cleaning up from the painting. I see I have a call and I listen to voicemail – it's KidsPeace, they have a referral, can I please call them back? I text my husband that we got a referral and I would call him in five minutes.

9:10 am - I call the office back. They explain to me that it is a newborn baby boy, being discharged from the hospital, little information but no major medical needs. I say yes, but need to confirm with my husband. I hang up with KidsPeace, race to call my husband and blurt out all the information. He confirms my initial instinct and I call KidsPeace back.

8:00 AM

9:00 AM

7:00 AM

8:00 AM

9:00 AM

Then, The Phone Rings ....

8:30 am – On the line is a county worker with an emergency placement of a newborn baby boy who is being discharged from the hospital. The county states that there are no known medical needs

8:40 am - I review the referral with my coworkers. I call all the available families who have a stay-at-home parent, and wait to hear back.

(*... note: there's no such thing!)

9:12 am - I inform KidsPeace we could be a resource. They tell me that two other families have also confirmed, and that they would call me back once they hear from the county.

9:30 am - I try to go about my set plans and pack up my daughter as we head to a meeting at our church. My head is spinning thinking about a newborn potentially arriving in hours and all the laundry to wash, bottles to clean, formula to buy...

10 am - KidsPeace calls back. The county placed the baby boy with another family. I text my husband. We exchange some sentiments of disappointment, some of relief, and we move on with our day.

11 am- I am gathering all my items after the meeting, and hear my phone buzz. It's KidsPeace, again. I answer it. They have another referral! A DIFFERENT baby boy, this time 3 months old being discharged from the hospital after a few days of being observed after his removal from home. He has brothers who would be placed in a different home. I said yes (this time without calling my husband).

11:30 am- After a quick stop at the grocery store for diapers and formula, my daughter and I go home to sift through the bins of clothes in the basement that we have collected for emergency placements. We start laundry of baby blankets, crib sheets, clothes, and burp cloths. We find and wash our bottles that were stored in the pantry and pull down the travel cribs, baby swing, and car seats from the attic. My husband makes plans to leave work early so he is home in time for the new arrival.

12:30 pm- KidsPeace calls back. The baby boy was placed with his brothers in a different home, but together. Disappointed, but happy they could be together, I begin to disassemble our house full of baby items and go back to painting. I text my husband there is no need for him to leave work early.

10:00 AM 11:00 AM 12:00 PM 1:00 PM 2:00 PM

10:00 AM 11:00 AM 12:00 PM 1:00 PM 2:00 PM

9:40 am - I have heard back from all of the families and call with county with a list of our available families and send over their profiles.

9:45 am - The county calls back: one of our families was selected. We notify all the families of the news. I know that it is heartbreaking for the families not selected, but for the one that is selected their foster care journey begins.

10:50 am - A call comes from a different county worker with a referral for a 3-month-old baby boy who is being discharged from the hospital after being removed from his biological home. He has twin brothers who will be placed separately unless a home for all three boys is found. After talking to my coworkers we determine we do not have a home for all three boys, but can try to place the baby. I start calling foster families.

11:15 am - The county worker calls and is interested in our family and has no home for all three kids. The county says our family should go buy formula and should expect the baby at 4 pm.

12:30 pm - We get a call from the county that they have found a home for all three boys together. I call our family with the good news that the boys will be together but the sad news that they will not be getting a placement today.

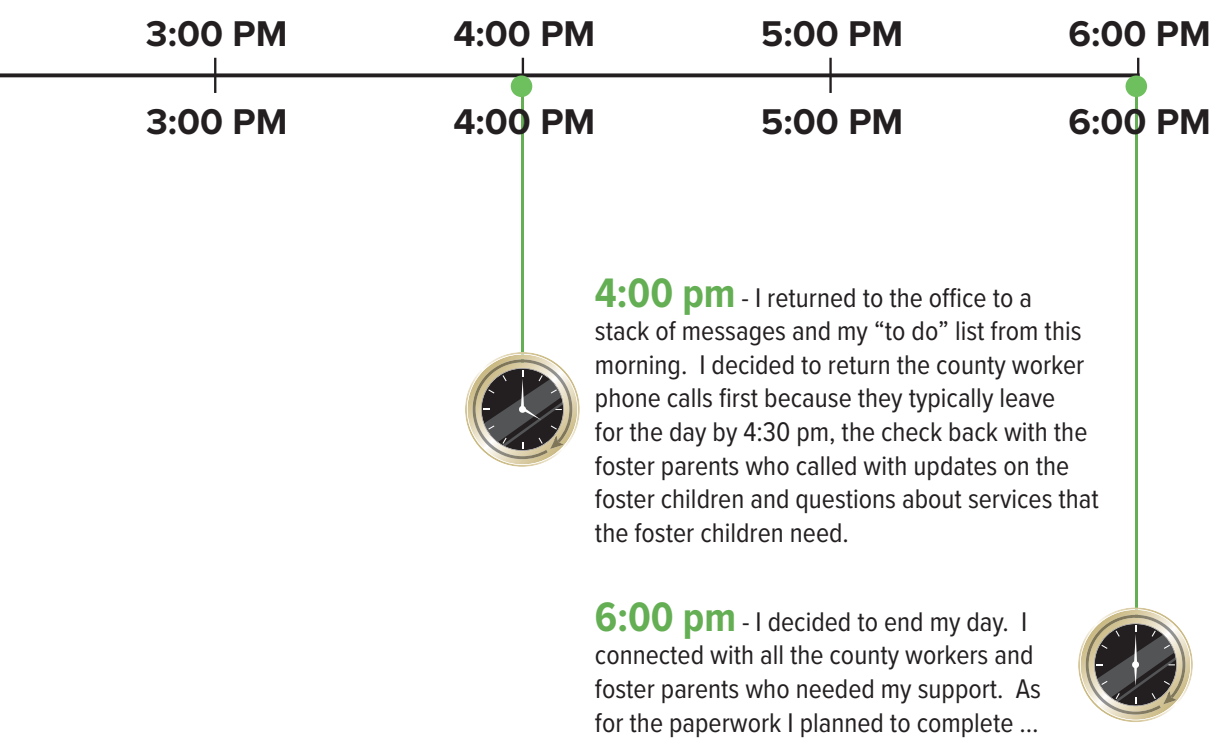
1:00 pm - I supervised the visit between a foster child and their biological mother and father and paternal grandparents. It is clear that the biological family loves their child and it is sad that they are not able to overcome their own life challenges to have the child return to their care. It's helpful that the foster mother has a great relationship with the biological family and brought them school work and pictures for them to take with them.

(Continued on page 16)

FAST FORWARD TWO WEEKS

10 am- Our family is on the shuttle at the airport as we excitedly anticipate a warm getaway for the long weekend. **Then, my phone rings.** It's KidsPeace. That baby boy who was placed with his brothers was needing a new home due to an overwhelming amount of medical needs between the three of them. Were we still a resource? I place my phone on hold, explain the situation to the family, and we say yes as long as the county can wait until we return home.

10:15 am- Approaching security at the airport, KidsPeace confirms with the county that Monday, when we return, the baby boy would join our family. Done deal, enjoy your vacation.



4:00 pm - I returned to the office to a stack of messages and my "to do" list from this morning. I decided to return the county worker phone calls first because they typically leave for the day by 4:30 pm, the check back with the foster parents who called with updates on the foster children and questions about services that the foster children need.

6:00 pm - I decided to end my day. I connected with all the county workers and foster parents who needed my support. As for the paperwork I planned to complete ... well, I'll tackle that tonight.

Heather Moore is Regional Manager for KidsPeace Foster Care in Southeastern Pennsylvania, and Megan Craig is a foster parent in Bucks County, PA. You can read more about their experiences and what they've learned on the Foster Talk blog at fostercare.com/fostertalk

(Foster Parent Perspective continued from page 13)

Teenagers in general test our limits, wear out our patience and make us question our resolve. I found that teenagers I did not give birth to and had to parent with my values and standards taught me a lot about who I was as a person and a mother. That all prepared me for when I took in my last foster son, Derrick, who's troubled past, incredible lack of faith in adults and need to argue about everything was a constant battle in my house. It has taken time, patience and applying the "forever family" concept to the multitude of challenges he has presented to me, but we are in a good place. We trust and love each other, which are the two most important elements in any relationship.

My foster daughter Terry adopted me when she was 23, legally making me her "momma." My foster son Nick just turned 21, is working full time and just moved out on his own. I still have Derrick living with me. He struggles from time to time, but is putting one foot in front of the other and moving forward in his life. He will make it because of his own resiliency. In addition to that, the fact someone believed in him, gave him a safe place and accepted him for who he is (and maybe more importantly, who he wants to be), is giving him hope for a better future.

The credit all goes back to my parents. They gave me a wonderful life, full of love, laughter and warmth. They taught me how to open my heart and home to someone in need of a safe place to heal and grow. Mark Twain said, "The two most important days in your life are the day you are born and the day you find out why." What I found out was, I was meant to foster.

Love your life, love your parents, love your kids ... no matter how it all came together, whether it was biological, fostering or adoption. If you have the chance, pay it forward, foster a child and change a life.

Betsy Farkas (second from the left), is a licensed master's social worker and has been a Program Manager for KidsPeace for 14 years. She is also a Niagara County (NY) foster parent.

SF

Like what you're seeing in Healing Magazine? Interested in finding out how you can sponsor an upcoming issue? Email us at healing@kidspeace.org.

Perspectives from Foster Kids

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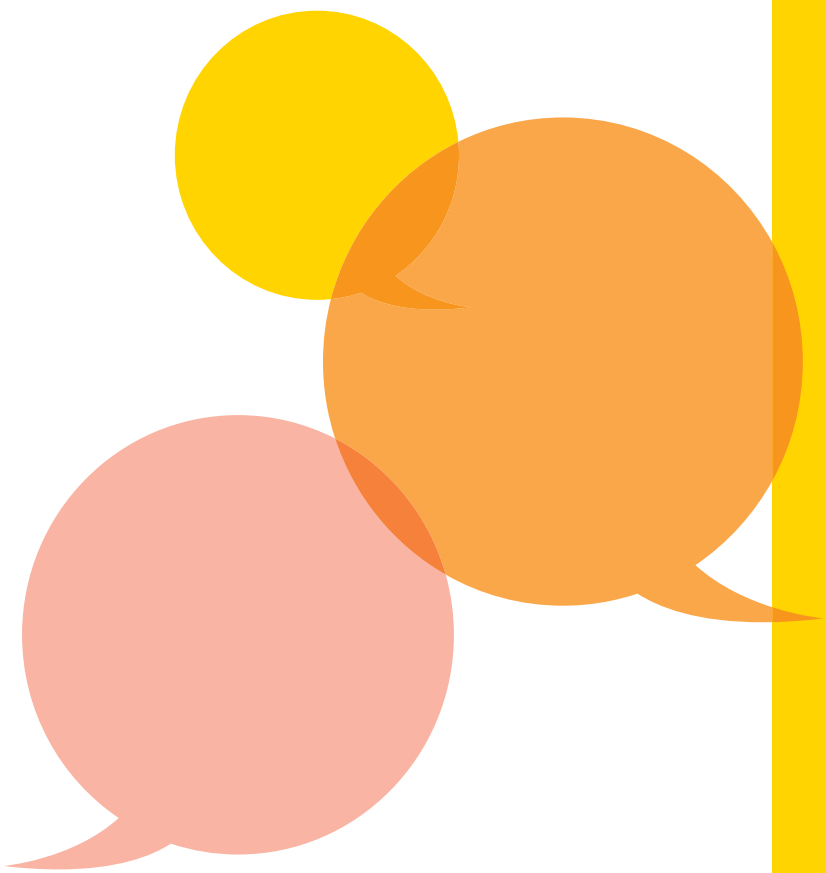
Editor's Note: *When we were planning this special section on foster care, we knew we wanted to include perspectives from the people with the most to gain or to lose in the system – foster kids themselves. We reached out to foster children in the KidsPeace network, asking them to answer three questions about their experience in foster care. Those who submitted answers had the option to either remain anonymous or identify themselves by first name and age.*

Here's a sampling of the responses we received; we at Healing Magazine thank the children and young adults who participated.

- Bob Martin, Executive Editor



Q1

What is something about being in foster care that you think most people don't understand?

Something that people don't understand about foster care is that it's not a punishment for the kids. This mostly applies to the students in elementary, middle, and high school. The stigma of kids in foster care is that you're a troubled child and should be avoided if possible. I hated that - always having to defend myself for being put into a position I didn't ask to be in. It got to the point that I "played" the stigma and made kids think I was troubled because I was tired of explaining myself once again.
- Chris, 22

- The difference between adopted and foster care
- That you are no different than any other child

- Keiniyah, 13

Foster care isn't so bad; most time people say the parents suck, but they actually are very nice.
- Anonymous

Children in the foster care system are often viewed as being "problem children". This stereotype is due to the fact that most people automatically assume this when they hear "foster" in front of child. But that is not true. Although children in the system do struggle with the fundamentals of being a part of a family, what people fail to recognize is that these kids have had their own families taken from them.

For all the people reading this I just have one question I would like you to consider: how would you feel if you were labeled something based off what has happened to you in your past?
- Karrie, 17

Just because we are in foster care doesn't mean we are weird or different. We are just not in the same situation as them.
- Spenser, 16

It's a very difficult situation that most people don't understand. But it can make you or it can break you in the long run – it's all about how you choose to look at it.
- Anonymous

Q2

If you could talk to your younger self as they entered foster care, what advice would you give that person?

This question is a tough one. When I look back now on the 11 years I was in foster care I have to admit there were many times where I just lost it. I would cry and scream and fight everyone trying to help me. So if I could go back and tell my past self something it would definitely be this: "Let all those trying to help you do just that. I know it seems like they are the bad guys but they aren't. They are looking out for you." I had a lot of built-up anger that I took out on everyone but the people I was truly angry at. Looking back now I regret how I treated the people who were there for me and wish I could have realized this then. - *Karrie*

"Don't worry – life will get better. Also, you aren't alone."
- *Spenser*

"Stuff will get better – there's hope. Eventually you will figure out your way."
- *Anonymous*

I think the thing I would try to embed in my brain is that these people are only here to help. Although it seems like a horrible thing, it isn't. Chances are it's the best thing that might ever happen to you. Take advantage of every opportunity given and be thankful along the way. I never knew the potential I had until I was gone and it was too late. These people want to see you succeed, not fail.
- *Chris*

I would tell him to look at the long-term situation and not just be short-sighted. When you're young, everything seems to move in slow motion and nothing happens fast enough, but it definitely does get better.
- *Anonymous*

"Remind yourself: it's only temporary."
- *Keiniyah*

Q3

Based on your experience, what changes would you recommend for the foster care system in the next 10 years?

Well, my personal experiences with foster care led me to believe that the only thing that could help evolve foster care in the next decade is putting foster parents through more extensive training. Not all foster parents are put in a position where they can fully understand the kid and how to help them. For example, my foster parents were old enough to be my grandparents and I took advantage of it. I'm not going to say I was horrible, but I could have been a lot easier to handle had they been prepared for someone like me. I think they had been trained well and they were amazing people; I just wish they could relate to some of the things I'd talk about more. You give parents more books on how to help kids, foster care would evolve in front of your eyes.

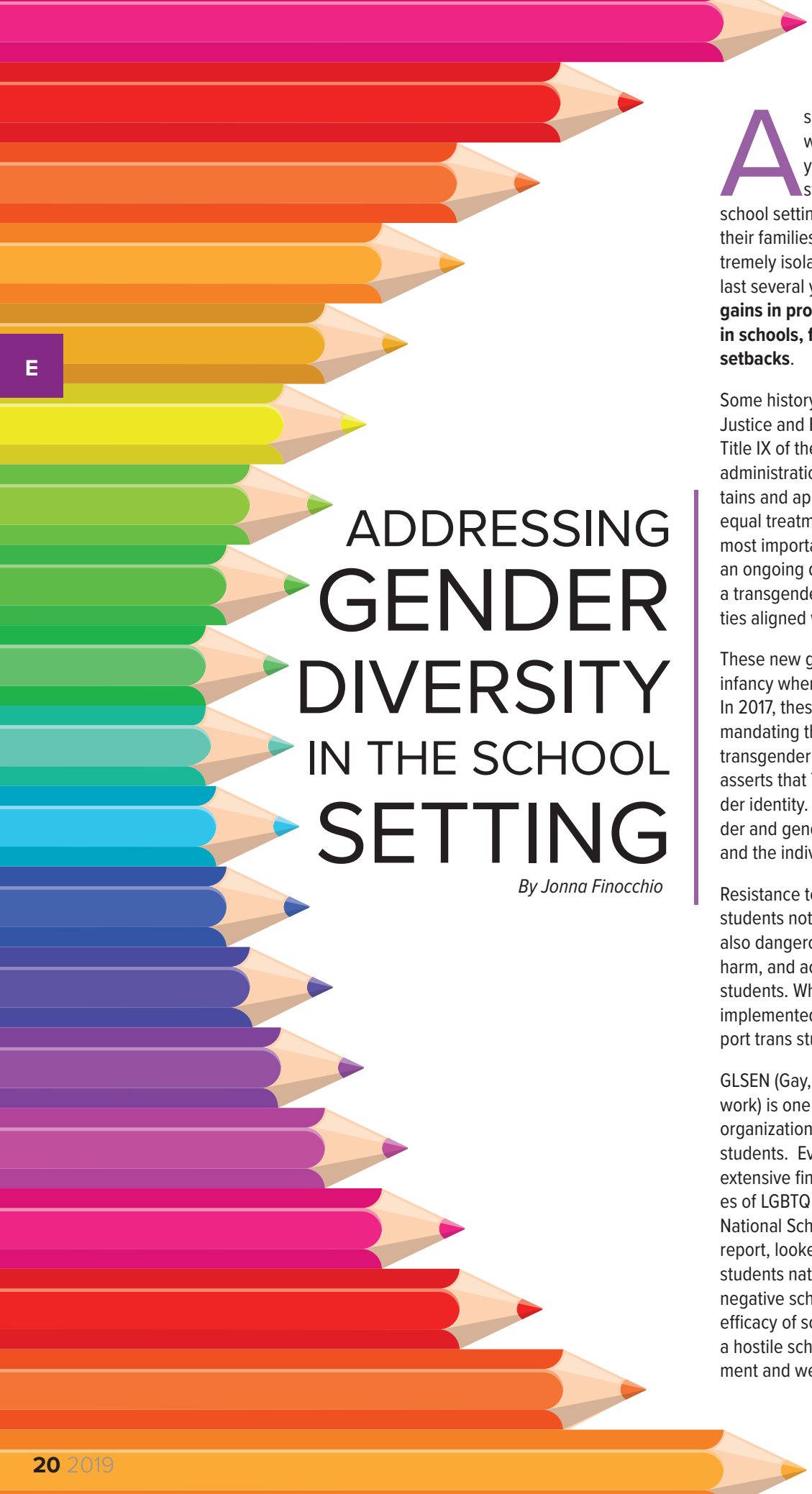
Kids need help, not just a place to lay their heads at night.
- *Chris*

I feel like there should be more communication between foster parents and the whole team about the kid's long-term goals. No one person should make all the decisions when it comes to the kid's future or other important factors that impact his life.
- *Anonymous*

As for change, I strongly am against the 30-day rule. This is the deal that if a child is placed in a home and the foster parents choose not to foster that child anymore, whether it be for behavioral reasons or that they have struggles within the home, they can give a 30 day notice - meaning that the workers have 30 days to find the child a new home. This rule is an easy out for the parents but what people don't consider is how it negatively affects the children. The system puts kids in various support groups and therapies to help the children with handling their emotions but yet this just adds to it. Many cases of this happens solely because the child has emotional and behavioral problems but not very often is it because they are actually a danger. I understand that the parents are the ones going out of their way to take care of these children, but when they sign up they are informed and trained on how to handle situations. As soon as the parent mentions it, that's it - there's not much intervention. I just don't think this is fair to the children and would like to see a more positive way to handle this for the children's sake.
- *Karrie*

(Help make) more normal lives for foster kids that don't already live a somewhat normal life.
- *Spenser*

A Concluding Thought from Karrie: I want to remind everyone involved in the foster care system - workers, parents, and children - that whether change happens or things stay the same, there is always a chance to thrive and have a happy ending; I'm proof of this. And to all the children in the system right now: you will get your "happily-ever-after" too, but for now just keep enduring; after all, we are called "survivors" for a reason.



ADDRESSING GENDER DIVERSITY IN THE SCHOOL SETTING

By Jonna Finocchio

As a mental health professional working with transgender and gender-diverse youth, I've learned that having an understanding of the challenges faced in the school setting is imperative in helping children and their families navigate what can be for many an extremely isolating and unsettling experience. In the last several years, our country has seen **significant gains in protections for transgender students in schools, following by even more pronounced setbacks**.

Some history: In May 2016, the U.S. Departments of Justice and Education released joint guidance on Title IX of the Education Amendments. The Obama administration asserted that Title IX inherently pertains and applies to transgender students' rights to equal treatment within the school setting. Perhaps most importantly (and controversially), it put to rest an ongoing dispute by requiring that schools respect a transgender student's right to utilize school facilities aligned with their gender identity.

These new guidelines, however, were still in their infancy when the Trump administration took over. In 2017, these guidelines were rescinded, no longer mandating that schools uphold the civil rights of transgender students. This retraction instead asserts that Title IX refers only to sex and not to gender identity. As a result, the treatment of transgender and gender-diverse students is left to the state and the individual school districts therein.

Resistance to federal protections for transgender students not only limits human and civil rights, but also dangerously exacerbates the risk of threat, harm, and academic inequalities for transgender students. While many schools have created and implemented inclusive policies and practices to support trans students, many more schools have not.

GLSEN (Gay, Lesbian & Straight Education Network) is one of the preeminent national education organizations working to create safe schools for all students. Every two years, GLSEN publishes their extensive findings in order to capture the experiences of LGBTQ youth in our nation's schools. The 2017 National School Climate Survey, the most recent report, looked at data collected from over 23,000 students nationwide and examines areas such as negative school climate, the preparedness and efficacy of school administration, and the impact of a hostile school environment on academic achievement and well-being.

The study concluded that the **vast majority of LGBTQ students report victimization and discrimination at school** in the previous school year. Looking at transgender and gender-diverse students in particular, nearly a quarter of surveyed students reported being physically harassed (shoved or punched) based on their gender expression, and more than one in ten experienced physical assault (being punched, kicked, or injured with a weapon). More than half of the students surveyed reported being sexually harassed at school in the past year.

In addition to the threat of physical harm, 9 out of 10 students reported hearing negative remarks specifically about trans people, such as "tranny" and "he/she." Even more alarming, 71% reported hearing these remarks from their teachers or other school staff. Potentially for this reason, students have learned to feel that their teachers and school administrators cannot and/or will not effectively intervene on their behalf. As such, only half of all incidents were reported to school staff and, of those, 60% of students reported they were told to "just ignore it."

As you can imagine, transgender students are not only negatively impacted by their peers – whose behaviors some may chalk up to immaturity. They are also impacted by the policies shaping their environment. Only 10% of students reported that their school had official policies or guidelines to support trans and gender-diverse students. This often manifests as being prevented from using their chosen name and pronouns, being prevented from wearing clothing deemed "inappropriate" based on their gender, and being required to use the bathroom or locker room of their legal sex. One student wrote, "I was barred from using the boys' bathroom and when forced to use the girls' I experienced frequent harassment and physical assault. I frequently went a whole day without using the bathrooms, and this has led to severe health complications."

These issues, among others, impact trans students longitudinally - contributing to higher rates of school dropout, avoidance of school and school activities, lower GPAs, and increased rates of depression and low self-esteem. Where it may seem appropriate to involve a school-based mental health professional, one recent study showed that although the majority of school counselors, social workers, and psychologists held positive attitudes toward LGBTQ students, **roughly 8 out of 10 received little to no competency training in their graduate programs** in working with the transgender population (GLSEN, 2019).

Many families choose to place their transgender youth in cyber or home schools to avoid some of the egregious statistics I've outlined above. But this is not a solution to the program, nor would I recommend it on a long-term basis because the role of the school is still an important one. Schools provide opportunities for youth to learn healthy socialization, which is a critical part of children's growth and an indicator of later success.

For trans and gender-diverse youth in particular, so much of their identity formation is prompted by their interactions with their peers. Dr. Aaron H. Devor introduced the concepts of "witnessing" and "mirroring" as being vitally important to identity formation:

- *Witnessing* is validation that a transgender person receives from non-trans friends or loved ones
- *Mirroring* is seeing oneself in the eyes of others like oneself – that is, that people who we think are like us, also feel that we are like them.

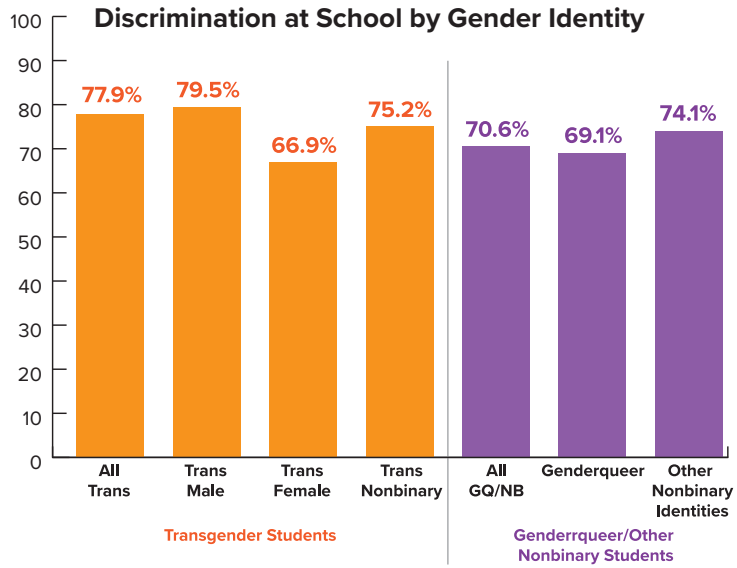
He summarized this with a powerful quote: "Each of us has a deep need to be witnessed by others for whom we are." These are social experiences that one would likely not be privy to if removed from a brick-and-mortar school.

The only solution, then, is that schools must do better. Large civil rights and education organizations such as GLSEN, the Human Rights Campaign, and the American Civil Liberties Union have created guidelines that schools can use to better support trans and gender diverse students through the use of best practices. Notably, these guidelines make the following recommendations:

- **Bullying, Harassment, and Discrimination**. Schools should be a safe space for all students. Bullying, harassment, and discrimination on the basis of gender identity must be expressly prohibited. In situations where it occurs, school staff are expected to respond immediately. Enforcement of such policies should focus on education and prevention, rather than punitive measures.
- **Privacy and Confidentiality**. School districts should ensure that a transgender student's personal information is kept confidential and shall not disclose any information that may reveal a student's transgender status to others without the student's consent.
- **Utilizing Name and Pronouns**. Regardless of legal name, schools should allow students to use their chosen name and pro-

(Continued on page 22)

Percentage of LGTBQ Students Who Experience Anti-LGBTQ Discrimination at School by Gender Identity



Source: GLSEN (2017). The 2017 National School Climate Survey

nouns. Students who identity as transgender or gender-diverse should be privately asked how they wish to be addressed in class and in school communications. In instances where a legal name is legally required, school staff shall record this information in a separate confidential file to avoid the inadvertent disclosure of information. "The school shall accept the gender identity that each student asserts. **There is no medical or mental health diagnosis or treatment threshold that students must meet in order to have their gender identity recognized or respected."**

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- **Gender Expression**. Dress codes shall not prohibit gender expression as it relates to gender identity.

- **Access to gender-segregated activities and facilities**. Students should have equal access to facilities that are consistent with their gender identity, as well as provide an alternative (private bathroom or separate changing schedule). They should not be required to use a private space against their wishes as it is both stigmatizing and revealing of one's trans status to others. They should not be forced to use gender-segregated facilities that are inconsistent with their identity. Where possible, schools should consider eliminating bathrooms designed for "males" or females" as it alienates some gender-diverse individuals. Single-stall, all-gender, or gender-inclusive restrooms are best.

- **Training and Development**. Staff should be trained on their responsibilities as highlighted above. The school should also implement professional development trainings to assist staff in building LGBTQ competencies. Teachers should also be encouraged to integrate more gender-inclusive practices into their classrooms.

While the role of the mental health professional is always to provide advocacy where possible, it is equally important to assist and encourage our transgender youth's families to be the strongest advocate for their child in the school system. Ask the important questions – What are your policies regarding transgender students? How do you plan to support my gender-diverse child? How does the administration address things such as bullying? Knowing the above guidelines on what a model school district looks like can be a critical factor in making sure that our transgender and gender-diverse students are protected in a time where our government does not demand it.

Jonna Finocchio is a licensed clinical social worker specializing in gender diversity. She is a Senior Clinician in the KidsPeace Diagnostic Program and provides gender services at the KidsPeace Family Center. Jonna also works as a consultant and trainer providing both micro- and macro-level support to improve service provision to trans and gender-diverse individuals.*

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *(Journal of Gay and Lesbian Psychotherapy, 8)*, 41-67.

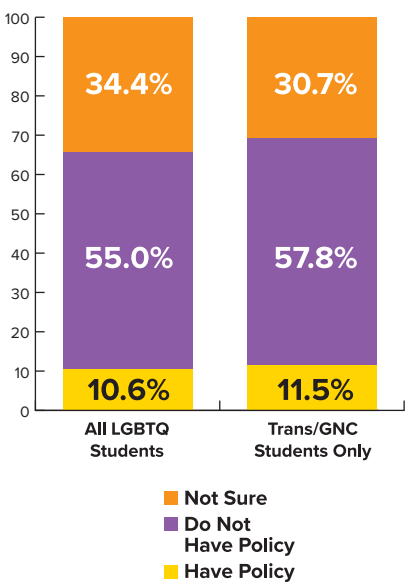
GLSEN (2017). The 2017 National School Climate Survey: the experiences of Lesbian, Bisexual, Transgender, and Queer Youth in Our Nation's Schools. https://www.glsen.org/sites/default/files/GLSEN-2017-National-School-Climate-Survey-NSCS-Full-Report.pdf

GLSEN & The National Center for Transgender Equality (2018). Model school district policy on transgender and gender nonconforming students. https://www.glsen.org/sites/default/files/Model-School-District-Policy-on-Transgender-and-Gender-Nonconforming-Students-GLSEN_0.pdf

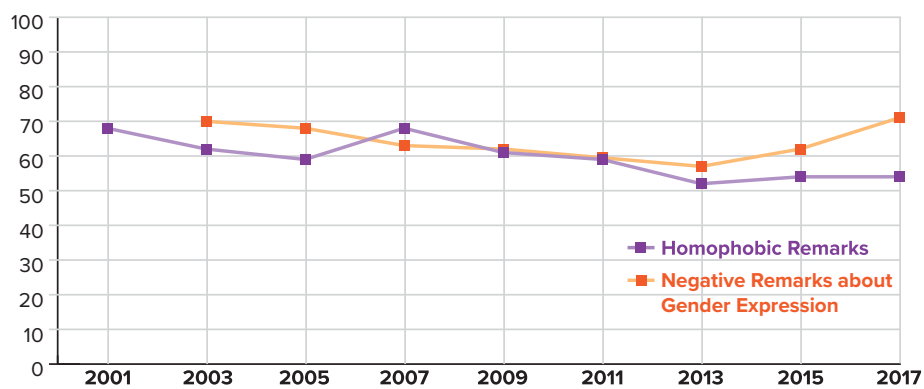
GLSEN (2019). New research on school mental health: New research shows school-based mental health professionals have a serious lack of training to support LGTBQ students. https://www.glsen.org/article/school-based-mental-health-professionals-have-serious-lack-training-support-lgbtq-students.

Orr, A., Baum, J., Brown, J., Gill, E., Kahn, E., & Salem, A. Schools in transition: A guide for supporting transgender students in K-12 schools. https://www.genderspectrum.org/staging/wp-content/uploads/2015/08/Schools-in-Transition-2015.pdf

Percentage of LGTBQ Students Reporting Their School has Policy/Guidelines Regarding Transgender/Gender Nonconforming (Trans/GNC) Students



Anti-LGBTQ Language by School Staff Over Time



Source: GLSEN (2017). The 2017 National School Climate Survey

COMFORT BOXES

ARE SOOTHING ANTIDOTE TO ANXIETY – AND A GREAT ART PROJECT

By Karen Carnabucci, LCSW, TEP

Picture this: You're stressed. Your body is feeling a strange combination of frozen and jittery at the same time. Your brain is zigging and zagging here and there, and you can't locate a reasonable thought in between the zigs and the zags.

When people feel emotionally triggered, they are invariably needing experiences of calm and grounding. Yet ironically, this is the very time when the pre-frontal thinking brain goes offline and the parts of brain that hold panic and unresolved trauma get louder. The ability to rationally review healthy choices and make good decisions seems to disappear. That nice list of helpful anxiety-reducing hints that your friendly therapist reviewed with you four weeks ago seems wiped from your memory.

This is a perfect time to bring out what I have come to call Comfort Boxes, which is a box or other kind of container that holds a variety of items that serve to comfort and calm people who are reeling under significant anxiety.

Comfort Boxes bring several important reminders and supports for calming and strength together in one place. It's a "one-stop solution" so the stressed one doesn't need to take time and energy to search out various items and reminders when strong feelings show up. And having the items in one place removes generalities – instead of "call a friend," there is the name of the friend and his or her phone number – and maybe even a photo of the friend.

I created this Comfort Box assignment when I was seeing several clients who reported that they felt too distracted to think easily and make good decision for themselves. It seemed to make sense to have all the items in one place and serves as an important adjunct to therapy.

How to Make a Comfort Box

The first step is to find or make a suitable container, making sure it will be large enough to hold all the items the individual wants to include. Next, you will have to decide what you want to put in the container.

I use the three categories of strengths from the *Therapeutic Spiral Model* (developed by Kate Hudgins, Ph.D., TEP) as a guide for the contents:

Personal strengths - traits within ourselves that we like and are proud of.

Relational strengths – aspects of relationships with others that feel supportive and loving or have felt so in the past.

Spiritual strengths - what nourishes and inspires the spirit, perhaps relating to a specific religious figure, nature, music, angels or other life-supporting reminders.

Typical strengthening items might include:

- Encouraging note from a favorite teacher, friend or counselor
- A piece of velvet or fake fur to touch
- Sensory putty
- Greeting card from a friend or family member
- Calming pictures cut out from a magazine
- Paper and colored pencils

- A journal and pen
- A postcard with a prayer
- Photo of you as a baby or younger self
- Names and phone numbers of three friends to call
- Stone to hold
- Calming essential oil like lavender or bergamot
- Hand-written message of support from a therapist, or from a group or 12-step members
- Favorite CD or DVD that is inspirational and life-giving
- Package of inspirational cards

I've worked with Comfort Boxes for several years and have since seen a similar concept online on sites like Pinterest, usually called "calm down kits," but they're often heavily commercialized, with lots of things to buy, rather than things to make or gather, and often are focused on distracting activities rather than therapeutic strength-building activities. Also, I do not suggest food or edible items like candy or gum in the Comfort Boxes because I don't want to encourage the use of junk food or sugary items as solutions to deal with stress.

Examples

• When I was working with Lenore, who had been sexually abused as a teen by her uncle, she admitted that there were times that she zoned out, felt panicked or was unable to concentrate. She knew this wasn't productive or helpful to her especially if she was trying to do her homework or another task, and she didn't like feeling shaky and out of control.

I walked her through a description of the Comfort Box, and we discussed some general items that she might want to include, such as a favorite DVD movie about a lost (then found) dog and a small journal with a colorful cover. Then we personalized it further –- what did Lenore find especially soothing? She told me that she loved to take time to brush her hair, or have her hair brushed, something her mother did for her when she was a small child. The hairbrush became an important ingredient of her box, along with a set of inspirational cards, and an amethyst crystal that her best friend gave her before she moved to another state.

• *Angelica* came to me feeling anxious about her upcoming separation from her drug-addicted husband and concerned about the well-being of their three children who had often been the focus of his angry outbursts. I introduced her to the concept of the Comfort Box, which she liked because she enjoyed crafts.

She found a pretty box that she had received as part of a birthday present and carefully lined it with glitter-speckled orange tissue paper; orange was her favorite color. Among her contents were a blue jay feather she had found on a walk (she described the birds as fiercely protective of their families), as well as a bottle of lavender-scented hand lotion, the written lyrics of a favorite song, a pair of pink plush socks that she could wear when she wanted to feel pampered and a small stone upon she had written the word "sing," one of her favorite activities.

At home, Angelica showed her box to her children and explained why she decided to make it. Then she encouraged each to make their personal boxes.

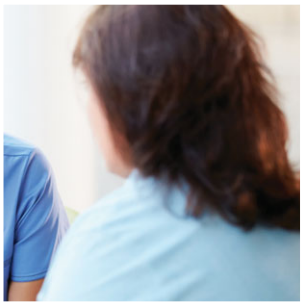
• *Devlin* became excited when he made his box during a group art project. The 15-year-old selected a large shoebox from a table of donated boxes and began decorating the box with pictures of muscular men as well as stickers of Spider-Man, a favorite super hero when he was younger. As he cut and glued, we talked about how Spider-Man wasn't just big and strong, he was also known for his "Spidey sense," an important kind of intuition that sensed imminent danger and other subtle feelings – feelings that humans have that are a real gift to help us function in the world.

Inside the box, Devlin placed items that he had brought from home for the project: a small plastic toy of a teen riding a skateboard, his favorite activity, and a blue bandana handkerchief that had belonged to his great-grandfather, who had served in the Army in World War II. Although he did not know a lot about history, he said he was proud of his great-grandfather's ability to survive a difficult and dangerous time. He added photos of himself and his cat, which lived at his "other" house and a leather bracelet that he had made, along with materials to make more bracelets if he wanted. When the box was closed, he collaged more words – such as "good," "truth" and "strength" on the outside of the box.

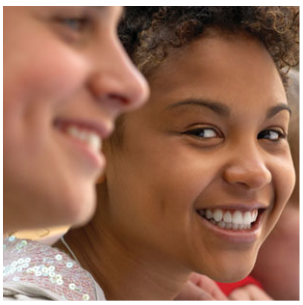
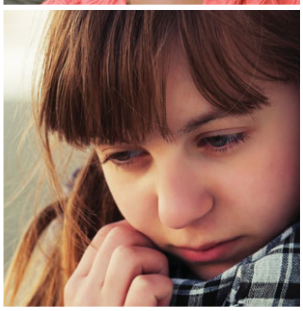
Comfort Boxes are great projects for a young person to make in a therapy group or during a 1-1 session. It can also be a great family activity; a box is could be made for the whole family, or each child (and parent) could make a box for himself or herself.

Karen Carnabucci, LCSW, TEP, is a nationally board-certified psychodrama trainer, licensed psychotherapist, and certified Family and Systemic Constellations facilitator in private practice in Lancaster, Pa. She is the author of "Show and Tell Psychodrama: Skills for Therapists, Coaches, Teachers, Leaders" and co-author of "Integrating Psychodrama and Systemic Constellation Work: New Directions for Action Methods, Mind-Body Therapies and Energy Healing" and "Healing Eating Disorders with Psychodrama and Other Action Methods: Beyond the Silence and the Fury." www.realtruekaren.com







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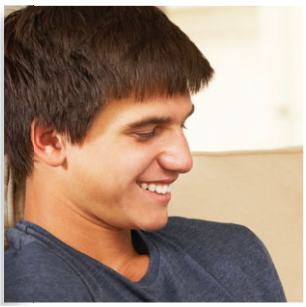

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Best of the Blogs

Best of the Blogs features highlights from the posts on our website. Going with our theme of perspectives on foster care, here are excerpts from two posts from a foster parent and a young woman adopted as a foster child...

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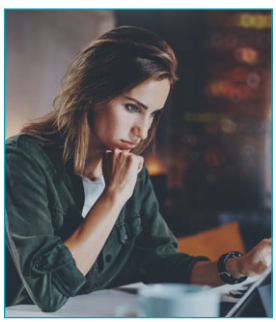


In "The Working Foster Parent," Rebecca Wood, a foster mom from Reading, PA, takes on one of the common myths: that it's not possible to be a foster parent with a full-time job:

"... When I talk to other families about becoming foster parents the number one thing they say to me is "I could never do that. I work full-time." Well, I am a loving foster parent and I work full-time as well, and it is very possible.

People say to me, "How do you do it?" To me, it's simple. I love what I do. And I do the same as I do (or did) with my own children...

I do completely understand that maybe this sounds good but not reality. But I know first-hand. My first placement was a sibling group (4, 6 and 7 years old), brought to my house at 2:30 pm on a Wednesday, and I needed to find day care for the next day until I could get assistance.

It is amazing the outpouring of support that comes when you receive a placement. Another foster parent called me and said, "I'll help watch them until your assistance goes through," and at that very moment I knew this is going to work out and I am meant to do this..."

In "Monica's Story," a young woman recounts a key lesson she learned on horseback, thanks to her "unsung hero" adoptive mom...

"...A few months after moving in with the Alexanders, they gave me riding lessons at Zephyr Farm. After a year of riding school horses at Zephyr, Debbie allowed me to start riding her horse Quincy...

The first thing that Debbie made me do was get the "perfect walk." This was frustrating to me at the time. I couldn't figure out why, when I could walk, trot, canter and jump in my lessons, that my mom would make me work so hard on the boring walk. Some days when we got the perfect walk, she would say "that's enough for today". Over and over she would say "You need to build a good foundation before you put the roof on". What in the world was she talking about?

Soon after we got the perfect walk, we would work on the perfect trot...then the perfect canter. It had to be a year later that I began to understand, if you get the perfect walk, the perfect trot will be easier. If you can get the perfect trot...now the straight, balanced and forward canter is right there.

And now that we are jumping successfully I can see how her building blocks have helped...

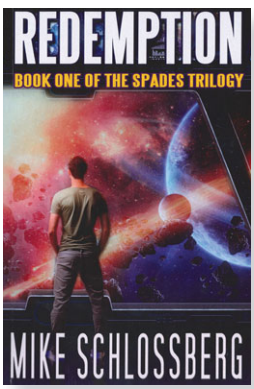
My mom and dad take foster kids in for usually one weekend a month. My mom asks me to help teach them to groom and wants me to share my story with them to help them out as they go through foster care...."

Read more from Rebecca and Monica on the blog at fostercare.com

Book Review:

Redemption: Book One of The Spades Trilogy

By Mike Schlossberg, Ellysian Press, 2018
Review by Celia Lansing



"A measure of leadership isn't what you're stuck with, it's how you deal with it." Asher Maddox wakes up as the captain of a ship he doesn't remember boarding, fighting aliens decades away from his time, and with a crew he's never met before. The fate of Earth depends on how he decides to handle the situation, and from his point of view, he's the least qualified person to carry this burden.

In the beginning of Mike Schlossberg's young adult novel, ***Redemption***, Asher is struggling simply to stay on top of his depression and anxiety, too nervous to even contemplate looking at the captain's chair meant for him. His mental health controls him through the beginning of the book. As I read through his struggles as he underwent multiple panic attacks and a depressive episode, however, it made it shockingly simple for me to get a better idea of what's going on inside the heads of my friends and classmates as they face similar challenges.

As a teenager in the twenty-first century, trying to better understand mental health issues that surround me on a daily basis, ***Redemption*** was not only an enlightening alternate perspective, but it was also a great example of mental health representation done properly in literature. It was a brutally refreshing change of pace, reading about a protagonist who is just as unsure as any other teenager would be in his situation, a protagonist who needed time before he could step confidently into his role as captain.

However, the best part of this book for me may have been that it showed that Asher's depression and anxiety did not render him useless. During the beginning of the book he was more focused on just getting through each day, but his mental health was always presented as a hurdle he needed to clear, not an impenetrable wall. Sure, he may encounter another hurdle a little further down the road, but throughout ***Redemption***, mental health was never the "end-all/be-all" that dictated any character's role, or determined other's opinions of him.

In fact, there have been very few books in the past that gave me the same strong sense of pride reading through their character's final actions, and I can attribute that to being given a chance to watch Asher grow as a character and overcome the setbacks he's learned to live with, with the support from those close to him. Throughout this book I watched as he learned to cope with his depression, anxiety, and so much more, and I watched as those around him helped him when he needed it. The ending of ***Redemption*** left me both intrigued and excited to see what is yet to come.

Celia Lansing is a student from Bethlehem, PA.

The Conversations with KidsPeace podcast brings the views and expertise of professionals in the mental health and child care fields right to you. You can listen to all the episodes at **www.kidspeace.org/conversations-with-kidspeace-podcast**, or subscribe at iTunes or Google Play

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