# ACLP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

SUMMER 2024 | VOL. 42 NO. 3



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**ADDRESS:** Association of Child Life Professionals
7600 Leesburg Pike, Suite 200 West
Falls Church, Virginia 22043

**PHONE:** (800) 252-4515
(571) 483-4500

**FAX:** (571) 483-4485

**WEB:** *www.childlife.org*

**EMAIL:** *bulletin@childlife.org*



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ASSOCIATION OF Child Life Professionals

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# CEO Shares

**By: Alison E. Heron, MBA, CAE**

Dear ACLP Community,

As summer ends and the vibrant colors of autumn approach, it's an opportune moment to reflect on the exciting changes and developments that lie ahead for the ACLP community. This transitional season brings new programs and initiatives that I am eager to share with you.

First and foremost, I am thrilled to announce the launch of our new member's only needs-based grant program. This pilot program, funded by Disney, marks a significant step in our ongoing commitment to supporting Certified Child Life Specialists (CCLSs). We aim to award grants ranging from $1,000 to $5,000 to help support or develop new or existing initiatives serving diverse, underserved populations. This essential funding aims to foster impactful work, encouraging creativity and innovation in our field. Applications for this pilot program will open later this fall.

Alongside the launch of our new pilot program, we're thrilled to share updates to the ACLP website to enhance your experience and keep you informed. This fall, you will notice a refreshed look with an improved header and footer for better navigation and accessibility. We're also introducing our new AI assistant, Scout! Scout is here to provide instant, intelligent support and answers to your questions. Whether you need information about our programs or help navigating resources, Scout will offer prompt and accurate assistance. We believe this innovative tool will greatly simplify your interactions with the ACLP and help you make the most of the resources available to you.

Furthermore, the Child Life Certification Commission will move to its own dedicated microsite! This new platform will establish a clear distinction between our two organizations while offering comprehensive information about the certification process, recertification process, requirements, and updates. We believe this resource will be incredibly valuable for those pursuing certification, maintaining certification and for anyone seeking to stay informed.

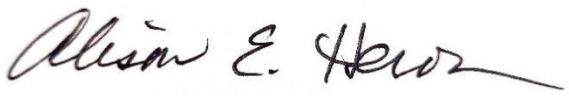
You spoke, and we listened! The ACLP Forum is making a return this fall! The enhanced platform, now built on updated technology, will provide a more intuitive and engaging experience for our members. While the Forum will have a refreshed look and feel, it will retain the core features you valued — such as enabling easy question-and-answer exchanges and the ability to create private groups based on shared interests or affinities. We believe these improvements will significantly enhance your experience as an ACLP member, fostering greater collaboration and connection within our community.

As we move into the fall, our staff and committees will be taking the time to pause

and evaluate several of our existing programs. We will thoroughly review our mentorship program, international scholarships, and diversity scholarships to ensure they align with current needs and best practices. The evaluation aims to offer recommendations to the ACLP Board of Directors on how to enhance these programs' impact. We are hopeful that this reflective process will help these initiatives continue to support our community and advance our shared mission effectively.

These updates and initiatives reflect our unwavering commitment to growth and improvement, fueled by your dedication and passion. As we embrace the coming season, I encourage you to explore these new resources, engage with our community, and keep driving progress in our field.

Thank you for your ongoing support and involvement. Together, let's make this fall productive and inspiring.



Alison E. Heron, MBA, CAE, CEO

# President's Perspective

**By: Sarah Patterson, MSc, CCLS**

Dear Colleagues and Members,

As summer is now winding down, I hope this season has offered you a chance to recharge, spend quality time with loved ones, and perhaps even explore new opportunities for personal and professional growth. It is a time when many of us reflect on the first half of the year and begin planning for what lies ahead. I want to take this moment to update you on our association's progress, share exciting developments, and express my heartfelt gratitude for your ongoing commitment to our shared mission.

As I begin my term as Board President, I am both humbled and deeply grateful for this opportunity. It is an honor to serve in this capacity, and I am committed to working hand in hand with our board, members, and partners to advance our profession. Together, we will continue to champion excellence in the field of child life, advocate for the needs of children, families, and our members, and nurture a culture of collaboration and innovation.

This past May, just before our conference in San Antonio, we engaged in a crucial strategic planning session. While this process usually takes place every three years in the fall, we chose to move it to May to better align with our budget planning cycle. Our discussions were enriched by the diverse voices of board members, ACLP staff, and members from various regions across the U.S. and Canada, each bringing unique perspectives and experiences.

In the months ahead, the ACLP Board of Directors will review and finalize our strategic plan during the November board meeting. Once approved, the ACLP staff will begin implementing the plan, and we look forward to sharing the final version with all of you in early 2025. This plan will guide our decisions and resource allocations, setting a clear path for our future endeavors.

A central focus will be continuing the incredible work of the Emotional Safety Initiative. Recognizing the paramount importance of emotional safety in healthcare, we are dedicated to continuing to develop increased collaboration with other healthcare providers, hospitals, and other vested interests and to champion knowledge translation and dissemination of the emotional safety initiative. The emotional safety initiative is a significant achievement, and we must continue our efforts to ensure that our members are fully equipped to prioritize, teach, and uphold emotional safety in healthcare practice. A recent partnership with the Pediatric Nursing Certification Board has led to the development of the Emotionally Safe Care Module. This module is a free CE for pediatric

nurses as well as ACLP members.

On a more personal note, this summer has been a time of deep reflection for me. Recently, I experienced an unexpected and profound loss that has had a significant impact on my life. During this challenging time, I have found great comfort in our community. These past weeks as I have assumed the President role, I have been able to connect with the child life community in a deeply meaningful way. I have reconnected with old friends, formed new connections, and met wonderful new individuals. The kindness, compassion, and support I have received from so many of you have been overwhelming and deeply appreciated. This experience has reinforced my belief in the power of our community to uplift and inspire one another, even in the face of adversity.

As we move through the summer and begin planning for the latter half of the year, I am filled with optimism and excitement about what lies ahead. Our foundation is strong, our direction is clear, and our future is bright. The work we do is incredibly important, and I am honored to serve as your President during this pivotal time.

Thank you for your unwavering trust, support, and dedication to our mission. I look forward to continuing this journey with you and to celebrating the incredible milestones we will achieve together in the coming year. Wishing you a wonderful and rejuvenating summer!

# From the Executive Editor

**By: Morgan Morgan, MS, CCLS**

I want to begin my first column as Executive Editor as a way for you, our readers, to get to know me and share some insight into why I am so passionate about the ACLP Bulletin. I have worked as a Certified Child Life Specialist (CCLS) for almost ten years, and in that time, I have worked at several children's hospitals in almost every type of coverage area you can imagine. I have volunteered on a variety of committees for both regional child life groups and the ACLP. Throughout the many changes to my professional life, one consistent thing is my commitment to the Bulletin. I have been a part of the Bulletin Committee for the past eight years. In my time on the committee, I have seen so many changes to this publication and the field of child life. Some examples include separating from the Journal of Child Life to produce two independent publications, changing to a digital publication platform to make the Bulletin more accessible and reader-friendly, and becoming open access to share these stories and resources with all our colleagues (not just ACLP members). I think these changes have been for the better and have shaped this publication into a unique place for child life professionals to share stories and ideas.

As I step into the role of Executive Editor, I hope that the Bulletin continues to evolve and be a space where people can share new ideas, practices, and beliefs. My goal is to have the Bulletin be a place where readers can turn to see themselves reflected in our (digital) pages. I have long said that the Bulletin is a place for the "tactical and practical with a side of personal," where students and professionals alike can share their perspectives on trends in the field, describe new programming they are developing, and dream of ways that the field of child life can continue to expand beyond the walls of the hospital.

Within these pages, we have a collection of authors doing just that. Katie Hart and Barbara Ramirez Quach share stories from working on hospital units, such as a D&E clinic or adult psychiatric ward, where child life services are far from the norm. Student author Rebecca Summers proposes how child life might integrate into the American justice system to support children of incarcerated parents. Maryam AlBahar and Alice Chiu share their perspectives as child life specialists, trained in the United States and working in healthcare settings in Kuwait and Taiwan. Sydney Stigge writes an honest reflection on her journey to working with patients with Developmental Disabilities as part of an Adaptive Care Team, a role that she had never pictured for herself or her skill set but that she has grown to love. Several CCLS

contributed to an interview about the role of child life in working with the growing behavioral health populations that many hospitals are seeing (including some excellent ideas for interventions for this population). Finally, we have a mentor/mentee team that shares their experience seeking mentorship through the ACLP's Mentorship Program and how they were both able to learn from each other.

As I prepare to hit "publish" on my first issue as Executive Editor, I am amazed by the creativity and resilience of my colleagues. Within these pages are the stories of people continuing to push themselves and expand the idea of what child life specialists can do. I hope that the stories here inspire you as well. I promise to keep pushing the limits of what this publication can be if you promise to keep sharing your stories.

# WELCOME TO THE BOARD ROOM

**By: Alisha Saavedra, MA, CCLS**
**ACLP Board of Directors, Immediate-Past President**

Service on the Association of Child Life Professionals (ACLP) Board of Directors can be one of the most rewarding career experiences. It provides an opportunity to see first-hand how the association operates at the highest level and to collaborate with colleagues in accomplishing various fiduciary duties.

The spring 2024 board meeting was held in May, just prior to the annual conference. Each year, incoming board members are invited to observe the spring board meeting to gain insight into their role, understand the meeting structure, and become acquainted with their mentor prior to assuming their official duties. A board manual and orientation are also provided to ensure new members have ample information to begin engaging in strategic discussions and future decision making.

It is also a pivotal time for ACLP committees, task forces and work groups as they submit board reports and prepare to transition to new leadership and members. Prior to the May board meeting, board reports that included a summary of each group's progress and applicable action items were submitted to the board to consider. Motions and requests for direction or clarity in addition to critical discussion topics are what informs the board meeting agenda. An overview of the board discussions and motions from the May 2024 board meeting are provided below.

## STRATEGIC DISCUSSIONS

### LICENSURE

A key point of interest that emerged in the ACLP Member Solution Sessions and accompanying survey data from U.S.-based child life professionals is the pursuit of licensure for the child life profession in the United States. Although strategic discussions on licensure have taken place at the board level in previous years, no formal decisions or actions have been initiated. Licensure is a multi-year endeavor that occurs on a state-by-state basis and requires action from child life professionals within their respective states. While the ACLP is unable to lead this charge under their purview, the board discussed ways to engage with interested groups and provide non-financial support to those

seeking information associated with licensure.

A motion was brought to the floor to approve ACLP executive leadership to engage in fact-finding to understand how other associations manage and/or engage with licensure.

### ENGAGEMENT WITH HISTORICALLY BLACK COLLEGES AND UNIVERSITIES (HBCU's), HISPANIC SERVING INSTITUTIONS (HSI's), AND TRIBAL COLLEGES AND UNIVERSITIES

The board engaged in discussion that focused on the desired outcomes for engaging with HBCUs, Hispanic-Serving Institutions, and Tribal Colleges and Universities.

- For action: The Diversity, Equity, and Inclusion (DEI) Committee will be tasked with creating talking points introducing child life to institutions. This information will also be relevant to other healthcare-related majors by increasing their awareness of the child life profession. Information will be intentionally created from a racially conscious perspective, with careful consideration of the intended audience.

### HEADQUARTERS REPORT

The board eagerly anticipates the Headquarters Report, a standing agenda item, during each meeting. ACLP CEO, Alison Heron, with contributions from the staff, provided a comprehensive look into operations and execution of board decisions and initiatives that are important to our organization. Of note, staff completed a re-evaluation of the platforms in use by the ACLP, exploring cost-effectiveness. Given the high cost associated with the platform housing the Internship Readiness Common Application, the application will be offered in a fillable PDF form, effective August 1st.

## MOTIONS

When a board report includes a request or the group needs clarity about fulfilling tasks within their charge and charter, the assigned board liaison will provide a brief verbal summary of the action items for the board to consider and reference any supplemental documents. The floor is subsequently opened for discussion before a motion is made and a vote is taken.

### GOVERNANCE

The Governance committee submitted their charter and four (4) policies for the board to review and vote on. The following motions were passed:

- A motion was brought to the floor to approve the revised Governance Charter.
- A motion was brought to the floor to approve the revised Conflict of Interest Policy.
- A motion was brought to the floor to approve the revised Intellectual Property Policy.
- A motion was brought to the floor to approve the revised Non-Discrimination Policy.
- A motion was brought to the floor to approve the revised Nominating and Election Process Policy. It was approved with edits.
- The board requested that specific language from the ACLP Bylaws, "The appointment of committee members will be identified through an application process and review conducted by the Governance Committee", be included in the policy.
- The Governance Committee was also tasked with adding further clarity and expanded details for the application, review, and selection process for incoming Nominating Committee members and chair-elect selection.

## MENTORSHIP

- A motion was brought to the floor to pause the Mentorship Program until the November board Meeting so the committee can re-imagine a program that will maximize the benefits of using Qooper, a mentoring software which provides an online platform. The motion carried.

## NOMINATING COMMITTEE

- A motion was brought to the floor to approve the updated Charter for the Nominating Committee with edits.
    - ◊ The board requested that the charter include language that states an Immediate-Past President or immediate past board member will move into the nominating committee as a member annually. This will help add supportive context to committee discussions.
- A motion was brought to the floor to approve funding and support for continued anti-bias training for the nominating committee.
- Committee members will attend a two-part anti-bias training course prior to reviewing applications and conducting board candidate interviews. There is an opportunity to expand this training opportunity to other ACLP committees that have selection processes within their charge and charter.

## PUBLICATIONS

- A motion was brought to the floor and passed to approve with edits, the revised Guidelines and Procedures for Publications of the Association of Child Life Professionals, with the trial year beginning in June 2024.

The next board meeting is scheduled for the end of August. This meeting will be virtual, followed by an in-person meeting in early November. More board updates will be shared in the ACLP Bulletin Fall issue.

This year, the board welcomed the 2024-2025 incoming members: President-Elect, Elana Brewer, MS, CCLS, Secretary, Rebecca Meyers,MS, CCLS Directors Katherine Bennett, MS, CCLS, and Nicole Gandolfo, MA, CCLS, Canadian Liaison, Emily Synott, RECE, CCLS, and the Child Life Certification Commission (CLCC) liaison, Toni Crowell-Petrungaro, MS, CCLS. Additionally, the board expressed sincere appreciation for outgoing 2023-2024 board members Immediate Past-President, Lindsay Heering, MS, CCLS, Secretary, Cristie Suzukawa Clancy, MS, CCLS, Directors Vicky Isaacson, MA, CCLS and Cassandra James, MS, CCLS, CPXP, Canadian Liaison, Sandy Baggott, CCLS and CLCC liaison, Tracey Craddock, MS, CCLS. Their volunteer commitment, hard work, and dedication were instrumental in guiding ACLP through a momentous time.

# "THEY'RE FINE" – ARE THEY?:

## Advocating for Adolescents in Family Planning and with Suicidal Ideation

By: Katie Hart, MA, CCLS, CPMT
and Barbara Ramirez Quach, BA, CCLS

Throughout the years, the role of child life specialists has evolved beyond the playroom and into various clinics, community-based programs, and other nontraditional settings where patients need further support for experienced traumas. Advocating for child life services has brought forth much reflection on assessing our role in these moments and providing the best care possible for the patients and families we work alongside. With all this in mind, we would like to share our experiences advocating for child life services even when others have questioned our inclusion and involvement.

### Case 1: Katie's Work with Adolescent Patients in the Dilation and Evacuation Clinic

After working for multiple years at various stand-alone children's hospitals, I ventured to work within a larger adult hospital. With that transition came a lot of learning, lessons, and reflection. I began working with adult nursing staff who are sometimes required to work with pediatric patients with little to no training in pediatrics. One early morning shift, I was notified of a pediatric patient at the hospital for a dilation and evacuation procedure. According to the nurse at the bedside, this fourteen-year-old patient was having a hard time coping and was alone, fearful, and withdrawn. This nurse expressed concerns and asked for help.

As I approached the adult unit where these procedures are performed, I received comments from various staff before entering the patient's room that included asking why a child life specialist was supporting a pediatric patient for an "adult choice." I remember feeling perplexed and shocked. I smiled and responded that my job was to help all pediatric patients cope with the various stressors of the hospital, especially patients who may have limited psychosocial support. However, as I turned the corner, I reflected- Am I qualified to help this patient? Is this within my scope of

practice? Am I doing something not in agreement with our child life standards of practice? I don't remember reading any articles recently about child life support for this procedure.

I then found a fourteen-year-old girl sitting alone on the exam bed, head down, fidgeting with her hands with a wide-eyed affect streaming across her face. After I introduced myself and my role within the hospital, this patient began to confide in me her various concerns. She talked about how she was feeling nervous as she had never been in the hospital or had an IV before. She had questions about how the anesthesia works and expressed concerns about waking up in the middle of the procedure. Her thoughts and concerns were on target with any other fourteen-year-old that I prepare for surgery every other day at work. At that moment, I realized at baseline that this was a scared teenager -without a fully developed prefrontal cortex and not an adult (Arain et al., 2013). She needed preparation and psychosocial support regardless of her reasons for being here. It is not my place to judge or deny my skillset to this patient due to any circumstance that brought her into my patient census that day. I continued to prepare and support her through an IV placement, discussed her concerns with her care team regarding her procedure, and advocated for her needs throughout her visit.

Throughout my time at this institution, I have continued to advocate for the opportunity for patients having dilation and evacuation procedures to have further child life support regardless of what others may think is "right" or within my "role." I believe the role of any child life specialist is to help others cope with the various stressors of hospitalization. As our field continues to expand and evolve into various settings, roles, and clinics, I think it is easy to revert to what we know to be "safe" and "known." However, if we continued with that thought process throughout time, child life specialists may not even exist today. I can't tell you how often I get told, "We need this for adults" when working with families… if we can laugh and agree with those statements, why deny our skillset to those in need regardless of the situation that brought them into our clinical world? I will continue to advocate for patients who exhibit the highest need for developing a coping plan with the various stressors associated with hospitalization and hope more discussions may be had within our community regarding these "nontraditional" cases.

## Case 2: Barbara's Work with Adolescents Admitted for Suicidal Ideation

There are a multitude of services child life specialists provide in several different departments. This complicates the job, particularly when some child life services are more recognized than others. Child life specialists navigating this disparity may feel self-doubt as "untraditional" or less utilized services get questioned or challenged. One of those instances for me was during an interaction with a thirteen-year-old girl admitted for suicidal ideation in an adult unit.

As I was passing the patient's room, I noticed a sign on the door stating, "No visitors." I checked in with the nurse to gain more information about this patient, as it is part of my job to understand better what intervention and resources I might be able to offer. The nurse looked at me and said, "You don't need to go in. She can't have anything fun." I was puzzled by her response but continued to listen. She elaborated, "She's here for suicidal ideation. She can't have anything that she might use to harm herself. Plus, we don't want to reward her behavior and make her stay in a fun place, or else she will continue to come back." I shared that I did not intend to bring anything into the room without first collaborating with her. My primary goal was to introduce myself and assess the patient's needs. At the end of our conversation, the nurse informed me that I could go into the patient's room but that the patient would not need anything from me.

As I walked away, several questions quickly came to mind: Should I enter the room? The nurse said I didn't need to go in but knew I could offer something. Providing child life services doesn't mean that it is always something physical. Is interacting with a hospitalized child who is here for suicidal ideation within my scope of knowledge and expertise? Is my presence as a child life specialist appropriate in this situation? I spent about an hour with the thirteen-year-old patient, building a therapeutic relationship, introducing long-term coping strategies, and ensuring the patient felt heard and seen. I realized that patients admitted with psychiatric needs could be easily forgotten; however, at the end of the day, they are still children. As child life specialists, our roles may differ daily depending on the population, setting, timing, etc. This varying role that child life specialists convey may create space for confusion amongst staff. Some might only see part of what we do, causing them to have a misrepresentation of what we can offer. In my case, the adult nurse appeared to associate child life specialists as entertainers and the "fun" person. However, as the ACLP (2023) states, "Child life specialists are trained professionals with expertise in helping children and their families overcome life's most challenging events." On this day, I was utilizing my expertise to help advocate for further psychosocial support for this patient on what many would consider to be the most challenging event of this patient's life thus far.

## Concluding Reflections

Without a doubt, every child life specialist will have a moment when others may question their role or involvement with a certain patient population. When that time comes, having a moment of doubt within yourself and potentially your role in the situation is normal. However, remember to take those moments with stride and use them as learning opportunities to reflect. We became interested in the field of child life because we want to help people. We want to empower others to obtain coping skills and utilize our techniques within and outside of their time with us.

If the field of child life continues to expand into various roles, settings, and patient populations… how do we continue to support one another? How do we continue to advocate for one another? How do we provide opportunities for growth and sharing perspectives?

These experiences showcase the constant need for education with the healthcare team to further understand our role within various settings. Furthermore, we need to have the confidence to advocate for ourselves and demonstrate that we are educated and qualified professionals who will help patients cope with some of life's most challenging moments.

**The following are reflection questions that helped us in these moments described above:**

1. Take a moment to pause and breathe: How is this situation making me feel? Why do I feel this way?
2. Remember your purpose: What is the goal? Why are you here and involved in this case? Why were you called or notified about this case?
3. Consider other perspectives: Who are you collaborating with? Are there shared/common goals? What is their expertise? How can you work with this person to address a gap in care? What is their communication style?
4. Advocate for yourself: What qualifications do you have to provide a certain service? What is your educational background? What other similar experiences can you relate this to? What evidence or ACLP guidelines can be utilized to demonstrate certain expertise?
5. Advocate for your patient: What does your patient need from you in this moment? How do you meet this patient's unique needs while working alongside the rest of the multidisciplinary team?
6. Take time to process: Is there a mentor or someone on your team you can debrief with about this experience? Is there an opportunity for clinical supervision where you can gain other perspectives on the situation? How might you use this experience to improve the care you provide to your patients and/or communicate your role with others?

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# BEHAVIORAL HEALTH ON THE RISE:

## Transferable Skillsets and Human Connection

By: Regan Muth, CCLS

In the past five years, patients admitted for suicide and self-injury have risen 50% in the emergency department (ED) and 30% in inpatient units (Children's Hospital Association, 2023). This notable increase in pediatric hospitalizations for mental and behavioral health reasons leads us as Certified Child Life Specialists (CCLS) to consider how to better support and show up for these patients. CCLS are called to serve and advocate for all pediatric patients to better their mental, physical, and emotional well-being, including patients admitted for mental health reasons. In an environment some patients have shared to be "more detrimental" to their mental health, it is important to recognize how impactful child life services are to these patients who have limited psychosocial support throughout their ED admission.

As a CCLS in the ED for the past three years, I have experienced how the increased prevalence of these patients has started to shift caregiver's perceptions of these patients, causing fatigue and burnout. Providing creative and therapeutic interventions becomes more challenging as these patients experience lengthened stays waiting for placement, admitted patients are becoming younger, and some have co-morbid diagnoses or developmental delays. Furthermore, once a patient is then admitted to an inpatient psychiatric unit, CCLS need to determine how to tailor interventions individually and to support groups. As some of the the few providers

### Individuals interviewed in this article

**Sara Webb**

Children's Minnesota

Inpatient Psychiatric Unit and Satellite Site Partial Hospitalization Program

**Bridgette Danielson**

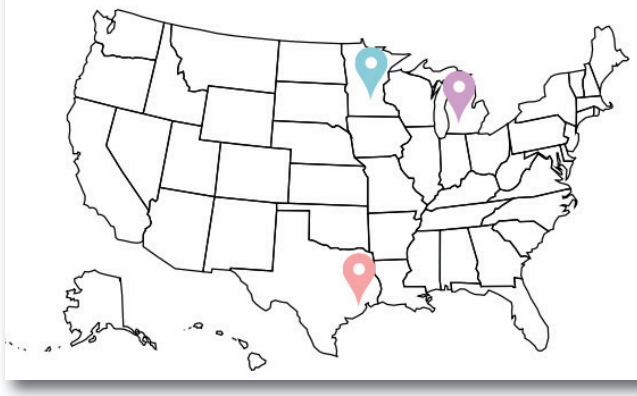
Bronson Children's

•Pediatric Emergency Department
•Previously Cincinnati Children's Inpatient Psychiatric Unit (Until 2023)

**Melissa Hernandez**

Children's Memorial Hermann Hospital

General Pediatrics/Behavioral Health Unit



stepping in to focus on the psychosocial being in a vulnerable space, we need to consider how we promote resiliency, healing, and coping in an appropriate and safe way.

After interviewing three CCLS from different backgrounds (see table), we will gain insight into different interventions and how we can better support behavioral health (BH) patients.

## Interview Questions and Responses

*Responses have been edited to condense and clarify without altering the main message

**What are some considerations when supporting mental health patients? (Assessments, Safety, Comorbid diagnoses, etc.)**

### Sara Webb

When supporting patients individually, I consider their interests along with their history of trauma and their anxiety, and I am constantly reassessing to see how they are coping or if they are triggered.

I also find myself collaborating with unit staff. If patients are dysregulated, I will do an activity like target practice, throwing tissue paper at a target with what they don't like about the hospital on it.

### Bridgette Danielson

Some considerations are their trauma backgrounds. This includes assessing their behavior as a reason for something that has happened to them. I am always thinking of the safety aspects of working with those patients, considering what kinds of things have been issues in the past and how to avoid those things while still encouraging ways to let them be a kid and teenagers.

**What are some interventions you usually do with these patients?**

### Sara Webb

For ages 6-13, I created an art activity called "Create Your Safe Place." We talk about mental imagery as a coping skill, what a safe place is, go through the five senses, and include one item for each of the five senses. Once they have brainstormed what they want their safe place to be, we have plates, Play-Doh, Wiki Sticks, packing peanuts, unit-safe art materials, and have them make their safe place come to life. This is a visual reminder of visual imagery as a coping skill and helps ground themselves in a coping place.

On the adolescent side of the unit, I implemented a "What Do You Meme" game with the original meme photo cards from the family-friendly version of the game with customized caption cards that highlight the unique experiences of the unit. Past patients helped me write the caption cards, and it is great for normalizing the environment. Some cards are, "When you forgot your therapist's name, but it's already been four days, so you are too embarrassed to ask," and "When you pretend to need a break from the group just so you can finally let your fart go."

I also run a movement group. One of the most popular events is races where participants slide on pieces of paper. When creating obstacle courses for younger kids, I use crepe paper for obstacles that are unit-safe. It makes the course like lasers or a jungle gym for the patients.

### Bridgette Danielson

With therapeutic child life groups, many interventions have focused on the core goals of child life, allowing patients to have opportunities to express themselves and encourage normalization and socialization.

Many groups have a silly surface-level theme; the kids' group had one on superheroes. We talk about the positive traits of superheroes and traits of villains and how sometimes superheroes can have a bad day and villains can have a good day. It helps them reflect that just because you have a certain day does not mean you are a bad person.

We did provide bereavement support, as sometimes that contributed to their reason for admission. I assess the situation and, if appropriate, offer memory-making. If it is more an abstract loss, like kids who have experienced trauma, I do an activity with them to process

it. I collaborate with social workers, so I am not crossing that therapy line but still provide some form of intervention.

For patients who have been there for a long time, I would provide individualized one-on-one interventions and try to align them with their treatment goals. One example is one patient who was into Dungeons and Dragons. He had a lot out of his control, and we came up with a D&D campaign he had control over. He could exert creativity and problem-solving, and we had reversed roles where he had mastery, control, and autonomy he wasn't necessarily getting from the hospitalization alone.

### Melissa Hernandez

One of the main ways I provide support is by preparing patients for transferring to a psychiatric facility using a binder of various psychiatric facilities in the Houston Area. In these prep books, there are pictures of the facility (patient room, restroom, common spaces), as well as reviewing information about the hospital's programming and visitation hours.

One of the popular therapeutic activities I have done includes creating collages using construction paper, stickers, magazine clippings, finger paints, and markers/pencils (if approved in the safety plan). During this activity, patients have the creative ability to create their collage, and it serves as a great tool for them to express their emotions as superficially or deeply as they would like to explore.

Another activity I have done includes dissolvable paper. I have had patients either write a letter or poem or create a drawing to process their emotions. Patients have chosen to discuss what they wrote/drew, while others have chosen to keep it private. Once they are done, the paper is placed in water and it slowly dissolves.

**What do you think behavioral health patients need from us?**

### Melissa Hernandez

Just like all patients in the hospital, I believe behavioral health patients need child life to see them as a person rather than a diagnosis. There is such a stigma with mental health that unfortunately exists even within the child life community. I have had BH patients tell me that they do not like talking with psychiatry or even with our psychologists because they will ask them medical questions (such as the reason behind their suicide attempt, overdose, etc.) without taking time to build rapport. During my initial session with BH patients, I intentionally do not ask any medical questions. I will strictly focus on building rapport, such as asking them if they are in school, their interests/hobbies, etc.

**Occasionally, I have heard staff invalidate patient's requests/emotions because of "attention-seeking behaviors" or their illness. How do you advocate for MH/BH patients? How do you assess this line of patient behaviors?**

### Sara Webb

When I started here, I didn't like some of the dialogue providers used when talking about patients. I didn't say much in the first few months, but now I will say, "This is sad. That is the way they know how to make their needs met." I help staff understand by identifying them as connection-seeking behaviors instead of attention-seeking behaviors. Wanting to understand the 'why' of the behavior helps to know that these actions must meet some type of need. This is something I'm still working on. I want to advocate more when I hear some negative talk, but I have recognized that the stigma reaches the clinical level.

### Bridgette Danielson

Unfortunately, I feel like this is not uncommon both in psych units and in the ED. As child life specialists, patients will often open up to us because we are good listeners and do well at advocating. Still, also as a CCLS, especially if not psychiatrically trained, it can be easy to be sucked into those things too.

My first step if a patient has something that needs to be advocated for is to reach out to staff. I will say this patient is bringing this issue up, what was your perspective of this story? It is important to hear where the nurses come from as they work with these patients a lot. However, it is important to bridge the gap and understand that staff is burnt out but also reframe it in a way that I, as a staff member, am speaking up for this patient because that's my job.

**What are things you have found that best support behavioral health patients in these environments?**

### Melissa Hernandez

Having approved safe activities for all BH patients (whether it is a safe art box, or I have worked at a hospital that had a green, yellow, red system). These items should be easily accessible to the staff so they can be available to the patient even when the child's life is unavailable.

Primarily, I have found that being a supportive presence is the best way to support BH patients. As child life, we have the privilege to meet the patient where they are and work together in identifying goals.

**What are ways we can better support behavioral health patients?**

### Bridgette Danielson

One of the biggest things we should rely on is our traditional child life skills. We can support behavioral health patients through normalization, self-expression, and socialization with normative development and provide developmentally appropriate activities while collaborating with other safeguards the hospital has, such as psychiatry, social work, and existing behavioral health staff. We need to hone the skillset we already have.

### Melissa Hernandez

Not make assumptions; trust your assessment skills. It can be easy to be hesitant to meet a BH patient based on what nursing staff or other medical team members have noted (such as potentially the patient being aggressive). However, the patient may display certain behaviors due to the medical team not taking the time to speak to the patient as a PERSON.

When working with BH patients, I think it is important to remember that as child life specialists, our skills are transferable. We know how to make assessments, support during procedures, and build rapport. Interacting with a

patient due to a physical illness or mental illness requires the same skillset. Do NOT be intimidated by the BH status.

## Concluding Thoughts and Takeaways

In incorporating individualized interventions and utilizing our child life skillset to support behavioral health patients, we can better provide comprehensive psychosocial care. It is important to advocate for these patients and remind ourselves as we see increasing numbers that significant things are going on in their lives- whether trauma, bereavement, lack of support, or need for understanding. While still assessing for our safety and appropriate interventions, we must acknowledge patients as human first before assuming things because of their diagnosis. Youth experiencing these crises need someone to see them for who they are. As CCLSs, we have the knowledge and ability to support patients in these distressing circumstances and environments to promote better mental, physical, and emotional well-being. Moving forward, consider how your interaction with a behavioral health patient may be the best interaction they have all day in a stressful environment. All it takes is someone to build rapport, invite normalization, and create that humanity to change a detrimental space into a seen and supportive one.

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# LESSONS FROM THE ADAPTIVE CARE TEAM:

## Strategies for Working with Patients with Developmental Disabilities

By: Sydney Stigge, MS, CCLS

As I started my career in child life, I imagined implementing medical play preparation with school-aged patients, using bubble wands and light spinners for distraction, and having play sessions in the playroom. However, what I had not pictured was developing a passion for working with patients with developmental disabilities.

During my child life education, the emphasis was primarily on understanding the behaviors and reactions of neurotypical children. While this knowledge is essential for our profession, it leaves a gap in preparing us to effectively engage with children who do not fall under the category of "typically developing." Throughout my internship, when tasked with providing services to patients who had developmental disabilities or exhibited behavioral concerns, I frequently experienced discomfort and a sense of unpreparedness. Healthcare students do not receive adequate training in working with patients with these types of disabilities, making them feel less competent and prepared when working with this population (Sharby, Martire, Iverson, 2015). Due to the lack of training and experience, I often prioritized other patients with whom I felt more comfortable working.

Upon completing my formal education, I worked as a therapeutic rec specialist on a pediatric inpatient psych unit. During this period, I gained experience in responding to intense behaviors, such as physical and verbal aggression, self-injury, and suicidal ideation. I developed essential skills in de-escalation strategies and crisis intervention. After a while, I took a position as a Certified Child Life Specialist working in a large children's hospital on the Adaptive Care Team. In essence, the Adaptive Care Team (ACT) is a group of child life specialists dedicated to supporting patients with developmental disabilities who encounter challenges in coping and cooperating during hospital encounters.

Since starting this work, I have gained a fresh perspective on working with patients with developmental disabilities and behavior challenges. Our team's priority is identifying each child's stressors/triggers and providing preventive recommendations. This approach addresses the child's specific needs, minimizing escalation risk and facilitating a productive visit through the thoughtful collaboration of staff, caregivers, and patients. I realized my previous hesitation in working with this population was due to my lack of understanding.

## Adaptive Care Team Approach

A large part of my role is to help create an "Adaptive Care Plan" for each patient, which is documented in the patient's chart. Our team provides support in outpatient clinics, but the plan can be accessed by staff in all areas of the hospital. We can easily identify the patients scheduled for outpatient appointments each day and prioritize support based on the patient's coping ability, current behavior concerns, and the invasiveness of the appointment.

These interventions often entail extensive pre-visit planning and involve discussions with the caregiver regarding the demands of the visit, relevant behaviors, transition needs, useful preparation materials, and items in the visit that may aid in coping. This information is then communicated to the interdisciplinary team that will encounter the patient. Specific adaptations for a patient may involve bypassing the waiting room and going directly to a designated exam room, reducing the number of staff present during the visit, limiting touch time and clustering care, and/or removing unnecessary equipment from the exam room. For procedure-based appointments, such as a blood draw, we also coordinate with prescribing providers to determine the appropriateness of using anxiolytic medication.

If I have assessed that the procedure is not safe, I ask myself, "Could the patient return at a later time with additional support or a more effective coping strategy in place?". If the procedure isn't urgent, it may be beneficial to consult the patient's primary care provider regarding behavioral observations and the potential need for medication. At times, caregivers may insist on proceeding despite safety risks. I emphasize the patient's emotional well-being at that time, highlighting the potential long-term impact on trust and future procedures.

## Additional Education and Training

I've had numerous opportunities to learn and develop personally in my current position. Each child life specialist on the Adaptive Care Team must complete Therapeutic Crisis Intervention training, a training dedicated to proactively preventing and de-escalating potential crises. This training gave me the knowledge and confidence to create a therapeutic space and aid in crises. TCI also provides hands-on teaching for physical interventions that reduce the risk of harm to

patients and staff. Another similar program that may be beneficial is Crisis Prevention Institute Training.

My most impactful learning experiences have undoubtedly stemmed from hands-on practice and guidance from mentors. I am a "learn by doing" individual, finding that I gain comfort and confidence through active engagement. Engaging in challenging patient scenarios has been instrumental in helping me identify my personal biases and areas where I lack confidence. Being part of a team of multidisciplinary professionals has provided me with the opportunity to collaborate, experiment with interventions, and receive valuable feedback. In hospitals without dedicated adaptive care staff, it may be beneficial to shadow and collaborate with staff who often work with patients with developmental disabilities. Some examples include occupational therapy, speech therapy, behavioral health facilitators, and psychiatrists. These individuals may be able to provide insight on strategies including visual supports, language and prompting, the use of medications, and ensuring safe positioning during care.

In my previous position, I often felt helpless in escalating situations and followed the lead of others around me in reacting. With experience and a team that helps me grow, I recognize factors that may play into a patient's behavior. In situations where escalation occurs, I have a toolbox of strategies to implement before physical interventions. I work diligently to inform other staff members on what to expect and how best to respond to the behavior. I love getting to highlight each patient's strengths and celebrate the things they can accomplish.

**Supportive Strategies**

1. Assess the environment and its potential impact on the patient. Environmental modifications may be beneficial, such as dimming the lights and limiting noise levels.
2. Use visual aids such as visual schedules and timers to provide ongoing reference points to track progress and establish predictability.
3. Utilize a slow, calm approach with few words. Repeat requests and allow extra time for the patient to process what is being said.
4. Avoid unnecessarily touching the patient, such as rubbing their hands, touching their face, or patting their back.
5. Silence can be effective during escalation. Use brief statements like "I understand you're upset" or "this is hard." Encourage non-essential staff to step out, allowing the child to calm down.

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# GLOBAL CONNECTIONS:

## Kuwait and Taiwan's Approach to Child Life

By: Tzu Yun (Alice) Chiu, CCLS, MS
and Maryam AlBahar, CCLS, HPS, MS

Child life practice is a beautiful testament to the universal language of compassion, transcending borders, cultures, and linguistic barriers. It also presents practitioners with diverse challenges worldwide. In this article, Certified Child Life Specialists (CCLSs), Alice Chiu and Maryam AlBahar, both graduates of Boston University Wheelock College's Child Life and Family-Centered Care program, delve into our experiences as CCLSs in the non-English speaking countries of Taiwan and Kuwait. We explore how specialists navigate language and certification hurdles and offer insights into the distinct educational and certification pathways in each region's distinct educational and certification pathways. Despite facing obstacles in work and funding, CCLSs in both areas demonstrate unwavering commitment to their cause. Through our perspectives, this article illuminates the resilience and dedication of international CCLSs, highlighting opportunities for advancement and innovation within our respective domains.

### Alice Chiu, CCLS, Taiwan

#### Language Barriers

As a CCLS in Taiwan, I encounter unique challenges when bridging language barriers, particularly when communicating with non-English speaking children and families. Terms like "poke" are commonly used in English to describe medical procedures, but their translation into Mandarin may not convey the intended meaning and could even evoke fear in children. Instead of saying "poke," which may be misconstrued as "making a hole" in Mandarin-speaking contexts and can sound intimidating, I prefer to use softer language such as "the straw will touch you" while preparing children for procedures. Despite these obstacles,

Alice (right) and Maryam (left) at their Child Life Pinning Ceremony, Boston University


Alice with her very first patient as a CCLS in National Cheng Kung University Hospital

I remain committed to embracing the ethos of child life by transcending linguistic barriers and employing descriptive language to help children comprehend medical equipment and procedures effectively.

### Certification Barriers

Divergent paths in education and certification criteria worldwide offer valuable insights into the profession's landscape in each region. In Taiwan, while there are Certified Child Life Specialists, only a fraction currently hold positions due to stringent licensing requirements. All healthcare members providing services directly to patients and families must be licensed, making it challenging to introduce the role of a child life specialist to healthcare teams and families. Despite completing training and certification to qualify as CCLS in the USA, Taiwanese CCLS are often employed as "research assistants" to provide child life services within the Taiwanese healthcare system. Continuous employment is not guaranteed, and the payment may not offset the high investment required for overseas child life training, which underscores challenges in expanding the profession's impact and funding high training costs.

### Opportunities for the Future

Despite these challenges, child life specialists in Taiwan demonstrate remarkable resilience and dedication. Our efforts are bolstered by funding from the Raising Children Medical Foundation, dedicated to creating a child-friendly healthcare environment. However, we are restricted to part-time contracts due to resource constraints, offering only 100 hours per month. Consequently, we lack benefits typical of full-time positions, such as paid time off and opportunities for professional development. These limitations strain our ability to attract aspiring child life specialists and hinder our capacity to provide comprehensive support, leaving hospitalized children without proper procedural preparation and therapeutic play opportunities.

Amidst these challenges, I remain hopeful about the future of child life development in Taiwan. Since establishing the first child life specialist in 2012, Taiwan has gradually embraced this unique role in healthcare. My experience at National Cheng Kung University Hospital showcases a growing acceptance of child life specialists as I pioneer new approaches and earn the trust of my colleagues. Introducing innovative ideas, such as utilizing Buzzy during pokes, underscores the potential for impactful change in pediatric care.

## Maryam AlBahar, CCLS, Kuwait

### Current Child Life Landscape in Kuwait

The landscape of child life in Kuwait faces many formidable challenges that significantly impact practitioners' experiences and the sustainability of the field. Salaries in Kuwait have long trailed behind those in the USA, with many practitioners earning only a fraction of the noted average CCLS salary. Despite incremental

progress in areas like increased recognition in hospital and educational settings and recent salary improvements, job opportunities remain scarce. The prevailing perception of child life as merely "playing with children" persists, even as education and certification among CCLS professionals rise. Exacerbated by low retention rates, practitioners frequently exit the profession within a few months to a few years, attributing their departure to unforeseen job demands, disparities in compensation, and limited opportunities for career advancement or clarity in progression pathways. These challenges are magnified by funding limitations, possibly from a misunderstanding of the profession's nature, insufficient government support, and financial management challenges.

### Certification Barriers

Alongside these professional and systemic challenges, language and cultural barriers further complicate the landscape for child life practitioners in Kuwait. The transcendent power of therapeutic play and family support helps overcome existing barriers, but these barriers can sometimes be insurmountable. Drawing from my experience at a child life organization in Kuwait, with Arab and non-Arab expatriate child life staff, language barriers posed significant challenges to my colleagues' education, examination, and skill development journeys. The language barrier in their education resulted in unsuccessful attempts to pass the certification exam for all but one practitioner, who passed on a second attempt. This scenario prompts reflections on the possible injustices international uncertified child life specialists may face in accessing equal opportunities for higher education, employment, and career advancement despite their years of service.

The complexities of child life practice in the Middle East add another layer to the challenges faced by practitioners with different approaches to accreditation utilized in each country. In Qatar, a structured approach mandates government-issued medical licensing for child life practitioners, mirroring the standards set in Saudi Arabia. Meanwhile, in Kuwait, the absence of a dedicated regulatory body or health ministry law specifically governing child life results in the responsibility for defining staff criteria falling upon non-child life board members and managers of a singular child life organization. This arrangement has led to ambiguity and challenges in establishing local standardized qualifications, with both certified and non-certified, experienced and new practitioners holding similar and equal positions as CCLS. Although the region has a unique landscape of child life practice, it presents opportunities to develop further the profession across various sectors, including private and public domains, and in diverse settings such as schools and other healthcare facilities.

### Opportunities for the Future

Despite these hurdles, I see a fertile ground for innovation and leadership in child life in Kuwait and the broader Middle East. The introduction of specialized programs, like the Master of Clinical Psychology with a child life track in Saudi Arabia, underscores the region's dedication to professional advancement and talent cultivation. A child life organization in Kuwait's recent


Maryam with a child at a local children's hospice, working on emotional expression and behavioral improvement goals.

investment in education and training programs for young staff interested in pursuing certification in child life reflects a commitment to enhancing the profession's standards and expertise. Their recent strategic efforts include improving benefits and salaries to bolster staff retention and ensure the sustainability of child life services. As awareness of the CCLS role increases, private schools and healthcare settings have shown a growing interest in hiring child life staff, eager to create nurturing environments for practitioners and their children. My journey, as one of only two Kuwaitis with a master's in child life, signals a positive trend toward local expertise, opening the door for others and exemplifying a positive trajectory towards local expertise and recognition.

Together, our narratives underscore the resilience and determination of child life practitioners in overcoming challenges and driving positive change in our respective regions. We hope our stories offer glimpses of a future where child life services flourish, enriching the lives of children and families across the globe. Despite these obstacles, CCLS's commitment to supporting children and families underscores the importance of continued advocacy and innovation within the field and shapes the future of child life practice worldwide.

# THE POTENTIAL FOR CHILD LIFE IN THE AMERICAN JUSTICE SYSTEM

By: Rebecca N. Summers, RBT

Certified Child Life Specialists (CCLSs) have extensive knowledge of human development and base their work on current and relevant research to provide developmentally appropriate socioemotional care and resources to children and families. CCLSs, with proper training and experience, can provide age- and developmentally-appropriate support and education about the justice system, preliminary hearings, sentencing hearings, arrests, etc. The U.S. justice system currently has employment opportunities available that focus on advocating for victims, but no profession focuses on the difficulty of transitions children will face, along with the emotional challenges that are inevitable when a loved one is being prosecuted, taken into custody, or having the rights to their children taken away.

## History of Federal Victim Services

In 1982, the President's Task Force on Victims of Crime was established by President Reagan to address issues that victims face, including feeling marginalized and neglected by the justice system (Lee, 2019). However, until the early 2000s, it was rare to see victim services within a police department (Foster & Ryan, 2023). The Austin Police Department supported the expansion of victim services and experimented with its benefits, finding several, including increased conviction rates and victims seeking and receiving necessary mental health support (Foster & Ryan, 2023).

Some organizations offer assistance to children who have one or both parents incarcerated. Lesley University (n.d.) states that common experiences of children who have incarcerated parents include having adverse living conditions, strained relationships with their parent(s), financial

hardships, and rare opportunities for contact with their incarcerated parent(s). There is research on the effects of having one or both parents incarcerated; however, there has been no research on how the socioemotional support that CCLSs provide could assist in coping with these stressful experiences and their lifelong effects. There are caseworkers for when these scenarios arise, but often caseworkers have an exorbitant number of cases to attend to.

Experiencing parents or loved ones being arrested and/or being processed through the judiciary can be a scary event, especially as a young child. Whether for an infraction or a felony charge, children should be informed of the proceedings, what to expect, and be provided with coping skills based on each child's age- and developmentally-appropriate assessment. According to the Bureau of Justice Statistics, roughly half of United States inmates were parents of minor children in 2007 (Glaze & Maruschak, 2008), with children of incarcerated parents increasing by 80% between 1991 and 2007 (Glaze & Maruschak, 2008). The question remains: how many of these children could have benefited from child life services, and would those benefits have remained beneficial throughout their childhood, adolescence, and adulthood?

## The Potential of the Child Life Role in the Justice System

Often, the family members of those who are incarcerated are known as "hidden victims" (Martin, 2017). Unfortunately, hidden victims receive little support and do not benefit from societal mechanisms "generally available to direct crime victims, despite their prevalence and…similarities to direct crime victims" (Martin, 2017, para. 1). Research shows that children who have a parent or parents who are incarcerated are at a higher risk for exhibiting antisocial behaviors, having psychological problems, having economic hardship, being suspended or expelled from school, and committing criminal activities themselves (Martin, 2017). Martin (2017) stresses the importance of practitioners building "strong partnerships with law enforcement, public schools, and child welfare agencies to understand the unique dynamic of the family…and try to ensure… safety…for the child" (para. 3). Though these practitioners Martin (2017) is referring to the fact that the way they are described is exactly the job a CCLS could confidently perform.

A social worker works to assess a client's situation and attempt to safely reunify families. However, if there is no therapeutic intervention done with the child before this reunification, the child may face socioemotional struggles. The CCLS can assess these struggles before they happen and assist the child in coping with these difficulties before a potential reunification. If the CCLS enters the scenario after a reunification has occurred, their training also assists them in targeting the socioemotional struggles they have faced because of the reunification. The child life specialist could also work with a child if reunification with a parent or family member is not possible. For example, the CCLS may work with the child on how to cope with missing their parent or family member during their incarceration. Additionally, any instance of an arrest, a court hearing, or a jail/prison release could be explained to the affected child in developmentally appropriate terms.

## Ethical Considerations for a CCLS in the Justice System

It is important to note that this proposal calls for CCLSs who have received adequate education and clinical training to work with children and families in stressful situations. Though not based in the typical hospital setting, CCLSs should remain consistent in their abidance with the ACLP's Code of Ethics (2023). Some ethical considerations when working in the non-traditional setting include remaining consistent in the commitment to psychosocial care and demonstrating child life competencies within this non-traditional setting while also continuously seeking knowledge on the specifics of the setting.

## Ideas for future research

If child life specialists are implemented within the justice system, research should also be conducted on the efficacy and value of their role in a child and family's life. Studies have shown that a child life specialist's presence and support is crucial to decreasing a child's pain during medical procedures (Drayton et al., 2019). If this is true, studies should also be conducted on whether anxiety, maladaptive behaviors, and confusion are decreased in those who receive child life services while their parents or loved ones are being processed through the justice system or are incarcerated.

## Conclusion

All in all, if implemented, a CCLS would be an extremely beneficial asset to children and families affected by the justice system. Not only could child life specialists provide age and developmentally-appropriate explanations of current and future proceedings, but they can also provide resources for functional, communicative and coping strategies. Child life specialists consider each child's specific needs and base them on their extensive education and training.

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# THE POWER OF WHY:

## An Exploration of Mentorship

By: Danielle Coleman, MS, CCLS
and Senta Greene, MA, CCLS

A short time ago, we chose to embark on a mentorship journey through the ACLP Mentorship Program. ACLP describes mentees as child life specialists who would like support in general or to reach specific goals, and mentors use their expertise, knowledge, and leadership skills to provide this support. However, mentorship is a relationship-based experience that involves a two-way dynamic. It was a leap of faith for us to start this relationship with someone new. Although we were both Certified Child Life Specialists (CCLS), we were from different parts of the country, representing two different time zones, ethnic backgrounds, ages, specializations, and lived experiences. We both understood the power of lifelong learning, professional connection, support, and sustainability.

Our mentor-mentee relationship led to fascinating conversations, critical inquiries about the profession, and a shared commitment to child life advocacy and education. We employed the following questions and experiences to steer our conversations, fostering a more profound understanding of ourselves and each other. This approach facilitated mutual support on both professional and personal fronts. As you dive into this article, we invite you to reflect upon the questions we explored. We hope they inspire you to seek mentorship actively, take on leadership roles within the child life community, and prioritize self-care.

**Why did we become CCLS? Why do we choose to stay?**

We know one of the first and most compelling questions often asked by a young child is, "Why?" The introduction of this word is a significant milestone in children and adults and punctuates a shift in development and experience. As CCLSs, asking why helps us explore information more deeply before making decisions. Humbly, through a stance of inquiry, we set out to do the same by asking each other why we became a CCLS and why we chose to stay in the profession.

## Mentor: Danielle

As our relationship grew with each conversation, Senta and I often reflected on why we chose to become CCLSs and what motivates us to continue in this role. The catalyst for my journey into the child life profession came when I volunteered as a high school student in the hospital playroom. I was fortunate to meet a compassionate CCLS who took it upon herself to mentor me. I learned about the profound significance of play in the hospital environment and the impactful role of advocacy. I never looked back or waivered from my commitment to becoming a CCLS.

My decision to persist in this profession is driven by my desire to apply my skills within the non-profit sector. After working with patients in an outpatient clinic's traditional child life setting for several years, I sought to expand my horizons by transitioning into the non-profit community. I am dedicated to supporting children and teenagers whose parents face serious illnesses or injuries at Wonders & Worries. In my current capacity, I employ a family-centered care approach, providing education and empowerment to the children and their parents. I aim to enhance communication and resilience within these families' dynamics during adversity.

## Mentee: Senta

As I reflected on my career pathway with Danielle, memories of my time working in a residential group home and running peer support groups at Children's Hospital Los Angeles as a child development specialist for children diagnosed with HIV/AIDS came flooding back. Working in these settings under the supervision of a CCLS was a turning point in my career and life. The children I worked with deeply touched my heart, and my experiences supporting their coping strategies and moments of normalization further emphasized the significance of child life across various settings. It also exposed me to the impact of adverse childhood experiences and the importance of advocating for children. Since then, my commitment to bringing the voice of child life into diverse settings has been unwavering. Currently, I work as the Director of Special Projects for the Child Abuse Prevention Council of Ventura and Co-Executive Director of Full Circle Consulting Systems, Inc., a professional learning and development consultancy firm specializing in trauma-responsive practices, DEI in action, and child-family-community engagement.

The opportunity to explore our why, led us to discuss the work of Simon Sinek, an inspirational speaker, and author, who stated that understanding our "why" is a higher compelling purpose that inspires us to know why we do what we do and "how much more we can achieve if we prompt ourselves to start everything we do by first asking why" (2009, 2017).

**Why did we join the ACLP Mentorship Program?**

From our conversations, we discovered the profession of child life has always been rooted in teaching and, equally important, mentorship. Additionally, throughout our career, we both encountered unintentional and intentional mentors who inspired us to give back and to understand and actualize our why. These mentors were lifelong learners, had a growth mindset, and were creative, innovative, and self-aware, demonstrating essential features of leadership and impact. Most importantly, these mentors inspired us to stay in the profession while translating our skills to other sectors of the mental health community.

Danielle:

I have been fortunate to receive mentorship as a student and work alongside those same mentors as a trained professional. The idea of paying it forward felt fulfilling, especially when the child life profession was facing its challenges due to the recent pandemic. As it turns out, the mentorship relationship became a two-way street of learning and growth because of our diverse backgrounds, ethnicity, age, and shared experiences. I gained a deeper understanding of how the skills of a CCLS can be applied in the community and how the concept of "The Power of Why" can guide my current practice as a CCLS.

Senta:

Mentorship has been an integral part of my professional journey for the past thirty years, both as a mentor and mentee. Looking back, I remember doubting my ability to sustain myself as a CCLS due to the stress and challenges I faced along the way. However, I am proud to say that I persevered and learned that age is no barrier to learning and growth. My commitment to mentorship led me to join the ACLP Mentorship program, where I was matched with Danielle. Throughout our time together, I approached the program with an open heart, mind, and a willingness to learn. I am grateful for the enriching experience we shared and the mutual benefits we gained from our partnership. I am thrilled that I joined the program and look forward to continuing my journey in mentorship.

**Why do you practice self-care?**

During our mentoring sessions, we explored the themes of collective care and self-care. One of the key insights we discovered was the importance of permitting ourselves to engage in self-care without feeling guilty or apologetic. This shared stance of empowerment was deep, enlightening, and comforting. By prioritizing self-care, we can sustain our passion, energy, and resilience, ultimately enhancing the quality of care we offer patients and families.

Danielle:

I regularly evaluate feelings of burnout, secondary trauma, or passion fatigue. I consistently question why my enthusiasm for my job may be waning or why I am experiencing decreased compassion. Through self-assessment, I can identify the underlying causes and initiate steps to reignite my passion. Prioritizing self-care involves seeking guidance, advice, and mentorship. By presenting facts and information that prompt reflection on my passion fatigue, I equip myself with actionable steps to counter those thoughts that may disturb my sleep.

Senta:

I believe self-care should be a top priority in our daily routine to lead a fulfilling and healthy life. Permitting ourselves to engage in self-care is a precious responsibility that we owe to ourselves. Being a CCLS requires a lot of emotional energy and commitment. To ensure that I can cope with my responsibilities, protect my peace, and stay committed to my profession, I engage in various self-care practices, from 5-minute journaling to enjoying a cup of tea to setting boundaries.

The demanding nature of child life can take a toll on one's mental health if not properly managed. Self-care practices, such as self-rejuvenation routines and continuing education, ensure that

a CCLS stays holistically healthy and updated on the latest research and therapeutic interventions. Self-care also nurtures professional growth and confidence in one's abilities. Seeking guidance through mentoring allows for personal growth, skill development, and emotional support, helping CCLSs navigate challenging situations more effectively.

Ultimately, the history of the child life profession is rooted in education, psychosocial care, and mentorship. Mentorship is vital to the growth of the child life profession as it fosters the development of essential skills and knowledge in emerging specialists, ensuring they are well-equipped to support children's emotional and psychological needs. Additionally, strong mentor-mentee relationships cultivate a sense of community and professional identity, which is crucial for the continued advancement and cohesion of the field. Unequivocally, if CCLSs want to continue supporting this profession's longevity and legacy, we must continue to inspire, teach, advocate, seek wellness, and, most importantly, mentor.