CIRCLE OF CARE

PLANNING GUIDELINES

Nisichawayasihk Cree Nation Family
and Community Wellness Centre Inc.

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Issue date:
November 2006

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ACKNOWLEDGEMENTS

NCN Family and Community Wellness Centre (FCWC):
Kimberly Linklater-Beardy, Support Services
Edith Moody, Community Development
Joy Burik, Home and Community Care
Felix Walker, Chief Executive Officer
Marilyn Linklater, Counselling Services
Jean Johnson, FASD Mentorship Program
Frances Potter, Public Health
Melody Genaille, Director of Health Related Services
David Sanderson, Traditional Counsellor

Partner Organizations:
Rubina Kirkness, NCN CFS DIA Office -Thompson Office
Shavonne Hastings, KSMA NCN CFS - Winnipeg Office
Walter Spence, First Nations CFS Northern Authority
Margaret Wood, NCN CFS
Jessie Duck, NCN CFS DIA Thompson Office
Barb Moore, NCN CFS

Nisichawayasihk Cree Nation Elders:
Jacqueline Walker, Co-author
Marjorie Gazan, Co-author and (Honorary)
Albert Gazan, Co-author and (Honorary)
Madeline Spence
Joshua Flett

INTRODUCTION

ABOUT THE CIRCLE OF CARE

The Nisichawayasihk Cree Nation Family and Community Wellness Centre (Wellness Centre) offers a significant combination of health and social services to the community. These assets create opportunities for people to share and work together and to support families to live in a healthful and positive way.

The Circle of Care is a service-planning model designed to:

1. Provide children, youth, elders, families and their communities with coordinated multi-service support, and
2. Build on the collaboration and strengths, which already exists within the Wellness Centre and its sub-offices, as well as other services and programs external to the centre.

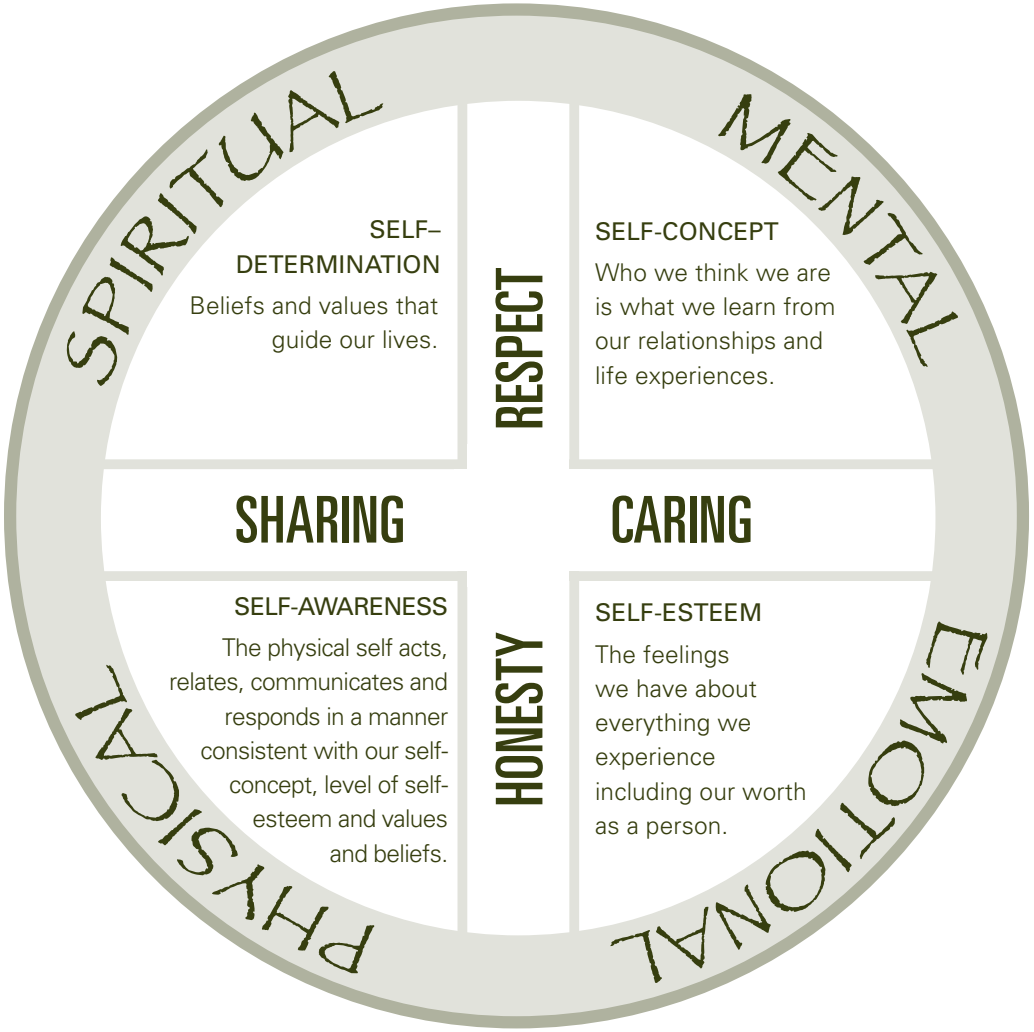
The Circle of Care planning process is based on the principles of the holistic teachings of the Medicine Wheel. It acts as a guide for working with families who require a combination of several services to support them in finding balance in their lives. In this context, the fundamental values of planning together with the direct involvement of family and implementing services collaboratively are essential. This means shared responsibility, shared decision-making, shared services goals and shared accountability.

The purpose of the manual is to describe some guidelines that help to facilitate such a process and assist in developing and implementing a Circle of Care Plan (CCP).

It describes a way of establishing a coordinated, multi-service plan intended to strengthen families who have a number of challenges and opportunities that will benefit from the involvement of two or more services. It supports and encourages the active participation of extended family, elders and spiritual leaders.

THE MEDICINE WHEEL

The Medicine Wheel is the holistic foundation on which the Circle of Care is based.[1] It is the goal of the Wellness Centre to provide services that enhance the mental, emotional, physical and spiritual wellbeing of families, their children and youth. This holistic approach is consistent with values and traditions of First Nations communities.[2]



[1] Based on a presentation by Percy Tuesday to Abinoojii Prevention Workers, Winnipeg, January 19, 2006.

[2] In a study conducted by the National Indian Child Welfare Association found that a "System of Care Model has very promising results: Terry L. Cross et al Promising Practices: Cultural Strengths and Challenges in Implementing Communities. http://cecp.air.org/promisingpractices/2000monographs/vol1.pdf

The Medicine Wheel represents all the elements required to live a healthful and balanced life. These elements are all connected and interdependent.

MENTAL ELEMENT – What We Think

The mind is like a hard drive on a computer. A computer stores information that is input. Similarly, the mind stores information and visual memories of everything a human being learns and experiences. The Mental Element is a very powerful storehouse of information and memories. We remember our life experiences in our relationships with family and our communities. We learn to see ourselves as someone worthy or unworthy of love and respect by how others treat us.

Historical trauma has had a profound effect in many communities. Attempts at forced assimilation separated families and their children. Family and community care was replaced by institutional care of residential schools and later, the child welfare system. These experiences disrupted family life and left intergenerational memory losses as to how families and communities protect, nurture and raise their children in a traditional manner. The intergenerational impact of being raised in non-familial settings resulted in passed on institutional childrearing experiences to children. This has influenced how children, families and their communities have developed their self-concept. Understanding this impact is an important step in redefining our self-concepts in positive ways.

EMOTIONAL ELEMENT – What We Feel

Feelings are part of everything we do in life. Imagine the fear you would feel if you were surprised in the bush by an angry mother bear standing a few feet away from you. The fear you experience lets your mind know it is time to do something with what you have in your physical energy reserves; it makes your adrenalin flow; it makes your heart beat faster. People can do extraordinary things to survive in this state. Feelings add texture to what we experience and these feelings are stored as part of our memories. You can remember something funny that happened years ago. You may start smiling and even laughing all over again when you think of it because you are reminded of how funny it felt when it happened.

The ability to store feelings in our memory bank applies to everything we experience in life. We remember through feelings when we felt safe and cared for, how we were treated at home, school and community, what we were good at, what hurt, what made us feel good and proud and made us feel, sad, angry, alone and sick-at-heart. It is from the collection of such feelings that we develop our self-esteem, which is how we feel about ourselves.

SPIRITUAL ELEMENT – What Guides Us

Values and beliefs play an important part in our lives because they are the guideposts by which we and others judge whether we are living a good life.

Values and beliefs can vary from person-to-person depending on the culture you are brought up in. Values describe the ideals or principles of a culture that a person should strive to achieve such as honesty, caring, sharing, kindness and courage. Values also describe beliefs about what "good" and "bad" choices might be and what is "right" or "wrong" behaviour in order to live life in a good way. If we really believe in certain values, but don't practice them in our everyday lives, it damages our self-concept and lowers our sense of personal worth.

It is within our families and our communities that we learn about cultural values and beliefs. The best teachers are people who live in a manner consistent with the values and beliefs they talk about. They "walk the talk". Family violence and the ways we abuse each other do not fit with "walking the talk."

The spiritual element not only has an impact on how we learn to see ourselves, it also affects how we act. The values of respect/honour, sharing/generosity, caring/kindness and honesty/courage are all related to each other. It is not possible to have some and not other values. How can you have respect/honour if you are not honest or have sharing/generosity if you do not have caring/kindness. These are high standards and none of us are angels. However, if we believe in these values and do not make the effort to walk the talk we risk feeling and thinking of ourselves as not being true to ourselves. This can even effect how a community sees itself.

PHYSICAL ELEMENT – What We Do

The physical element is the "what we do" part of our lives. It involves actions, and responding and communicating in all the ways that human beings do, with words, body language, positive and negative attitudes, a range of feelings and based on what we really believe and value in our hearts.

The quality of our relationships with family and community is deeply influenced by our mental, emotional and spiritual development. If we have learned from our life experiences and relationships to think of ourselves in very negative terms our self-concept and level of self-esteem is affected. That will influence how we are likely to act. With a negative self-concept and self-esteem we are likely to be easily threatened, appear unhappy, become defensive, angry, hostile, aggressive and more likely to have a life filled with conflict and forms of self-abuse and

abusiveness toward others. We may also have developed a lot of false beliefs about ourselves and think we are not competent, when in fact we have lots of unused gifts we could develop. When a person lives with self-putdown attitudes, it also creates difficulties in relationships. If you do not care for yourself, it is difficult to believe that anyone else can care for you. Sometimes people even think that when someone loves you, they must be sort of stupid. On the other hand, when our life experiences and relationships have been mostly positive we learn to feel competent and more trusting in our relationships.

SIX STEPS TO SETTING UP A CIRCLE OF CARE PLAN (CCP)

STEP 1: THE INTAKE PROCESS

The intake process involves gathering and documenting relevant information in accordance with the Family and Community Wellness Centre Central Intake Form (Appendix A).

The intake process is the beginning of the relationship between the Wellness Centre and a family. It is also a sign of strength because it takes courage to seek help, and the intake worker should acknowledge this courage.

It is not best practice to attempt a comprehensive multi-service assessment at the time of intake. For example, a family may be looking for some relief to an immediate problem.

The main goals at intake are to:
1. Gain a basic understanding of the immediate problems and concerns, and
2. Identify the service needs required (Appendix B).[3]

Another consideration is to recognize different attitudes families may have about their involvement with the Centre. Families whose involvement is involuntary, as may happen in child welfare matters, likely do not expect that services will be helpful. That is sometimes true for families who may also have had negative experiences with agencies outside the community. On the other hand, when families seek support from the centre on a voluntary basis, they are more likely to expect that services will
be helpful.

It is a common understanding that the extended family has a high value in First Nation communities. Therefore, when children need a place of safety, placement with extended family should be the first choice whenever possible. It is also helpful to involve the extended family as part of the support network. In most cases the extended family would be interested in being involved in the decision-making process for relatives.

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[3] In case of emergency child welfare issues and concerns, the Intake Worker is called upon to determine risk for children. Appendix B: Basic Risk Assessment Question describes key issues in completing an appropriate Risk Assessment. The Intake worker can also refer to the Provincial Risk Assessment information.

STEP 2: TRANSFER OF FAMILY TO PRIMARY WORKER

The intake worker refers the family to the appropriate service area, based on the information gathered during the intake process.

It is recommended that in addition to the handling of paper work, the intake worker will meet with the primary worker to share what occurred during the intake process, since written communication has definite limitations.

The primary worker is the one who will primarily work with the family and assume responsibility for planning and providing services developed as part of the Circle of Care process.

Role of the Primary Worker

The primary worker, as a coordinator and facilitator, is key to the success of a Circle of Care process. In this role he/she:

- Acts as an advocate for a family to ensure appropriate resources are made available
- Develops a relationship with the family in which the family feels safe to share information
- Develops an understanding of what strengths the family may have
- Identifies available resources including extended family members and contact those resources to explore how they might participate in providing support services
- Develops a plan with the direct involvement of the family that connects the family to the appropriate resources available in the community
- Prepares the family for participating in a Circle of Care approach to planning
- Arranges meetings involving the family with other services and supports the family with this process
- Ensures proper records are kept of all Circle of Care meetings and that the plan and role of the services involved is described and distributed to all Circle of Care participants
- Evaluates after a reasonable time period whether service goals are being met and whether adjustments to the Circle of Care plan have to be made
- Has a self-care plan that looks after the worker's own physical, emotional, mental and spiritual wellbeing.

STEP 3: INTRODUCTION TO THE CIRCLE OF CARE ASSESSMENT

The primary worker completes a comprehensive Circle of Care assessment, if two or more service areas are needed to support the family and after any immediate crisis has been addressed.

The opportunity to gain a good appreciation of the family's strengths and barriers to making healthful life changes develops as the relationship between the primary worker and the family develops. This naturally takes time. However, the more the primary worker and family understand each other, the more accurate the Circle of Care assessment will be. Often we learn more by asking questions than by being ready with advice.

The assessment process should help a family learn what may be contributing to the concerns that brought them to the centre. If we do not understand the patterns of our lives that create painful problems, these problems will reoccur, sometimes over and over again. That happens because we may not know how to do things differently. If we understand what we could do differently to improve our lives, we are more able to make changes that support a more healthful lifestyle.

The assessment process should also identify what resources and services will be needed to help the family facing multiple challenges. The ultimate goal is then to involve the family in a process of developing a Circle of Care Plan (CCP).

Things to Consider in a Circle of Care Assessment

The details of an assessment are important, but it is also helpful to understand how all the pieces fit into the big picture. In addition to the assessment checklists and outlines, there are also some considerations that help keep your mind on the big picture.

1. The Eurocentric emphasis in assessment and delivering services has generally been placed on "personal dysfunction models." A family preservation study sponsored by the National Indian Child Welfare Association concludes "dysfunction-based models ignore … First Nation family structures, kinship networks, customs, rituals and community resources."[4] Dysfunction-based models look at treating personal deficits and so most of the attention is paid to treating a dysfunction.[5]

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[4] Red Horse John G. Family Preservation: A Case Study of Indian Tribal Practice. National Indian Welfare Association , December 2001

[5] Cimmarusti, Rocco A. Family Preservation Practice Based upon a Multisystem Approach. Child Welfare. Volume LXXI,Number 3, May-June 1992.

It is true that we all have strengths and limitations and it is important to understand those patterns in life that are dysfunctional for us. However, human beings are more complex than "dysfunctions." Any assessment that that does not include the family's strengths, skills and motivation to change is totally incomplete.

2. Another matter that has an influence on how we approach assessments is that families differ in the kind of support services they need because they differ in what they are coping with in life. Anyone who has been very hungry and thirsty will most likely look after their thirst first and their hunger second. That is because you can do without food for many weeks but not nearly as long without water.

   Noted psychologist, Abraham Maslow (1908-1970) took this idea and described an order in which such needs influence how people do things in their specific life circumstances. (See Appendix C) For example, if your circumstances are such that you have to worry daily about food, clothing and shelter, and your basic physical needs and safety needs, it is very difficult to have enough emotional energy left over to worry about other family challenges.

   It is important for the primary worker to recognize what goals the family has and is ready and willing to work on. It is not the responsibility of the primary worker to identify problems the family should work on without the family's ability to recognize that it is a problem.

3. The concept that our personal history impacts on how we learn to relate in a family is also important. Destructive patterns creating crises in a family sometimes repeat themselves. Important questions are:

- How does what I have learned in my family of origin and kinship system affect how I relate at this stage in my life to members of my family, friends and acquaintances?

- What were the major influences in my life?

  It is in our past that we learned what is acceptable and tolerated and what is not. When a family understands these patterns, they are more open to choosing other directions. Most often, this is the focus of counselling services. It supports the family in understanding the barriers to healing as well as how the family functions as a unit. After all, we learned to behave and relate in certain ways as we learned to adjust to the circumstances in which we were born. Obviously people born in a very caring family learn to relate in different ways than those born into a situation involving domestic violence and abuse.

4. The community of Nelson House has a history of contact with a dominant culture. Often that experience has not been positive. The residential school experience, the colonization process and racism have seriously affected many communities. Duran and Duran (1995) refer to the effects of such experiences as a "soul wound that is passed from one generation to another."[6] Understanding what we have learned from these experiences in context of the community's history also helps us learn about our strengths as well as healthful living. This kind of discussion is also likely to occur in the counselling relationship.

5. The Wellness Centre is involved with people from the community, often relatives, neighbours and friends. The word "client" may not really describe the relationship workers have with the families they support. In that sense, it is difficult because any worker who works with families may be reminded of painful experiences that occurred in their own families. This can sometimes be traumatizing for a worker and is referred to as 'vicarious trauma' (Appendix F: Life Wheel). Information about vicarious trauma is available on the Internet. (Health Canada's Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers can be downloaded at the following link: www.phac-aspc.gc.ca/ncfv-cnivf/ familyviolence/pdfs/trauma_e.pdf)

6. Another consideration in the assessment process is to recognize that families vary, not only in the motivation they have to seek healthful change, but also in the opportunities and capacity they have to make such changes.

   Motivation: Generally people ask for support at times when things are not going well. The more serious the situation is, the greater the need for finding a solution. This in part affects the level of motivation. People would rather live a positive lifestyle than not and that too motivates people to find more satisfying ways of living.

   Opportunity: There is a song that has a line in it as follows: "We're all just seeds in God's hands. We start the same, but where we land is sometimes fertile soil and sometimes sand."[7]

   Because of opportunity, we can land in a setting that teaches us to be hard-hearted, mean-spirited, mistrustful, angry and destructive with ourself and others, or we could land in an opposite setting and have a view of the world as a really happy and nice place. One situation often promotes difficulties in relationships, while the other is more likely to result in a more positive outcome. Those experiences are defined by the opportunities with which we are presented. As children, it is difficult to understand such things. However, as adults, we grow to understand how we learned to relate in ways that often result in conflict. Based on

[6] Duran E.& Duran, B. (1995) Native American post colonial psychology. Albany State: New York University Press (in Red Horse et al.)

[7] Pat Alger and Ralph Murphy From the Album Seeds, 1994.

that understanding, choices can be made to live our lives in a more healthful way.

One of the roles of the primary worker is to explore with the family how those opportunities to learn can be created. To use Maslow's example again, if a family is in a situation where food and shelter are the most important priorities, it is difficult to focus the family's attention on change in other areas of life until those key issues are addressed. Families experience a lot of environmental stressors related to lack of income, appropriate housing, etc. Over time, there often develops a general sense of hopelessness or feeling of helplessness, "I have no power to change this situation." Such factors would obviously also affect the level of motivation.

Capacity: Families also vary in their capacity to change their situation. Differences in personality, ability to communicate, get along with others, having a support network through the extended family and friends are strengths that increase a family's resilience and capacity to make adjustments in their lives. Not everyone is at a stage where they have the capacity to change their lifestyle (See Appendix E).

7. How we use consultants, who periodically come to the centre, in the assessment process makes a lot of difference in how problems are solved. The way it usually works is that the family or a child from a family is referred, seen by the consultant who then provides information to the worker, usually in the form of a report.

   Another way of working with consultants is to actively participate in the assessment process as an observer and/or participant. It is important that the primary worker or the counsellor, whoever is most directly involved with the counselling component of the CCP understands the basis for the recommendations the consultant has made. All of us bring our own points-of-view, values, biases and skill sets to the assessment process, and a consultant may provide another perspective.

   Whether it is appropriate or not to sit in on the interview between family and consultant depends, in part, on what the consultant's role is with the family. If a psychologist is giving an intelligence test or a consultant is in fact the main counsellor, there is a need to meet in private. It can also be a matter of preference because some consultants may feel less comfortable when another worker is present at an interview. The bottom line is that the primary worker needs more than written recommendations. Personal contact is important because the consultant is part of the Circle of Care process and makes recommendations that may influence how services are delivered.

SPECIFIC CIRCLE OF CARE ASSESSMENT AREAS

Gathering assessment information for developing a Circle of Care plan should involve exploring a combination of some or all of the following areas with a family. The

purpose of this is to identify what services can best support a family's commitment to seek healthful solutions to their life challenges.

The needs of families vary and how each family responds will also be different. It is important, therefore, to know when to ask appropriate questions to open things up.

Planning with the family requires that the family understands the reasons for asking certain questions or discussing certain topics. For example, if you are talking about family-of-origin issues, it is important that the family understands that this is not meant to gossip or as criticism. It is a question that asks, "What have you learned as a parent from your own experiences as a child?" and "What are the parenting ways you have learned that you want to keep and what do you want to change?"

Keeping the Medicine Wheel in mind as a guide, the following is a list of the many areas that may be discussed as a primary worker and a family explore what the service needs are and how a Circle of Care Plan would address those needs:

SAFETY ISSUES

- If there were child welfare issues at intake, have these been resolved or is there a continuing need for follow-up services from child welfare?
- Is the home environment in a constant state of crisis that is traumatizing for the children?
- Have the children ever been placed in care? Under what circumstances and for what periods of time?
- Is there an ongoing concern about family violence and are there concerns about protecting other adults in the family, from spousal abuse for example?
- Do the children have special needs of a developmental nature, such as socialization in school?
- Are there special health problems, such as FASD-related difficulties or mental health problems?

LEARNING FROM OUR FAMILY RELATIONSHIPS

- Parents
  - What is the quality of the parental relationship?
  - Are the parenting skills appropriate?
  - How do the parents deal with problems when they occur? How do the parents deal with conflict?
  - Are there patterns that are barriers to positive relationships that keep re-occurring?

- Are the demands on the parents manageable? (eg. Single parent looking after five children with three of them being preschool age)
- What are the strengths in the parental relationship?

• Children
- What is the quality of the relationship between parents and children?
- What is the quality of the relationships between the siblings?

• Live-in relatives
- Are there family members living with the family? Does this add positive or negative pressures?

• Extended family
- Are there members of the extended family who the family trusts to participate in the planning process? (eg. An uncle who can teach the father to hunt or an aunt who can teach a young mother how to care for her baby)

• Others (friends, elders, spiritual mentors etc)

ARE BASIC SURVIVAL NEEDS MET?

• Income/budgeting
• Shortages of food, not enough for utility costs
• Housing/overcrowding
• Access to community services
• Lack of recreation

FAMILY OF ORIGIN INFORMATION

Understanding what we have learned from our family of origin contributes to our strength and health as well as what we have learned that we want to change. This is an area that ongoing counselling would most likely address and explore.

PHYSICAL HEALTH

Identify any health related areas that are of concern.

• If our physical health is weak, we may lack the energy to do the things we need to do. For example, poor diet and wide spread diabetes have a very negative effect on many of our families.

If there are concerns, it is possible to arrange for nursing consultation within the Wellness Centre.

FAMILY STRENGTHS, SKILLS (See Appendix D)

- How has the family managed to deal with problems in the past?
- What has been successful?
- Is the family connected to its extended family in ways that are supportive to a healthful lifestyle?
- How does the family see themselves in the community?
- What are family's self-care skills – hobbies, recreation and relationships with others?

CONNECTING WITH RESOURCES IN THE COMMUNITY

- Are options available for involvement in community activities?
- Is the family involved in traditional activities, church-related activities or other ways in which spiritual needs are met?
- Does the family have a close relationship with an elder and/or clergy who could be involved as a positive support for the family?

DEVELOPING A COORDINATED SERVICE PLAN

The Assessment should identify other community members, services and programs that are currently or should be involved.

- Elders
- Services provided by the Wellness Centre
- School services that may be/should be involved
- Community/volunteer services
- Medicine Lodge
- NNADAP
- Self-help groups

SUMMARY OF THE CIRCLE OF CARE ASSESSMENT

When the family and primary worker have completed the assessment, the information can be used to develop a CCP. It is the needs/strengths assessment that provides an understanding of the family's communication patterns, the nature of the relationships and the context in which concerns and problems occur. The summary of the assessment will identify family strengths, which will reduce the risks of family problems from reoccurring. It will also identify service areas that need to be involved to promote positive growth. In this way we can support families in finding a life based on the teachings of the Medicine Wheel.

STEP 4: SETTING UP A MEETING OF SERVICE PROVIDERS TO DEVELOP A CIRCLE OF CARE PLAN (CCP)

With families who need only the service of the primary worker, there is no obvious need to involve other workers, agencies, self-help groups, etc. However, if it becomes clear that in order to support a family, two or more services need to be involved, the primary worker with the family will have to find out what resources are available.

The primary worker identifies and involves other service areas based on the results of a needs/strength assessment. It is how these services collaborate and are coordinated in supporting healthful change that become the Circle of Care. It is an approach that is based on empowerment, because it directly involves the family and community resources in developing an appropriate plan.

The next responsibility of the primary worker is to contact those service areas that are already involved and to explore whether other services may be required. In that context, the primary worker is an advocate for families. In that role he/she needs to collaborate with colleagues from within the centre as well as maintaining good working relationships with service providers in other agencies. This is to ensure that the family receives the appropriate combination of service support

CIRCLE OF CARE PLANNING WITH INVOLUNTARY FAMILIES

There are families who are involved with the Wellness Centre on an involuntary basis. The Circle of Care process can still take place, except the family will not participate directly. In such a case, the primary worker who, for example, might be involved in a child welfare case, could do an assessment by visiting with the family and extended family to determine what the needs of the parents and children are.

Once this has been completed, a meeting with the representatives from the various service areas, but without the family, could develop a plan for providing some support. This is obviously more difficult than working with a family that wants to receive services.

However, it is important to develop a positive working relationship between a worker and a service-resistant family and that every effort is made to seek the advice of the family. This keeps the possibility open that a family may move from being resistant to centre-involvement to becoming more open to being involved in the planning process.

STEP 5. FACILITATING A CIRCLE OF CARE PLANNING MEETING

PURPOSE

The purpose of the meeting is to define what each service will contribute in terms of resources. This could include a whole range of services and activities as the CCP is put into place. Each plan is tailored to suit the individual needs of each family.

PREPARATION FOR A CIRCLE OF CARE MEETING

The primary worker must prepare the family for what will occur in the meeting. The primary worker provides support and advocacy for the family throughout the meeting and ensures child care is provided if necessary.

The family's concerns regarding confidentiality and privacy should be respected and protected at all times. This is important in Circle of Care planning.

Please note that privacy and confidentiality are not the same.

Privacy is an individual's rights to control his or her personal information.

Confidentiality is the obligation on a worker to keep confidential any information communicated in circumstances of confidence.

While the primary worker and others in the Circle of Care have a legal obligation to maintain the privacy of the family's information, there may arise circumstances where confidentiality cannot be maintained. For example, in cases where an individual has admitted abusing a child in their care, the worker has a legal obligation to report that information to the appropriate authority including the police. Therefore, workers need to clearly and plainly explain this to the family so that the family's expectations of privacy and confidentiality are tempered by the realization that such disclosures must be treated in a different way and may involve others outside of the Circle of Care.

In this context, the primary worker needs to review and check with the family in advance of the Circle of Care meeting as to what information will be shared. **This is important because the family must feel safe.** For example, the family has agreed with the primary worker that couple counselling is a very important part of the CCP. However, because one of the service representatives at the meeting may be a close relative, the family may not want to share details as to why counselling will be involved. In that case the primary worker could just indicate without further comment that the couple has already requested counselling services and arrangements for that have or are being made. It is of greatest importance that the family feel respected and protected knowing that their personal information is shared only with those who need to know and whose help will benefit the family.

The primary worker is responsible for:

- Setting the agenda. The agenda could include:
  - Reason for the current involvement
  - Areas of need and the service priorities as identified with the family in the Circle of Care assessment
  - Identification of the kinds of services needed, timelines for providing service, etc.
  - Setting the date for the first review of the Circle of Care Plan team (a six-week meeting date is recommended)
- Contacting all the service providers involved with the family and providing them with information they require for the meeting
- Presenting the background and assessment information.

It is in context of understanding a family's strengths as well as barriers to healthful living that guides a CCP meeting and determines what and how services will be delivered. The meeting puts the pieces of the puzzle together. The centre provides the opportunity to resolve concerns. It is the family, however, that controls the process and, depending on their capacity and motivation, determines whether healthful change will occur.

CHAIRING THE MEETING

There are several ways of running a multi-service meeting. The primary worker who has the background information could chair the meeting. The advantage is that, as chair, the primary worker can steer the agenda and ensure the family is heard. The disadvantage is that, as a primary worker is directly involved in the discussion, this may conflict with facilitating the meeting.

A Circle of Care meeting is probably more effective if it is chaired by someone other than the primary worker. The chairperson/facilitator needs the background information before the meeting about the assessment process so that the facilitator is in a position to focus the discussion on developing a CCP.

What is of primary importance is that the atmosphere in which the meeting takes place is one of safety, where communication is respected and appreciated. The chairperson/facilitator needs to recognize the vulnerability of the family, which is expected to share personal issues in a group setting. If only two services are involved, the primary worker and the second support service may be able to develop the plan with the family without a facilitator. If more than two services are

involved, particularly if one or more are external to the Wellness Centre, using a facilitator may be most effective.

The primary worker must ensure that careful notes are kept of the recommendations made and the resources to be provided. Copies of these notes should be circulated to the family and the service providers involved.

SETTING SHARED SERVICE GOALS

At the meeting, each service provider would make a commitment to provide support based on:

- The needs assessment information
- The comments of the family at the meeting and
- The input of the primary worker who has completed the needs/strengths assessment.

Rather than having each service operating in isolation, the service providers meet to develop a holistic approach. This is possible because they have developed shared-service goals based on a common understanding of what the family's service needs are. It is this common understanding between service areas that guides the implementation of the Circle of Care plan. This ensures that the service components are integrated and coordinated.

There may be community services external to the centre, which need to be or are involved with a family, but for one reason or another do not agree to participate in a Circle of Care meeting. This may occur because they may have a policy to not attend meetings with other community agencies, or perhaps they do not understand the value of a Circle of Care approach.

If this occurs, the primary worker could act as a liaison with such services. This will let them know what the Wellness Centre is doing, so that they are aware of other community involvement with the same family they work with. The purpose is to keep communication open so that there is continuity and consistency between services in supporting a family.

Over time, as service providers become familiar with the Circle of Care approach, there may be more flexibility in working together. It is helpful to reach out to such services because it serves the best interests of the family.

STEP 6: SERVICE COORDINATION AND FOLLOW-UP MEETINGS

The primary worker has responsibility for coordinating and monitoring the Circle of Care Plan. It is a good idea to meet after about six weeks to make sure everyone is still on the same page and there are no new concerns. It is also an opportunity for the family to report how the plan is working. This is a positive role for the family, because it underlines the family's commitment and responsibility in the process.

When families try to change their lifestyle it is more common that the process is a dance of two-steps-forward and one-step-back. Old learning takes time to change and old habits are difficult to give up. In fact, change can also be very upsetting because as we change, our relationships also change. (For example, a man with a long history of alcohol abuse decides to quit, but within a short time his drinking buddies stop visiting with him after he refuses to have "just one drink".)

When problems do arise with one or more service areas in the Circle of Care, there may be a need to meet. The service provider needs to bring the concern to the attention of the primary worker. The primary worker would check this out with the family and if changes to the plan are required, a meeting of the Circle of Care team should be arranged.

Meetings should also be scheduled to evaluate whether shared service goals are being achieved. This is not report-card-time, but an exchange on how things seem to be going as experienced by the family and members of the team. It is an opportunity to give positive feedback about what is happening and to discuss any changes to the plan that might be needed.

The evaluation meeting is also a time when it is appropriate to discuss whether a particular service component in the plan is no longer needed. For example, if part of the plan was to involve a teaching homemaker with the family and the need for that is no longer as urgent, this support could gradually be cut back.

It is important to consider the timing during the transitional phase, when services are removed and how this will impact on the family. It is also important to recognize the strengths of the family. Providing services at a level that is not really needed may be a sign that the service providers may not recognize that the family has the strength to be independent. A gradual withdrawal of support, in consultation with the family, is recommended because withdrawing the support all at once could leave the family in crises again. Ultimately, it is not the plan, but the workers who support the family that makes the difference. It is what we do with our hearts and minds that make a Circle of Care Plan work.

APPENDIX A

FAMILY & COMMUNITY

WELLNESS CENTRE

CENTRAL INTAKE FORM

FAMILY & COMMUNITY WELLNESS CENTRE

CENTRAL INTAKE FORM

Date: _____ Time: _____ am/pm

Intake Worker: _____

Presenting Issue(s): _____

_____

_____

****

PART A CLIENT PROFILE

****

Client: _____ DOB: _____

Treaty #: (10 Digit) _____ MHSC:_____

Marital Status: _____

Address: _____

_____

Phone #: _____ _____

HOME WORK

****

PART B FAMILY INFORMATION

****

CHILDREN:	DOB:	TREATY #:	LOCATION:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

****

PART C SIGNIFICANT OTHERS

****

1. Name: _____ Relationship to client: _____

Address: _____

_____

Phone #: _____ _____
HOME WORK

2. Name: _____ Relationship to client: _____

Address: _____

_____

Phone #: _____ _____
HOME WORK

3. Name: _____ Relationship to client: _____

Address: _____

_____

Phone #: _____ _____
HOME WORK

****

PART D SOURCE OF REFERRAL

****

Law Enforcement Contact: _____

NNADAP Contact: _____

Self Referral Contact: _____

Nursing Station Contact: _____

School Contact: _____

F&CWC Division: _____ Contact: _____

Other: Contact: _____

****

PART E MEDICAL INFORMATION

****

a) Does client have any medical problems? (Physical, Mental) _____ Yes _____ No

If yes, please state _____

b) Is client receiving treatment? _____ Yes _____ No

If yes, please explain _____

c) Does client have pending appointments? _____ Yes _____ No

If yes, Please note Date, Time, & Location_____

_____

d) Does client have any allergies? _____ Yes _____ No

If yes, please state _____

****

PART F F & CWC REQUIRED SERVICES

****

Fitness Centre ❒	Daycare (4ms - 5 yrs old) ❒	Arts & Culture Program ❒
Public Health ❒	Head Start (0 - 6 yrs old) ❒	Mediation ❒
Therapist ❒	Home & Community Care ❒	Child & Family Services ❒
Recreation ❒	Maternal Resource Program ❒	Child & Family Resources ❒
Family Supports ❒	Rediscovery of Family ❒	Elder's Program ❒
Counselling Services ❒		

****

PART G CONSENT TO RELEASE INFORMATION

****

I, _____ do hereby give consent to the Family & Community Wellness Centre
CLIENT

to release my information to _____
NAME OF PROGRAM

Signed this _____ day of _____, 20__. _____
CLIENT'S SIGNATURE

CIRCLE OF CARE
PLANNING GUIDELINES

APPENDIX B

BASIC RISK ASSESSMENT QUESTIONS

Basic Risk Assessment Questions

A RISK ASSESSMENT ATTEMPTS TO ANSWER 4 BASIC QUESTIONS:

1. Has the child been physically abused, sexually abused or neglected?

2. Is the child at risk of further harm or maltreatment

3. Is the child in need of immediate protection?

4. If the child is at imminent risk, what must be done immediately to protect the child?[8]

Risk Assessment[9]

CONCEPTUAL FRAMEWORK

The primary purpose of child protective services is to identify children who are at risk of harm or injury due to acts of commission or omission by their parents or caregivers, and, when necessary, to initiate immediate action to protect them.

The potentially harmful effects to children of abuse or neglect have been well documented. Negative outcomes of maltreatment include serious and often permanent physical injury; developmental disability; delays in physical, social, cognitive, language, and emotional development; emotional disturbances or personality disorders, and sometimes death. When we conduct an assessment of risk, we are attempting to determine the likelihood that a child will suffer harmful or detrimental outcomes due to the act of the child's parent or caregiver.

Risk assessment is an ongoing decision-making process throughout the life of a case. An initial assessment of risk must be conducted at the time of intake to determine whether the children named in the complaint are endangered, and whether immediate protection is necessary. The evaluation of risk is incorporated in the ongoing case assessment and case planning process, and informs all case decisions. The level of risk is assessed again, when children are being reunited with their families, and after they have returned home.

Risk assessment technology is essential to family-centered practice and placement prevention. We cannot safely maintain children at risk of harm in their own homes unless we can quickly and accurately calculate the level of risk, identify the particular factors that create the high-risk condition, and begin immediate interventions that target those contributing factors.

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[8] Ryeus, Judith S. & Hughes, Ronald, C. Field Guide to Child Welfare, Volume 1, Institute of Human Services, Columbus, OH, CWLA Press, 1998, p. 94-96

[9] Ryeus, Judith S. & Hughes, Ronald, C. Field Guide to Child Welfare, Volume 1, Institute of Human Services, Columbus, OH, CWLA Press, 1998, p. 93-98

ISSUES IN THE MEASUREMENT OF RISK

Risk assessment theory basically assumes that there are factors within the family and its environment that, when present, increase the likelihood of harm to child from abuse and neglect. When risk factors coexist, they may potentiate each other and increase risk. There are also factors within the family and its environment that can mitigate risk and increase safety for a child. The identification of these safety factors is an often overlooked, but integral part of the risk assessment process.

By identifying the factors that increase risk, and the factors that promote safety in the family environment, and by understanding their individual and interrelating dynamics, a valid assessment of potential risk of abuse or neglect can be made. An intervention plan can then be developed that promotes the safety of the child and the least degree of intrusion into the family.

The process of risk assessment is, therefore, a methodical review of factors that are known to contribute to child maltreatment, and those that are known to decrease the likelihood of future maltreatment. The risk assessment process determines the degree to which key risk and safety factors are present in a family situation, and attempts to determine the likelihood of future harm to a child as a result.

Because maltreatment usually results from the combined effects of many variables, the determination of risk can become quite complicated. A formal risk assessment process is an attempt to make this decision-making process more objective, systematic, consistent, and predictively valid.

Risk assessment is a proven and practical concept in many areas of science and industry. It is regularly used in labor safety, aeronautical engineering, and the aerospace industry. In these fields, statistical processes have proved to be relatively reliable in predicting the frequency of accidents and mechanical breakdown in large, complicated systems. This has been possible because of the scientific understanding of the variables related to risk, and the ability to quantify or measure them.

In child welfare, the variables that contribute to and mitigate child maltreatment are related to psychological characteristics of parents, parental behaviors, developmental and behavioral characteristics of children, and the effects of environmental factors of the family. Many of these factors are difficult to quantify, and their inter-relationships are not always well understood. Neither do they lend themselves to easy measurement, quantification, or prediction. In addition, there are different contributing factors to various types of maltreatment, such as physical abuse, sexual abuse, emotional abuse, and neglect.

There are many different models of risk assessment used in child welfare agencies. There are also many variations of particular models, as different states and provinces adopt risk assessment models to fit perceived needs. These risk assessment models may include different risk factors, may weigh them differently, may or may not use scoring instruments and may use them at different times and in different ways during the life of a case. Recently, there has been considerable research of the validity

and reliability of specific factors in predicting child abuse. The research has identified some factors that are statistically correlated with future abuse (English & Pecora 1994).

The goal of standardized risk assessment models and instruments is to make our judgments about families, and the risk to their children, less subjective. Risk assessment models and instruments attempt to standardize the questions workers ask and the data they gather, thereby promoting a decision-making process that is more thorough, more objective, more consistent, more accurate, and presumably more just. Given the present state of risk assessment technology in social service, the risk assessment instrument is best used to support the clinical decisions of professional, well-trained, well-supervised, and experienced caseworkers, rather than to supplant such decisions.

THE RISK ASSESSMENT PROCESS

The risk assessment process is a fact-finding process, which gathers pertinent information to make the following determinations:

1. Has the child been physically abused, sexually abused, or neglected?

Risk assessment is not simply the substantiation of prior maltreatment. The goal of risk assessment is to establish the likelihood of future harm to a child. However, a history of prior maltreatment is often a strong predictor of future harm. The accurate substantiation of prior maltreatment and the determination of its extent and causes, are critical for the prevention of future maltreatment.

To establish that a child has been harmed, the worker must look for the physical, emotional, and behavioral indicators of maltreatment. The worker must see and talk to the child, and must examine him for evidence of injury, illness, or other types of harm. Medical or psychological assessment can substantiate certain types of maltreatment. The worker must also look for environmental conditions and family dynamics that commonly contribute to maltreatment.

It is easier to determine that a child has been abused or neglected when there is clear, substantiating evidence of physical injury or harm. The determination is more difficult when there are no visible signs of injury, when medical evidence is inconclusive, when stories conflict, when there is no corroboration of a complaint, when there is questionable history of previous maltreatment, or when there are no eyewitnesses to maltreatment.

2. Is the child at risk of further harm or maltreatment?

If a child has been previously maltreated, the worker must determine the factors that most likely contributed to the maltreatment, and assess whether they are still present and whether they have been or can be mitigated or eliminated. For example, it is unlikely that a child will be harmed again, as long as the perpetrator of the abuse remains in jail. Similarly, if a mother's depression, which placed the child at high risk of neglect, can be effectively treated with antidepressant medication, it is unlikely that neglect will recur, as long as the mother remains on her medication. If nothing has altered the family situation in which a child was harmed, the likelihood is high that the child may be harmed again.

At times there is no evidence that a child has been previously maltreated, but there are significant factors in the family environment that are, in general, highly correlated with maltreatment. The degree of potential risk is determined by assessing the combined interactions of these factors.

The risk assessment process therefore, a) identifies the probable causal or contributing factors to maltreatment in the family, b) identifies the degree to which the child is still exposed to these factors; and c) identifies safety factors that can or have mitigated risk factors to assure the child's safety.

Risk assessment models that focus only on deficits are half complete and wholly inaccurate. The measure of human behavior must consider the complicated, synergies and interactions of individual and interpersonal strengths and limitations.

However, it is dangerous to assume that identifying and building on strengths can, by itself, prevent or mitigate maltreatment. Families that maltreat their children do have contextual deficits, sometimes very serous deficits. We cannot ignore the fact that it is a very disturbed parent who would kill or attempt to kill a child. We must also remember that there are many parents who live in continually stressful, even dire consequences, who never harm their children.

Correctly identifying and interpreting parental acts that reflect underlying problems or dysfunction is absolutely necessary for child protection. However, our assessment will be fairly biased if we do not concurrently identify those traits and factors that can be developed and strengthened to help eliminate or mitigate deficit factors; and when we do not identify disruptive environmental factors.

An approach to child protection that concurrently considers both deficits and potentials can appropriately be developmental. A deficit model might assume that deficit traits and behaviors are permanent conditions, immutable and unchangeable. A development model recognizes the importance of environmental context, and suggests that with the proper interventions and support, most people can learn new and different ways of behaving and rearing their children. A developmental model, therefore, identifies deficits, but contends that they can often be modified, albeit to varying degrees. A balanced assessment of both risk and safety allows us to concurrently consider the factors that lead to risk, and the qualities within a family and its environment that can be further developed and strengthened to eliminate the risk condition.

To be legitimate, a strengths assessment in a risk assessment model must identify the presence and extent of relevant factors or dynamics that can directly act upon and alter the conditions that increase risk. In this model, risk and safety are viewed as the behavioral expressions of opposite ends of a continuum for an identified characteristic or trait. A condition of "low risk" is not simply the absence of destructive behaviors. Rather, low risk requires the presence of constructive reciprocal behaviors that provide for healthy development and protection from harm. The presence of these constructive and healthy elements are, by definition, the safety factors that mitigate risk, and the presence of these factors in a family constitutes a family strength.

For example, a mother's volatile temper and poor emotional control may greatly increase the likelihood of abuse to her child. Low risk is not simply the absence of a volatile temper. Low risk requires the presence of a

constructive reciprocating behavior – the ability to control and manage emotions, and to express anger and frustration in ways that are not harmful to others. If we can identify and make explicit the positive behaviors or dynamics we believe to be reciprocal to the more harmful, high-risk behaviors or dynamics, we will have identified the relevant safety factors that can be strengthened to mitigate risk.

If we try to identify strengths independently of risk, we are likely to develop a laundry list of qualities and characteristics that, while admirable in and of themselves, may not constitute mitigating strengths. For example, in the Jones family, we might observe that the mother does volunteer work and is active in her church; that the father works two jobs and is able to comfortably support his family; and the family goes camping together. However, none of these are remotely relevant strengths when the principal cause of maltreatment is the volatile, irrational, and physically abusive behavior of the father when he is drinking. Viable and relevant strengths in this family that could be further developed and supported to mitigate risk might include:

The father is aware of the problems his drinking is causing for his family, and he exhibits periodic attempts to control his condition, even though he seems unable to change it himself.

The mother has clearly indicated that she will take the children and leave, if her husband does not "get sober and stay that way."

The father has controlled his use of alcohol in the past, with the help of Alcoholics Anonymous, and was sober for two years, but he began drinking again when he was laid off from his job for six months.

The mother and children can predict from the father's behavior when he is becoming abusive, and they leave the house and go to the grandmother's home.

The mother's behaviors to protect her children, and the father's history of prior management of his alcoholism are strengths that, if developed, could greatly reduce the risk to the children.

WHEN TO CONDUCT A RISK ASSESSMENT

In addition to the initial intake assessment, there are several points in the ongoing casework process at which a follow-up risk assessment should always be conducted. These include:

- Anytime the agency receives another complaint or referral on a case that is open and receiving services from the agency;
- Within several days after a child is returned home after having been in substitute care placement, and again every few weeks, until the case can be closed. The absence of risk on the follow-up risk assessments can justify case closure;
- When there is a change in the composition of the family, such as when a parent or other significant family member leaves or returns to the family, or when another child is born.

CIRCLE OF CARE
PLANNING GUIDELINES

APPENDIX C

ABRAHAM MASLOW

RE: HIERARCHY OF NEEDS

ABRAHAM MASLOW

1908-1970 DR. C. GEORGE BOEREE

Biography

Abraham Harold Maslow was born April 1, 1908 in Brooklyn, New York. He was the first of seven children born to his parents, who themselves were uneducated Jewish immigrants from Russia. His parents, hoping for the best for their children in the new world, pushed him hard for academic success. Not surprisingly, he became very lonely as a boy, and found his refuge in books.

To satisfy his parents, he first studied law at the City College of New York (CCNY). After three semesters, he transferred to Cornell, and then back to CCNY. He married Bertha Goodman, his first cousin, against his parents wishes. Abe and Bertha went on to have two daughters.

He and Bertha moved to Wisconsin so that he could attend the University of Wisconsin. Here, he became interested in psychology, and his school work began to improve dramatically. He spent time there working with Harry Harlow, who is famous for his experiments with baby rhesus monkeys and attachment behavior.

He received his BA in 1930, his MA in 1931, and his PhD in 1934, all in psychology, all from the University of Wisconsin. A year after graduation, he returned to New York to work with E. L. Thorndike at Columbia, where Maslow became interested in research on human sexuality.

He began teaching full time at Brooklyn College. During this period of his life, he came into contact with the many European intellectuals that were immigrating to the US, and Brooklyn in particular, at that time -- people like Adler, Fromm, Horney, as well as several Gestalt and Freudian psychologists.

Maslow served as the chair of the psychology department at Brandeis from 1951 to 1969. While there he met Kurt Goldstein, who had originated the idea of self-actualization in his famous book, ***The Organism*** (1934). It was also here that he began his crusade for a humanistic psychology -- something ultimately much more important to him than his own theorizing.

He spend his final years in semi-retirement in California, until, on June 8 1970, he died of a heart attack after years of ill health.

One of the many interesting things Maslow noticed while he worked with monkeys early in his career, was that some needs take precedence over others. For example, if you are hungry and thirsty, you will tend to try to take care of the thirst first. After all, you can do without food for weeks, but you can only do without water for a couple of days! Thirst is a "stronger" need than hunger. Likewise, if you are very very thirsty, but someone has put a choke hold on you and you can't breath, which is more important? The need to breathe, of course. On the other hand, sex is less powerful than any of these. Let's face it, you won't die if you don't get it!

Maslow took this idea and created his now famous **hierarchy of needs**. Beyond the details of air, water, food, and sex, he laid out five broader layers: the physiological needs, the needs for safety and security, the needs for love and belonging, the needs for esteem, and the need to actualize the self, in that order.

1. **The physiological needs**. These include the needs we have for oxygen, water, protein, salt, sugar, calcium, and other minerals and vitamins. They also include the need to maintain a pH balance (getting too acidic or base will kill you) and temperature (98.6 or near to it). Also, there's the needs to be active, to rest, to sleep, to get rid of wastes (CO_2, sweat, urine, and feces), to avoid pain, and to have sex. Quite a collection!

Maslow believed, and research supports him, that these are in fact individual needs, and that a lack of, say, vitamin C, will lead to a very specific hunger for things which have in the past provided that vitamin C -- e.g. orange juice. I guess the cravings that some pregnant women have, and the way in which babies eat the most foul tasting baby food, support the idea anecdotally.

2. **The safety and security needs**. When the physiological needs are largely taken care of, this second layer of needs comes into play. You will become increasingly interested in finding safe circumstances, stability, protection. You might develop a need for structure, for order, some limits.

Looking at it negatively, you become concerned, not with needs like hunger and thirst, but with your fears and anxieties. In the ordinary American adult, this set of needs manifest themselves in the form of our urges to have a home in a safe neighborhood, a little job security and a nest egg, a good retirement plan and a bit of insurance, and so on.

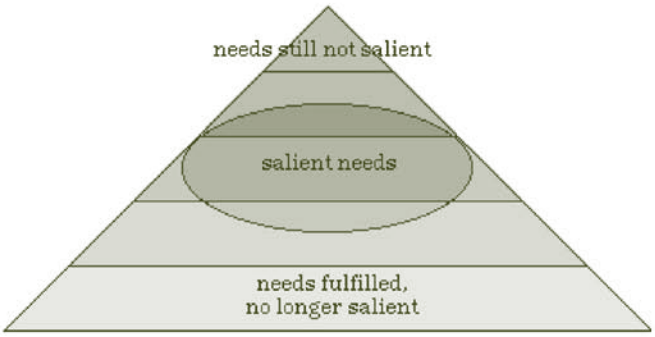
3. **The love and belonging needs**. When physiological needs and safety needs are, by and large, taken care of, a third layer starts to show up. You begin to feel the need for friends, a sweetheart, children, affectionate relationships in general, even a sense of community. Looked at negatively, you become increasing susceptible to loneliness and social anxieties.

In our day-to-day life, we exhibit these needs in our desires to marry, have a family, be a part of a community, a member of a church, a brother in the fraternity, a part of a gang or a bowling club. It is also a part of what we look for in a career.

4. **The esteem needs**. Next, we begin to look for a little self-esteem. Maslow noted two versions of esteem needs, a lower one and a higher one. The lower one is the need for the respect of others, the need for status, fame, glory, recognition, attention, reputation, appreciation, dignity, even dominance. The higher form involves the need for self-respect, including such feelings as confidence, competence, achievement, mastery, independence, and freedom. Note that this is the "higher" form because, unlike the respect of others, once you have self-respect, it's a lot harder to lose!

The negative version of these needs is low self-esteem and inferiority complexes. Maslow felt that Adler was really onto something when he proposed that these were at the roots of many, if not most, of our psychological problems. In modern countries, most of us have what we need in regard to our physiological and safety needs. We, more often than not, have quite a bit of love and belonging, too. It's a little respect that often seems so very hard to get!

All of the preceding four levels he calls **deficit needs**, or **D-needs**. If you don't have enough of something -- i.e. you have a deficit -- you feel the need. But if you get all you need, you feel nothing at all! In other words, they cease to be motivating. As the old blues song goes, "you don't miss your water till your well runs dry!"



He also talks about these levels in terms of **homeostasis**. Homeostasis is the principle by which your furnace thermostat operates: When it gets too cold, it switches the heat on; When it gets too hot, it switches the heat off. In the same way, your body, when it lacks a certain substance, develops a hunger for it; When it gets enough of it, then the hunger stops. Maslow simply extends the homeostatic principle to needs, such as safety, belonging, and esteem, that we don't ordinarily think of in these terms.

Maslow sees all these needs as essentially survival needs. Even love and esteem are needed for the maintenance of health. He says we all have these needs built in to us genetically, like instincts. In fact, he calls them **instinctoid** -- instinct-like -- needs.

In terms of overall development, we move through these levels a bit like stages. As newborns, our focus (if

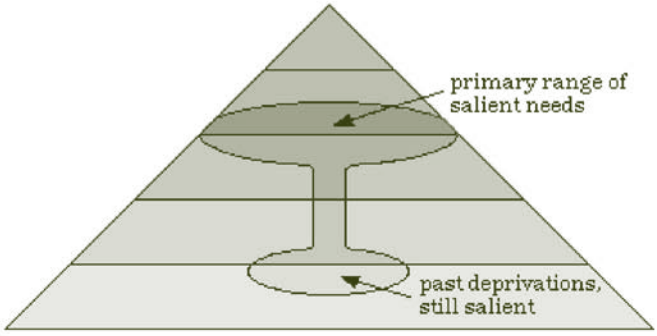
not our entire set of needs) is on the physiological. Soon, we begin to recognize that we need to be safe. Soon after that, we crave attention and affection. A bit later, we look for self-esteem. Mind you, this is in the first couple of years!

Under stressful conditions, or when survival is threatened, we can "regress" to a lower need level. When you great career falls flat, you might seek out a little attention. When your family ups and leaves you, it seems that love is again all you ever wanted. When you face chapter eleven after a long and happy life, you suddenly can't think of anything except money.

These things can occur on a society-wide basis as well: When society suddenly flounders, people start clamoring for a strong leader to take over and make things right. When the bombs start falling, they look for safety. When the food stops coming into the stores, their needs become even more basic.

Maslow suggested that we can ask people for their "**philosophy of the future**" -- what would their ideal life or world be like -- and get significant information as to what needs they do or do not have covered.

If you have significant problems along your development -- a period of extreme insecurity or hunger as a child, or the loss of a family member through death or divorce, or significant neglect or abuse -- you may "fixate" on that set of needs for the rest of your life.



This is Maslow's understanding of neurosis. Perhaps you went through a war as a kid. Now you have everything your heart needs -- yet you still find yourself obsessing over having enough money and keeping the pantry well-stocked. Or perhaps your parents divorced when you were young. Now you have a wonderful spouse -- yet you get insanely jealous or worry constantly that they are going to leave you because you are not "good enough" for them. You get the picture.

Self-actualization

The last level is a bit different. Maslow has used a variety of terms to refer to this level: He has called it **growth motivation** (in contrast to deficit motivation), **being needs** (or **B-needs**, in contrast to D-needs), and **self-actualization**.

These are needs that do not involve balance or homeostasis. Once engaged, they continue to be felt. In fact, they are likely to become stronger as we "feed" them! They involve the continuous desire to fulfill potentials, to "be all that you can be." They are a matter of becoming the most complete, the fullest, "you" -- hence the term, self-actualization.

Now, in keeping with his theory up to this point, if you want to be truly self-actualizing, you need to have your lower needs taken care of, at least to a considerable extent. This makes sense: If you are hungry, you are scrambling to get food; If you are unsafe, you have to be continuously on guard; If you are isolated and unloved, you have to satisfy that need; If you have a low sense of self-esteem, you have to be defensive or compensate. When lower needs are unmet, you can't fully devote yourself to fulfilling your potentials.

It isn't surprising, then, the world being as difficult as it is, that only a small percentage of the world's population is truly, predominantly, self-actualizing. Maslow at one point suggested only about two percent!

The question becomes, of course, what exactly does Maslow mean by self-actualization. To answer that, we need to look at the kind of people he called self-actualizers. Fortunately, he did this for us, using a qualitative method called **biographical analysis**.

He began by picking out a group of people, some historical figures, some people he knew, whom he felt clearly met the standard of self-actualization. Included in this august group were Abraham Lincoln, Thomas Jefferson, Albert Einstein, Eleanor Roosevelt, Jane Adams, William James, Albert Schweitzer, Benedict Spinoza, and Alduous Huxley, plus 12 unnamed people who were alive at the time Maslow did his research. He then looked at their biographies, writings, the acts and words of those he knew personally, and so on. From these sources, he developed a list of qualities that seemed characteristic of these people, as opposed to the great mass of us.

These people were **reality-centered**, which means they could differentiate what is fake and dishonest from what is real and genuine. They were **problem-centered**, meaning they treated life's difficulties as problems demanding solutions, not as personal troubles to be railed at or surrendered to. And they had a **different perception of means and ends**. They felt that the ends don't necessarily justify the means, that the means could be ends themselves, and that the means -- the journey -- was often more important than the ends.

The self-actualizers also had a different way of relating to others. First, they enjoyed **solitude**, and were comfortable being alone. And they enjoyed deeper **personal relations** with a few close friends and family members, rather than more shallow relationships with many people.

They enjoyed **autonomy**, a relative independence from physical and social needs. And they **resisted enculturation**, that is, they were not susceptible to social pressure to be "well adjusted" or to "fit in" -- they were, in fact, nonconformists in the best sense.

They had an **unhostile sense of humor** -- preferring to joke at their own expense, or at the human condition, and never directing their humor at others. They had a quality he called **acceptance of self and others**, by which he meant that these people would be more likely to take you as you are than try to change you into what they thought you should be. This same acceptance applied to their attitudes towards themselves: If some quality of theirs wasn't harmful, they let it be, even enjoying it as a personal quirk. On the other hand, they were often strongly motivated to change negative qualities in themselves that could be changed. Along with this comes **spontaneity and simplicity**: They preferred being themselves rather than being pretentious or artificial. In fact, for all their nonconformity, he found that they tended to be conventional on the surface, just where less self-actualizing nonconformists tend to be the most dramatic.

Further, they had a sense of **humility and respect** towards others -- something Maslow also called democratic values -- meaning that they were open to ethnic and individual variety, even treasuring it. They had a quality Maslow called **human kinship** or *Gemeinschaftsgefühl* -- social interest, compassion, humanity. And this was accompanied by a **strong ethics**, which was spiritual but seldom conventionally religious in nature.

And these people had a certain **freshness of appreciation**, an ability to see things, even ordinary things, with wonder. Along with this comes their ability to be **creative**, inventive, and original. And, finally, these people tended to have more **peak experiences** than the average person. A peak experience is one that takes you out of yourself, that makes you feel very tiny, or very large, to some extent one with life or nature or God. It gives you a feeling of being a part of the infinite and the eternal. These experiences tend to leave their mark on a person, change them for the better, and many people actively seek them out. They are also called mystical experiences, and are an important part of many religious and philosophical traditions.

Maslow doesn't think that self-actualizers are perfect, of course. There were several flaws or **imperfections** he discovered along the way as well: First, they often suffered considerable anxiety and guilt -- but realistic anxiety and guilt, rather than misplaced or neurotic versions. Some of them were absentminded and overly kind. And finally, some of them had unexpected moments of ruthlessness, surgical coldness, and loss of humor.

Two other points he makes about these self-actualizers: Their values were "natural" and seemed to flow effortlessly from their personalities. And they appeared to transcend many of the dichotomies others accept as being undeniable, such as the differences between the spiritual and the physical, the selfish and the unselfish, and the masculine and the feminine.

Metaneeds and metapathologies

Another way in which Maslow approach the problem of what is self-actualization is to talk about the special, driving needs (B-needs, of course) of the self-actualizers. They need the following in their lives in order to be happy:

Truth, rather than dishonesty.
Goodness, rather than evil.
Beauty, not ugliness or vulgarity.
Unity, wholeness, and transcendence of opposites, not arbitrariness or forced choices.
Aliveness, not deadness or the mechanization of life.
Uniqueness, not bland uniformity.
Perfection and necessity, not sloppiness, inconsistency, or accident.
Completion, rather than incompleteness.
Justice and order, not injustice and lawlessness.
Simplicity, not unnecessary complexity.
Richness, not environmental impoverishment.
Effortlessness, not strain.
Playfulness, not grim, humorless, drudgery.
Self-sufficiency, not dependency.
Meaningfulness, rather than senselessness.

At first glance, you might think that everyone obviously needs these. But think: If you are living through an economic depression or a war, or are living in a ghetto or in rural poverty, do you worry about these issues, or do you worry about getting enough to eat and a roof over your head? In fact, Maslow believes that much of the what is wrong with the world comes down to the fact that very few people really are interested in these values -- not because they are bad people, but because they haven't even had their basic needs taken care of!

When a self-actualizer doesn't get these needs fulfilled, they respond with **metapathologies** -- a list of problems as long as the list of metaneeds! Let me summarize it by saying that, when forced to live without these values, the self-actualizer develops depression, despair, disgust,alienation, and a degree of cynicism.

Maslow hoped that his efforts at describing the self-actualizing person would eventually lead to a "periodic table" of the kinds of qualities, problems, pathologies, and even solutions characteristic of higher levels of human potential. Over time, he devoted increasing attention, not to his own theory, but to humanistic psychology and the human potentials movement.

Toward the end of his life, he inaugurated what he called the **fourth force** in psychology: Freudian and other "depth" psychologies constituted the first force; Behaviorism was the second force; His own humanism, including the European existentialists, were the third force. The fourth force was the **transpersonal psychologies** which, taking their cue from Eastern philosophies, investigated such things as meditation, higher levels of consciousness, and even parapsychological phenomena. Perhaps the best known transpersonalist today is Ken Wilber, author of such books as ***The Atman Project*** and ***The History of Everything***.

Discussion

Maslow has been a very inspirational figure in personality theories. In the 1960's in particular, people were tired of the reductionistic, mechanistic messages of the behaviorists and physiological psychologists. They were looking for meaning and purpose in their lives, even a higher, more mystical meaning. Maslow was one of the pioneers in that movement to bring the human being back into psychology, and the person back into personality!

At approximately the same time, another movement was getting underway, one inspired by some of the very things that turned Maslow off: computers and information processing, as well as very rationalistic theories such as Piaget's cognitive development theory and Noam Chomsky's linguistics. This, of course, became the cognitive movement in psychology. As the heyday of humanism appeared to lead to little more than drug abuse, astrology, and self indulgence, cognitivism provided the scientific ground students of psychology were yearning for.

But the message should not be lost: Psychology is, first and foremost, about people, real people in real lives, and not about computer models, statistical analyses, rat behavior, test scores, and laboratories.

Some criticism

The "big picture" aside, there are a few criticisms we might direct at Maslow's theory itself. The most common criticism concerns his methodology: Picking a small number of people that he himself declared self-actualizing, then reading about them or talking with them, and coming to conclusions about what self-actualization is in the first place does not sound like good science to many people.

In his defense, I should point out that he understood this, and thought of his work as simply pointing the way. He hoped that others would take up the cause and complete what he had begun in a more rigorous fashion. It is a curiosity that Maslow, the "father" of American humanism, began his career as a behaviorist with a strong physiological bent. He did indeed believe in science, and often grounded his ideas in biology. He only meant to broaden psychology to include the best in us, as well as the pathological!

Another criticism, a little harder to respond to, is that Maslow placed such constraints on self-actualization. First, Kurt Goldstein and Carl Rogers used the phrase to refer to what every living creature does: To try to grow, to become more, to fulfill its biological destiny. Maslow limits it to something only two percent of the

human species achieves. And while Rogers felt that babies were the best examples of human self-actualization, Maslow saw it as something achieved only rarely by the young.

Another point is that he asks that we pretty much take care of our lower needs before self-actualization comes to the forefront. And yet we can find many examples of people who exhibited at very least aspects of self-actualization who were far from having their lower needs taken care of. Many of our best artists and authors, for example, suffered from poverty, bad upbringing, neuroses, and depression. Some could even be called psychotic! If you think about Galileo, who prayed for ideas that would sell, or Rembrandt, who could barely keep food on the table, or Toulouse Lautrec, whose body tormented him, or van Gogh, who, besides poor, wasn't quite right in the head, if you know what I mean... Weren't these people engaged in some form of self-actualization? The idea of artists and poets and philosophers (and psychologists!) being strange is so common because it has so much truth to it!

We also have the example of a number of people who were creative in some fashion even while in concentration camps. Trachtenberg, for example, developed a new way of doing arithmetic in a camp. Viktor Frankl developed his approach to therapy while in a camp. There are many more examples.

And there are examples of people who were creative when unknown, became successful only to stop being creative. Ernest Hemingway, if I'm not mistaken, is an example. Perhaps all these examples are exceptions, and the hierarchy of needs stands up well to the general trend. But the exceptions certainly do put some doubt into our minds.

I would like to suggest a variation on Maslow's theory that might help. If we take the idea of actualization as Goldstein and Rogers use it, i.e. as the "life force" that drives all creatures, we can also acknowledge that there are various things that interfere with the *full* effectiveness of that life force. If we are deprived of our basic physical needs, if we are living under threatening circumstances, if we are isolated from others, or if we have no confidence in our abilities, we may continue to survive, but it will not be as fulfilling a live as it could be. We will not be *fully* actualizing our potentials! We could even understand that there might be people that actualize *despite* deprivation! If we take the deficit needs as subtracting from actualization, and if we talk about *full* self-actualization rather than self-actualization as a separate category of need, Maslow's theory comes into line with other theories, and the exceptional people who succeed in the face of adversity can be seen as heroic rather than freakish abberations.

I received the following email from Gareth Costello of Dublin, Ireland, which balances my somewhat negative review of Maslow:

> One mild criticism I would have is of your concluding assessment, where you appeal for a broader view of self-actualisation that could include subjects such as van Gogh and other hard-at-heel intellectual/creative giants. This appears to be based on a view that people like van Gogh, etc. were, by virtue of their enormous creativity, 'at least partly' self-actualised.
>
> I favour Maslow's more narrow definition of self-actualisation and would not agree that self-actualisation equates with supreme self-expression. I suspect that self-actualisation is, often, a demotivating factor where artistic creativity is concerned, and that artists such as van Gogh thrived (artistically, if not in other respects) specifically in the absence of circumstances conducive to self-actualisation. Even financially successful artists (e.g. Stravinsky, who was famously good at looking after his financial affairs, as well as affairs of other kinds) do exhibit some of the non-self-actualised 'motivators' that you describe so well.

Self-actualisation implies an outwardness and openness that contrasts with the introspection that can be a pre-requisite for great artistic self-expression. Where scientists can look out at the world around them to find something of profound or universal significance, great artists usually look inside themselves to find something of personal significance - the universality of their work is important but secondary. It's interesting that Maslow seems to have concentrated on people concerned with the big-picture when defining self-actualisation. In Einstein, he selected a scientist who was striving for a theory of the entire physical universe. The philosophers and politicians he analysed were concerned with issues of great relevance to humanity.

This is not to belittle the value or importance of the 'small-picture' - society needs splitters as well as lumpers. But while self-actualisation may be synonymous with psychological balance and health, it does not necessarily lead to professional or creative brilliance in all fields. In some instances, it may remove the driving force that leads people to excel -- art being the classic example. So I don't agree that the scope of self-actualisation should be extended to include people who may well have been brilliant, but who were also quite possibly damaged, unrounded or unhappy human beings.

If I had the opportunity to chose between brilliance (alone) or self-actualisation (alone) for my children, I would go for the latter!

Gareth makes some very good points!

Bibliography

Maslow's books are easy to read and full of interesting ideas. The best known are ***Toward a Psychology of Being*** (1968), ***Motivation and Personality*** (first edition, 1954, and second edition, 1970), and ***The Further Reaches of Human Nature*** (1971). Finally, there are many articles by Maslow, especially in the ***Journal of Humanistic Psychology***, which he cofounded.

CIRCLE OF CARE
PLANNING GUIDELINES

APPENDIX D

EXAMPLE OF REDISCOVERY OF FAMILIES' PROJECT INTAKE SCREENING AND EVALUATION FORMS

Family and Community Wellness Centre Inc.

Rediscovery of Families' Project Screening Intake Form

Date:_____ Worker:_____

Father's Name: _____Treaty #:_____

Mother's Name: _____Treaty #:_____

Children's Names	Age	Grade	Special Gifts/Talents

Source of Employment

Are you employed? ❒ Yes ❒ No ❒ Part-time ❒ Full time

Where do you work? _____

What kind of work do you do? _____

Did you make an arrangement with you employer to participate in this project? ❒ Yes ❒ No
If no, are you going to make the arrangement? ❒ Yes ❒ No
Are you receiving social assistance? ❒ Yes ❒ No or Employment Insurance? ❒ Yes ❒ No
Are you seeking employment: ❒ Yes ❒ No
What type of employment: _____
What kind of work do you do that is not paid employment (for example, you could be hunting fishing, house keeping, parenting, cooking sewing, etc.)? _____

_____

_____

_____

What are some of the important things that you and your family need to make life better for you? Please check off what applies to you.

Food and Clothing	❒	Housing	❒
Recreation	❒	Health Related	❒
Job Skills	❒	Cooking Skills	❒
Traditional Skills	❒	Employment	❒
Family Supports	❒	Counselling Therapy	❒
Education	❒	Parental Skills	❒

Traditional Skills (learning to live off the land, fishing, hunting, picking medicine and berries) ❒

Please add any other needs not listed: _____

_____

How have you tried to meet these needs? _____

_____

_____

_____

What support have you found helpful in addressing those needs? _____

_____

_____

_____

What kind of support do you and your family require at this time? _____

_____

_____

_____

What are the strengths in your family?

Help one another when needed	❒	Public speaking/translation	❒
Sewing	❒	Story teller/legends	❒
Tanning	❒	Fluent Cree and English	❒
Cooking	❒	Writing in syllabics	❒
House cleaning	❒	Maintaining culture and language	❒
Hunting	❒	Communication	❒
Fishing	❒	Carving/painting	❒
Hunting	❒	Sharing family responsibilities	❒
Canoeing	❒	Family discussions to plan events activities, or just in general	❒

Please add anything that is not on this list: _____

_____

Would you be willing to share your skills and knowledge with families that participate in this project? ❒ Yes ❒ No

Please list any health related concerns that require attention when you are Leftrook Lake?

_____

_____

_____

What family and/or community member(s) can you call on for support? _____

_____

_____

_____

If you are to continue receiving support from the Family and Community Wellness Centre, what services would you require support for?

Family Resource

Prenatal	❒
Postnatal	❒
Chronic (meals for fasting, diabetes)	❒
Child development	❒

Child & Family Services

Family Support Services	❒
Intervenor	❒
Foster Care	❒
Respite	❒
Homemaker	❒
Traditional Counselling	❒
Psychological Assessment	❒

Counselling Services

Individual Counselling	❒
Family Counselling	❒
Workshops	❒
Conference	❒
Sharing Circles	❒

Other Programs

Arts & Culture	❒	Headstart	❒
Elders	❒	Day Care	❒
Midwifery	❒	Home & Community Care	❒

What date are you interested in participating in Rediscovery of Families Project? _____

If all available spots are filled, are you willing to be placed on a waiting list and prepared to leave on short notice if a spot becomes available? ❒ Yes ❒ No


SELF-DETERMINATION
Beliefs and values that guide
our lives.

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APPENDIX E

NOT EVERYONE WANTS TO CHANGE THEIR LIFESTYLE, EVEN THOUGH IT MAY BE SELF DESTRUCTIVE.

THIS ACTUAL LETTER from a teenager can be used as an example for participants to support the concept that children with histories of very traumatizing experience may see the world differently than those trying to help. Yet, in context of her history, marked by extreme family violence and abuse, her world view that custodial care is like "home" fits when driven by her need for "safety" and predictability. She was in and out of foster homes, group homes, treatment centres, open and closed custodial settings and as an adult is serving time in jail.

Dear Mom and Dad,

Hi there!

I wanted to say a few things that I cant say to you's face to face, although I would like to.

I would like to explain what I felt when I was there. I know that I caused a lot of trouble and wasn't healthy.

I thought I would make it when I got out of treatment but I was wrong. Im used to just being locked up and being in group homes or what not and I thought I would get use to being in a normal home to be a normal person, but I was wrong.

When I moved in, I was willing to got started on my new life, but as soon as I was beginning to live it, I got scared, so I did'nt want to live anymore. All I could think about was my old life of abousing booze, solvents, drugs. I used the excuse of missing home. yes I did think about my family but I didn't really want to go home. As each, day went by it was harder and harder, I didn't know what to do. I started drinking that shit so I can just get numb, so I did'nt have to feel or face anything, I was ready to commit suicide but I just thought of moving back home and living a life that I would dread, plus living at your house caused money and that was one of my other reasons why I wanted to go home so fast, I had no money to pay with.

Thank you all so much for trying hard to help me. I really really appreciate it with all my heart. I did'nt think it would end this way but it did.

I'm not making excuses, Im telling yous my heart.

While Im in jail I realize a lot of things, I think a lot about things and things are simple, this is my home, this one of the places I feel safe in, this is the place I go to for survival from home, and it'll always be like that.

Please don't hate me for giving up and losing hope, just try to understand me.

Love Bye!

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APPENDIX F

LIFE WHEEL

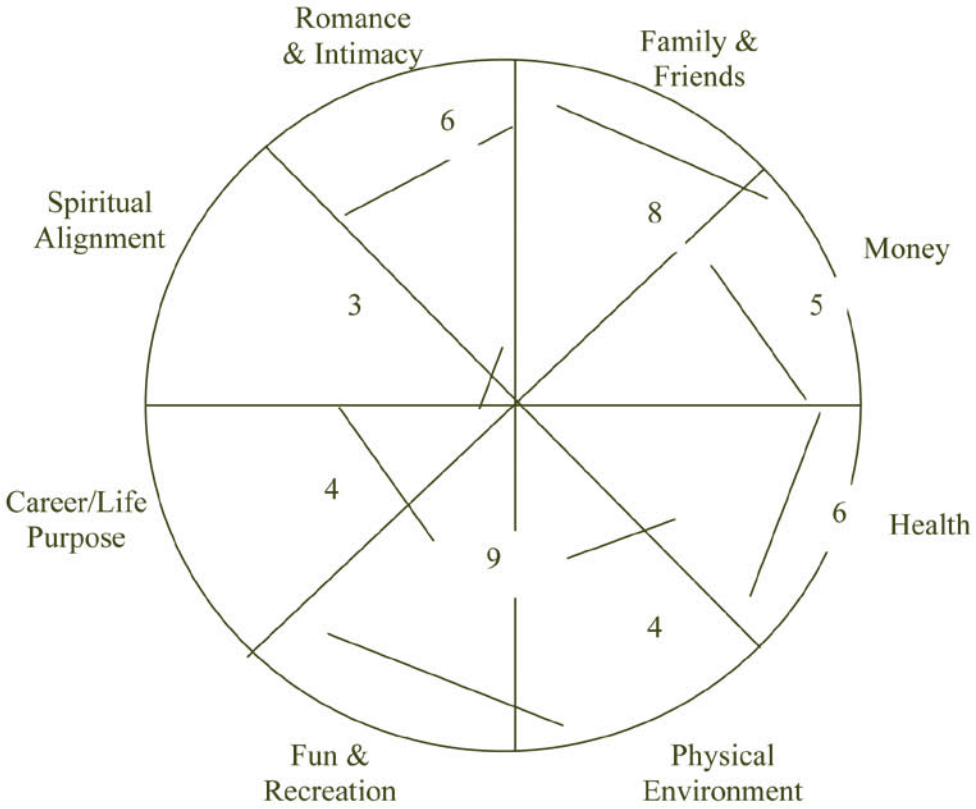
Life Wheel[10]

Instructions:
This exercise is for your own information. You do not have to share your results with anyone.

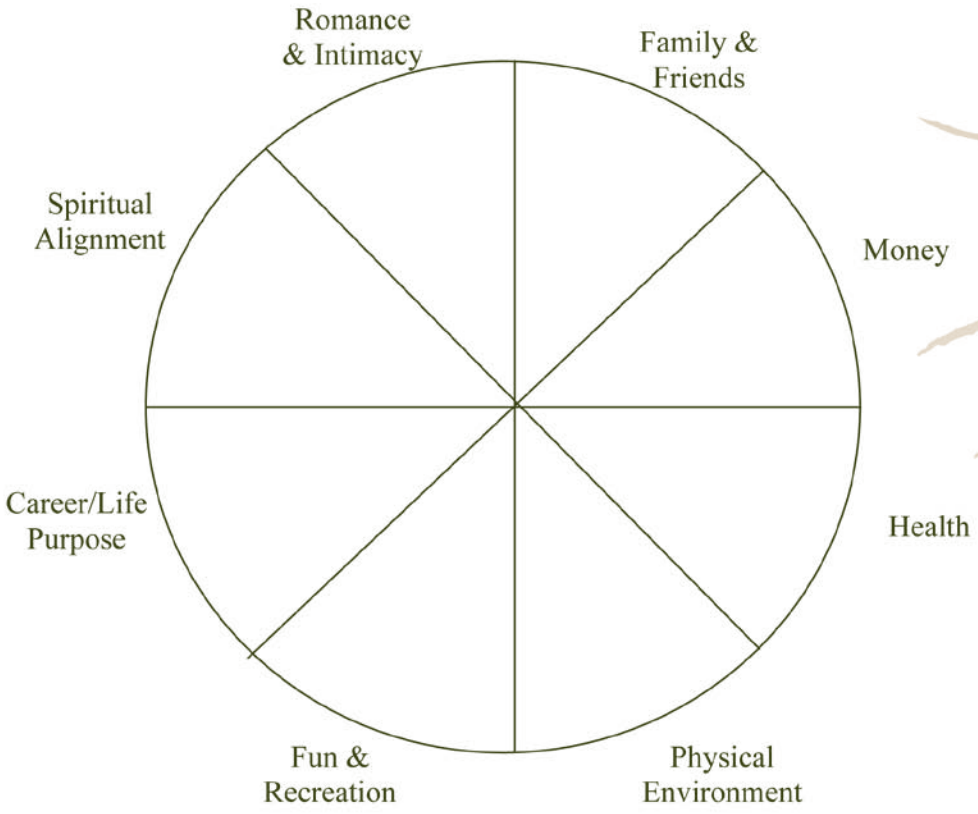
The eight sections of the wheel represent different aspects of our lives. Seeing the centre of the wheel as zero and the outer edge as 10, rank your level of satisfaction with each area of your life by drawing a line creating a new outer edge (see Example). The circle with your lines drawn, represents your Life Wheel.

Turn the page and complete your Life Wheel.

Example:



[10] Sexual Assault Network. Self Care for Professionals. Ottawa, ON. http://www.sanottawa.com/selfcare.html



Questions to ask yourself:

1. What areas in my life are going really well? Is there anything that I need to do to maintain that level of health?

2. What would be a satisfactory level of health for each section in my circle?

3. For each section that is below my satisfactory level of health, what would I like to do to move to a more satisfactory level of health?

VISION

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IN UNITY, WE PROMOTE COMMUNITY AWARENESS, EMPOWERMENT,

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NISICHAWAYASIHK CREE NATION CHILD & FAMILY SERVICES – NORTHERN AUTHORITY AMALGAMATED OFFICE

BOX 29 205-59 ELIZABETH DRIVE

THOMPSON, MANITOBA,

R8N 1X4

PHONE: (204) 778-1960 FAX: (204) 778-1989

NISICHAWAYASIHK CREE NATION FAMILY AND COMMUNITY WELLNESS CENTRE INC.

P.O. BOX 451

NELSON HOUSE, MANITOBA

R0B 1A0

PHONE: (204) 484-2341 FAX: (204) 484-2351

WEBSITE: WWW.NCNWELLNESS.CA

Nisichawayasihk Cree Nation Family and Community Wellness Centre Inc.