ACLP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

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ASSOCIATION OF Child Life Professionals

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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*

EXECUTIVE EDITOR: Shannon Dier, MS, CCLS

ASSOCIATE EDITOR: Morgan Morgan, MS, CCLS

MANAGING EDITOR: Keri O'Keefe, Director of Communications and Publications

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ASSOCIATION OF Child Life Professionals

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Front cover photo provided by Samantha Johnson, CCLS, at Stanford Children's Hospital. Pictured is Margie, trained as a facility dog and donated by Canine Companions.

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CEO Shares

by Alison E. Heron, MBA, CAE

Greetings!

With its endless possibilities and leisurely moments, summer has once again graced us with its presence. We hope you've had the opportunity to create cherished memories, embark on new adventures, and enjoy the beauty of nature's abundance.

As autumn draws near, I am reminded of the success of the ACLP Child Life Conference and Emotional Safety Summit II in Grapevine, TX, in June and the launch of our first diversity, equity, and inclusion course. I want to thank all our conference sponsors - Disney, United Therapeutics Oncology, and Children's Health - and our exhibitors for supporting the ACLP's mission to promote community and enhance learning through face-to-face networking and education. This year's attendance and exhibitor turnout surpassed the previous years, and we remain committed to continually improving and innovating our annual conference.

We are excited to share with you the release of a new course on diversity, equity, and inclusion called "Introduction to Intersectional Relationships in Child Life Practice." Thanks to the kind grant from Disney and the expertise of Amanda Lockett, Michelle McIntyre-Brewer, Troy Ragsdale, and Nate Seroski, this course is now accessible to the child life community. The course is both self-paced and intensive, providing an in-depth exploration of how different identities intersect and impact relationships. ACLP Members can easily earn 4.0 PDUs in the DEI domain for free. Once registered, individuals have a generous one-year timeframe to access and complete the course, with the added benefit of open navigation, enabling learners to progress at their own pace.

With limitless opportunities to revisit and explore the course, we're confident that our learners will find it to be a valuable and worthwhile investment of their time. Our course has received outstanding feedback and numerous requests for more topics, and we're delighted to confirm that we're currently working on future courses based on your valuable feedback.

In June, the ACLP Patient and Family Experience Committee organized the second Emotional Safety Summit, which was made possible with the help of a grant from Disney. The committee worked hard with the staff to create a welcoming atmosphere to invite leaders from allied organizations. The summit had two main objectives: to make emotionally safe medical care the standard practice in pediatrics and prioritize framework strategies to promote safe, reliable care that fosters a culture of emotional safety in healthcare. We are excited to announce that we are actively forging and

strengthening connections to tackle emotional safety concerns within medical environments.

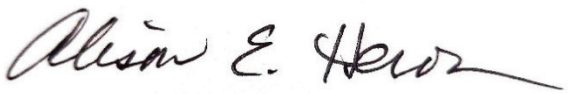
Committees play a crucial role within associations by contributing to the organization's overall effectiveness, efficiency, and success. They provide a structured way for members to contribute their expertise and work collaboratively toward the association's success. Over the past several months, the ACLP Governance Committee developed ACLP's first-ever Professional Code of Conduct, which was approved by the Board and will launch this Fall. Maintaining a professional code of conduct is essential for associations to uphold ethical standards, guide behavior during ACLP activities and events, and ensure the organization's integrity. It is a powerful tool that reinforces ACLP's values and contributes to a highly positive, inclusive, and professional environment for all stakeholders.

Please note that the ACLP Professional Code of Conduct is not a substitute for the Certified Child Life Specialists Code of Ethics. Additional details will be forthcoming in the following weeks. We recommend that you mark your calendar and join ACLP's Association Update on October 18, 2023, from 1-2 pm ET. During this time, the Governance Committee will discuss this matter in greater detail.

We are pleased to share that in early September, we will be launching our Call for Board of Directors Applications. We encourage you to consider applying or nominating an outstanding candidate who can serve on the ACLP Board of Directors. You can make a significant impact on the association's strategic direction, increasing community involvement, and advancing the overall progress and achievement of ACLP by joining our leadership team. Let's collaborate and build a strong and diverse team together.

Kindness is a powerful force that can bring joy and hope during tough times. Let's spread positivity and be a source of solace for each other. Together, we can navigate challenges with determination, unity, and unwavering support.

On behalf of the ACLP staff, I want to express my gratitude and appreciation to each of you.



President's Perspective

by Alisha Saavedra, MA, CCLS

First and foremost, I am deeply honored to be serving as your new ACLP Board of Directors President. It is a pleasure to work alongside such an incredible group of esteemed colleagues on the Board. Their level of diverse expertise, dedication, and volunteer service is impressive!

As a collective, we have continued to make great strides, using the strategic plan as our guide, while maintaining focus on ACLP's mission and core values. Diversity, equity, and inclusion remain at the core of our collaborative dialogue, and open-mindedness paired with innovation has allowed for great contributions to the profession. I invite you to join us on this journey. Whether it is through volunteering on a committee, task force, work group, or micro-volunteer opportunity or attending an affinity group meeting, webinar, or meet-up, there are many way to engage in work that is meaningful with ACLP. Our goal is to continue developing new opportunities, whether it is through committee, task force or work group, participating in our newly updated mentorship program, responding to be a part of a focus group or micro volunteer offerings such as being an abstract reviewer, or attending an affinity group meeting. Each of these actions helps to propel the profession forward and reflects our core values of integrity, equity, inclusivity, collaboration, and excellence.

In our June Board meeting, we reviewed updates and motions put forth by our remarkable ACLP committees, work groups, and task forces. Our Board meeting was followed by the Emotional Safety Summit II and the week culminated in our 2023 Child Life Conference. To provide some highlights, I'll share some insight on a few topics.

The first item is the ACLP Bylaws revision. To reflect the new organizational structure of the Child Life Certification Commission (CLCC) becoming a 501(c)6, a Bylaws revision was necessary. Additionally, the Bylaws changes signify that our organization's governance is dedicated to further promotion of anti-racism, diversity, equity, and inclusion. View the ACLP Bylaws Changes & Rationale Document for a full list of all proposed changes.

There was also robust and purposeful discussion about the program evaluation of ACLP's Clinical Internship Accreditation and recommendations brought forth by outside consulting agency, SeaCrest. The Board also took into consideration the future of academic endorsement by extensively reviewing information and recommendations brought forth by the Academic Excellence Task Force. Both programs were recognized as having significant value across all stakeholders. You may read

more about the decision outcomes and future work related to recognizing clinical and academic excellence in Welcome to the Board Room.

During the Emotional Safety Summit II, ACLP hosted leaders from various allied organizations. The summit, facilitated by Lowell Aplebaum of Vista Cova, was designed with two primary goals in mind: to further promote emotional safety as a standard of practice in pediatrics and healthcare; and to provide framework strategies to support institutions in implementation of care which fosters a culture of emotional safety. The two-day summit provided valuable insight into the opportunities and challenges related to advancing emotional safety. Continued engagement in the future, through the formation of an emotional safety coalition, will provide ongoing support of the summit goals.

The 2023 Child Life Conference offered an array of session topics and new opportunities for attendees, such as a half-day intensive on creating a culture of sexual orientations and inclusion (SOGI), a session about making difficult changes in child life coverage models, and effective precepting in the age of Generation Z. This year, aspiring professionals were able to visit the new Student Resource Center and inquire about the pathway to the profession. Child life specialists and ACLP staff were present and available to offer information about specialties, child life career experiences, applying for internships, and tips for professional communication, such as resume writing.

The closing keynote speaker at this year's conference was provided by Rebekah Taussig, author of Sitting Pretty: The View From My Ordinary Resilient Disabled Body. I had the pleasure of meeting Rebekah and felt a kindred connection with her as we talked about loss and living in the "both and" where grief and joy coexist. Our conversation and her speech deeply resonated with me as I think about the year ahead. As we navigate a post pandemic era and are hopeful in our work to address the staffing crisis and pathway to the profession, we can also acknowledge that it has been challenging these past few years. Rebekah reminded us that we don't have to choose between grief and joy, we get to experience both.

The glimmers of joy we feel when working with children and families and the passion to keep our child life profession going is strong. Earlier this year, it was at the Staffing Crisis and Pathway to the Profession Think Tank where I was reminded of the joy so many of you share for child life and witnessed a shared interest in supporting ACLP and strengthening connections across all stakeholders. It was a glimmer of joy and inspiration to see! My hope for you in the year ahead is that there are glimmer moments that bring joy and peace as we forage ahead with new opportunities and possibilities to create change.

Warm Regards,
Alisha Saavedra

From the Executive Editor

by Shannon Dier, MS, CCLS

Typically, when I sit down to write this column, I look over the planned articles for the issue and consider what theme ties them together. Like looking at puzzle pieces scattered across a table, at first it often feels impossible that these different parts could form a common picture. But with reflection, patience, and a little creativity, gradually it is possible to uncover the underlying ideas the articles share even as they represent different aspects of child life practice. For me, an avid puzzler, this process makes the task of writing the Executive Editor column less like an intimidating responsibility and more like a playful challenge. Who says you can't "child life" yourself?

Yet, as I considered the articles we have in this Summer issue, I was struck not by their similarity but by the breadth of topics covered. Attempting to unite articles about gun violence, facility dogs, and neurodivergent students felt contrived rather than authentic. I wondered if this editorial writing strategy was less effective than I imagined, and I began to rethink my approach. This led to reflecting on how often we find ourselves in this position as child life specialists. Maybe we have been approaching an intervention – a therapeutic activity, a procedure prep, a diagnosis teaching – the same way for years, and then suddenly we find this approach doesn't work for a certain patient or family. Sometimes these challenging moments of "failure" prompt exciting new ideas and approaches as we reexamine the places where we may have leaned into what was familiar and routine rather than experimenting with new techniques, tools, or technology. Other times, we recognize that what we have been doing usually is best; it just wasn't the best fit in the situation, and so we learn to better identify moments when more individualization or innovation is needed.

Ironically, it was this line of thinking that led me to recognize something common among many of this issue's articles: they provide an opportunity to reconsider taken-for-granted ideas and explore new approaches to existing challenges.

For instance, two articles tackle the challenge of supporting a more diverse pool of learners and professionals. Child life specialist Mary Ann Gill describes strategies that would better support autistic and neurodivergent child life students, deftly combining personal experience with evidence-backed recommendations. Several of the ideas she shares may seem to challenge established practices, including how person-first language is not always preferred and that neurodivergent child life students may benefit from using scripts to learn conversational patterns common in medical settings. In a similar

vein, Lindsey Murphy, Genevieve Lowry, and Cara Smith encourage us to refocus the pathway to the profession on the child life competencies rather than health care settings. These authors explain how current guidelines for training and certification prioritize experience and knowledge of health care settings, which has the unintended consequence of restricting learning opportunities in community settings and limiting access to the field.

Other articles might prompt you to rethink what you know about a topic. Laurel Johnson and Jenna Read go beyond talking about the importance of resilience to detail specific mindfulness strategies that you can easily learn and implement in your everyday practice. The history of facility dog programs from Lynn McGurgan may be a helpful reminder of how recently our canine friends became a part of child life programming and how much we still have to learn about their impact. For me personally, talking with Erika Croswhite of the Benchmarking Committee about her article on the Child Life Professional Data Center was especially informative. It is easy to forget in our day-to-day tasks of patient care how impactful tracking what we are doing is and how far-reaching those daily statistics can be when compounded across programs and across many months and years.

Finally, I would like to highlight a reformatted column that will hopefully continue to reshape what you think of when you consider writing for *ACLP Bulletin*. In Scenes From the Life, a handful of child life professionals share their experiences and perspectives on timely topics. This issue, Jennifer Fieten, along with Sidney Moreno and Brielle Swerdlin, contribute their experiences with children and families affected by gun violence and share avenues for support and advocacy. Going forward, we hope to continue to publish pieces like this that highlight the work of our professional colleagues. This effort will start with our Bulletin committee members who will lead several new columns over the coming year to demonstrate the type of writing that is possible.

The Bulletin committee is also excited to announce updates to our submission process. First, we are officially moving to a rolling submission process. No need to consult specific issue deadlines; articles will be reviewed and receive feedback as received. This better fits what has been happening in practice since publication timing depends on a number of factors. Second, we have a new submission form on the ACLP website. Whether you have an idea for an article or a draft ready to submit, now you will complete a simple Jotform that provides the editorial team with the information they need to support you wherever you are in the writing process. Related to this, we are also in the process of updating our writing guidelines and support documents on the website. You will find all these updates on the ACLP Bulletin webpage.

Innovation is an ongoing process, and one that we should continue to rely on in child life practice. Though it turns out my writing strategy of looking for the common thread worked out after all, the act of questioning, rather than relying on, my typical approach was what mattered most. I hope the articles in this issue prompt new questions, spark new ideas, and help you decide where to reconfirm and where to renew your practice.

WELCOME TO THE BOARD ROOM

by Lindsay Heering, MS, CCLS, ACLP Immediate Past President

Each spring, the ACLP Board of Directors welcomes incoming Board members. A Board manual and orientation is provided, and incoming Board members observe the Spring Board meeting to learn how these meetings function, before being expected to participate and vote. The Board book, inclusive of committee board reports, previous meeting minutes, ACLP Headquarters report, and supplemental documents, is posted for Board members to review two weeks prior to Board meetings. In preparation, Board members are expected to review all documents and engage on Basecamp, our project management platform, with questions and feedback. This helps the Board ensure all voices are heard and increases efficiency of Board meetings. Additionally, new Board members are paired with mentors for their first year of service to aid in their preparation for their fiduciary duty.

At the Spring 2023 Board meeting, the Board welcomed incoming Board members Janelle Mitchell and Alyssa Luksa as Directors and Tracey Craddock as the Child Life Certification Commission (CLCC) Liaison. Sarah Patterson transitioned into the role of President-Elect and Riley Hammond into the role of Treasurer; both previously served as Directors on the 2022-2023 Board. Additionally, the Board expresses sincere gratitude for outgoing 2022-2023 Board members Quinn Franklin (Immediate Past President) Teresa Schoell (Treasurer), and Monica Gibson (CLCC Liaison) for their service, hard work, dedication,

and commitment to advancing the ACLP and child life profession.

The Board functions at a strategic level and maintains oversight for the vision and direction of the association connecting all decisions to our strategic plan and considering the associations' resources, finances, wide array of programs, and critical issues facing the association and child life profession. The Spring Board meeting included several major topics of discussion. These topics were covered on Day 1, allowing the opportunity for processing and further discussion on Day 2.

Internship Accreditation:

The following motions were passed.

- Motion to decommission the internship accreditation program as it stands today.
- Motion to reimagine, revise, and implement a sustainable process to support and recognize high-quality clinical training programs.
- Motion to provide currently accredited programs with the ability to maintain their internship accreditation status through the end of their five-year cycle if they submit their annual maintenance forms and fees and adhere to the internship accreditation standards.

Based on consultant recommendations and overall Board discussion, there was clear support for high standards; however, ACLP cannot operationally sustain the internship accreditation program as it stands today. Consideration was given to: 1) expanding the pathway to the profession and an inclusive approach to all types and sizes of clinical programs and 2) pivoting to training for new internship programs, internship coordinators, and rotation supervisors.

Academic Excellence Task Force (AETF):

This task force proposed the following motion:

- Whereas the Co-Chairs as part of the Association of Child Life Professionals, Academic Excellence Task Force, we make the motion that these final recommendations of changes to the academic endorsement process be considered and approved fully or in part by the Board of Directors.
    - ◊ Primary recommendation: "ACLP should offer an accreditation rather than endorsement process for child life academic programs."

There was robust dialogue related to the task force's recommendation to pursue accreditation for academic programs. The Board understands and recognizes the importance of academic accreditation and sees it as a valuable designation for academia. This motion was not passed as written. The Board voted to create an expansive group (including the AETF chairs) to explore and determine the feasibility of academic accreditation. Considerations will include the strategic, operational, and financial impact for academic programs as well as organizational impact to ACLP. In the meantime, academic endorsement will continue. Subsequently, the AETF charge was completed; therefore, that task force was decommissioned.

Staffing Crisis & Pathway to the Profession Think Tank:

Recommendations from our think tank participants were compiled with associated timelines, organizational and financial impact, and suggested committee/task force alignment. The Board considered the need for prioritization, alignment with the 2022-2024 strategic plan, and a parking lot for consideration within the 2025-2028 strategic plan.

Bylaws:

Revisions are necessary since the CLCC has become its own 501(c)6 organization, and the ACLP aims to reflect its organizational dedication and transformative efforts towards anti-racism, diversity, equity, and inclusion. The motion below was passed. Voting to approve our revised bylaws is currently underway, and voting members are encouraged to vote.

- Whereas the ACLP Bylaws Work Group as part of the Association of Child Life Professionals, we make the motion that the revised bylaws be approved by the Board of Directors.

The next Board meeting is this month (virtual) followed by an in-person meeting in November. More Board updates will be shared in the ACLP Bulletin Winter issue.

CULTIVATING RESILIENCE TO COMBAT BURNOUT IN EMERGING PROFESSIONALS

by Laurel Johnson CCLS, Nemours Children's Hospital, Florida and Jenna Read, MS, CCLS, Supervisor of Child Life and Creative Arts Therapies, Nemours Children's Hospital, Florida

Child life specialists are frequently exposed to high-intensity and stressful situations in their work, which we know can put them at risk of developing emotional burnout and compassion fatigue. However, when compared to nurses who have similar risk levels of burnout, child life specialists have a significantly higher level of compassion satisfaction, making them more resilient to burnout (Lagos et al., 2022). It's hypothesized this is because child life specialists typically have more intrinsic motivation, or "calling," to the profession and find immense satisfaction advocating for children (Lagos et al., 2022). We also know that entrance into the field of child life is becoming increasingly competitive due to limited internship availability, which can lead to one's outlook of the field and self-perception becoming bleak. Many feel that the fight does not stop once they achieve certification; they then must change their stance and turn their fighting tactics into advocacy within the multidisciplinary team and to hospital leadership for a seat at the table. This early experience of competition, paired with a high-stress and potentially negative work environment, is a recipe for early burnout in our emerging professionals. Therefore, the necessity

to cultivate resilience in child life specialists is imperative to promoting longevity in the field.

Resilience Strategies

Cultivating resilience in clinicians involves maintaining interest, developing self-awareness, accepting personal limitations, prioritization and balance, and having supportive relationships (Rakesh et al., 2017). The inability to regulate negative emotions can lead to generally empathic people losing their empathic responses in the work setting. Resilience building strategies, such as

mindfulness, thought-stopping, seeking support, and establishing a personal mindfulness coping plan, can be used to mitigate this.

Both mindfulness and thought-stopping are forms of mental training to enhance awareness and the ability to disengage from maladaptive pathology (Shapiro et al., 2005). Mindfulness, or mindfulness-based stress reduction (MBSR) can be used to pay attention to one's present experiences in a nonjudgmental way. With the practice of mindfulness, we can not only reflect on our own experiences, but also build empathy. In fact, the introduction of MBSR strategies increases the activation of brain regions involved with emotional regulation as well as empathy, encouraging strengthened emotional withstanding against burnout symptomology (Rakesh et al., 2017).

The practice of thought-stopping, an example of an MBSR strategy, is used to undermine negative thoughts and replace them with positive ones (Bakker, 2009). Thought stopping is the opposite of the acceptance quality of mindfulness and is an essential part of building self-awareness. With origins in Cognitive Behavioral Therapy (CBT), thought-stopping can help one shift the internal narrative surrounding emotional stress and dismiss negative internal stimuli. The CBT model addresses stimuli presentation, cognitive recognition, and emotional or behavioral response (Bakker, 2009). Thought-stopping is a technique that is applied to block a response to stimuli at the cognitive level which encourages a positive change in attitude and responses to negative stimuli (Bakker, 2009). Thought-stopping has been shown to be a worthwhile tool in combating depression, anxiety, and insomnia, symptomology that can also be present in a burnout state (Rakesh et al., 2017). However, a healthy balance between the reframing of thought-stopping and complete repression and compartmentalization needs to be practiced.

An acronym used in thought-stopping practice, S.T.O.P. (Stop, Take a breath, Observe, Proceed), can be helpful for clinicians to utilize in the moment (Liao et al., 2020). For example, a child life specialist might choose to use S.T.O.P when a multidisciplinary team member questions a child life intervention as a way of self-regulating. Instead of internalizing staff behavior as a negative reflection of self-worth or the efficacy of the intervention, the child life specialist pauses to breathe, recognizes and reframes negative thoughts, and redirects focus back to the needs of the patient while educating the team member on the intention of the intervention.

Many child life specialists may be familiar with the idea of avoidant coping, wherein an individual ignores or actively avoids a stressor in hopes of making it go away. When in a heightened stress state, it is easy to become lost in our mental noise. In these moments, it is important to utilize approach coping strategies rather than avoidant coping strategies to cultivate resilience and decrease the likelihood of experiencing compassion fatigue and burnout (Lagos et al., 2022). Approach coping strategies can include engaging in breathing exercises to bring our mental awareness back down to a calm baseline where we can then address the negativity to which we are being exposed. Other examples of effective approach coping strategies include crowdsourcsing, reflection with members of the child life team, clinical supervision, and one-on-one sessions with child life leadership (Lagos et al., 2022). Paired with approach coping strategies, one suggested MBSR technique is to engage in Body Scanning, a progressive focus of attention to the body, observing body sensations one experiences, and recognizing and reflecting on thoughts and feelings experienced during the exercise (Moody et al., 2013).

Creating a Mindfulness Coping Plan

Clinicians are encouraged to build a coping plan to utilize in the moment when experiencing workplace stress. Following the model above and including MBSR and approach coping strategies, a suggested mindfulness coping plan for a child life specialist could include:

1. S.T.O.P. thought-stopping
   - ◊ Recognizing negative thoughts
   - ◊ Mindful breath-work
   - ◊ Accepting reality and reframing focus
2. Body Scan
   - ◊ Assess tension in body
   - ◊ Gentle stretching for mindful movement and to decrease tension
3. Debriefing with supervisor or trusted team member
4. Journaling and privately reflecting on experiences

The identification of tools to use, such as thought-stopping, approach coping strategies, and developing a mindfulness coping plan, within the child life sphere is pivotal for establishing healthful coping strategies to combat the challenges of child life practice. When we create a personal mindfulness coping plan, similarly to how we do every day with our patients, we are setting ourselves up for resilience to continue to advocate for the role of child life within the interdisciplinary team and to lift each other up in solidarity.

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REFOCUSING ON COMPETENCIES:

A "Yes AND" Approach to the Child Life Crisis

Lindsey Murphy, PhD, CCLS, Missouri State University
Genevieve Lowry, MS.Ed, CEIM, CCTSF, CCLS, Bank Street College of Education
Cara Smith, MA, CCLS, Sidra Medicine Doha, Qatar

"In recent years, the child life community has experienced an unprecedented amount of fatigue, burnout, and turnover across the U.S. and Canada. For many reasons, this has led to internship placements becoming even more limited, which has had a downstream impact on job postings remaining open with limited applicants for extended periods. These vacancies and continuous onboarding subsequently compound CCLSs burnout" (Association of Child Life Professionals, "ACLP Staffing Crisis & Pathway to the Profession Think Tank", March 8, 2023).

The definition of a Certified Child Life Specialist (CCLS) in the simplest form is an individual that is proficient in the child life competencies. The competencies (see Table 1) provide the foundation for child life services that are individualized, developmentally grounded, trauma-informed, relationship-oriented, play-based, and resilience-focused (Boles, et al. 2020). Child life competencies are applicable to diverse settings and populations (Lowry, et al., 2023), yet an overarching theme in the current pathway to the profession is that it is largely situated within healthcare settings. This creates incongruence. The authors recognize and value the historical roots child life has in healthcare settings and the services provided in these settings. However, it is time to equally recognize that child life services, rooted in the child life competencies, are not setting-specific, and therefore the pathway to child life must also reflect this reality. Once this is accomplished, the pathway becomes less restricted and services become more accessible to all children and families in need.

Table 1: Child Life Competencies

I. Care of Infants, Children, Youth, and Families	A. The ability to assess the developmental and psychosocial needs of infants, children, youth, and families. B. The ability to initiate and maintain meaningful and therapeutic relationships with infants, children, youth, and families. C. The ability to provide opportunities for play for infants, children, youth, and families. D. The ability to provide a safe, therapeutic and healing environment for infants, children, youth, and families. E. The ability to support infants, children, youth, and families in coping with stressful events. F. The ability to provide teaching,specific to the population served, including psychological preparation for potentially stressful experiences, with infants, children, youth, and families.
II. Professional Responsibility	A. The ability to practice within the scope of professional and personal knowledge and skill base. B. The ability to continuously engage in self-reflective professional child life practice. C. The ability to function as a member of the service team.
III. Education and Supervision	A. The ability to represent and communicate child life practice and psychosocial issues of infants, children, youth, and families toothers. B. The ability to supervise child life students and volunteers.
IV. Research Fundamentals	A. The ability to integrate clinical evidence and fundamental child life knowledge into professional decision making.
V. Administration	A. The ability to develop and evaluate child life services. B. The ability to implement child life services within the structure and culture of the work environment.

Summarized from the Official Documents of the Association of Child Life Professionals (ACLP, 2019)

Refining the Current Pathway

Disrupting the current system of education and clinical experiences to include community settings brings many benefits and solves many crises currently in the field, including:

- Facilitates an expansion in pre-internship and internship opportunities providing much needed relief for healthcare settings.
- Supports diversity, equity, and inclusivity by expanding opportunities to be more accessible to all students pursuing child life.
- Increases sustainability by creating professional choice, decreasing burnout and increasing retention as child life specialists are afforded opportunities to learn and grow both the profession and professionally.
- Expands child life services to reach more children and families experiencing stressful circumstances.
- The child life field needs innovative solutions that support sustainability and growth throughout the entire pathway to the profession.

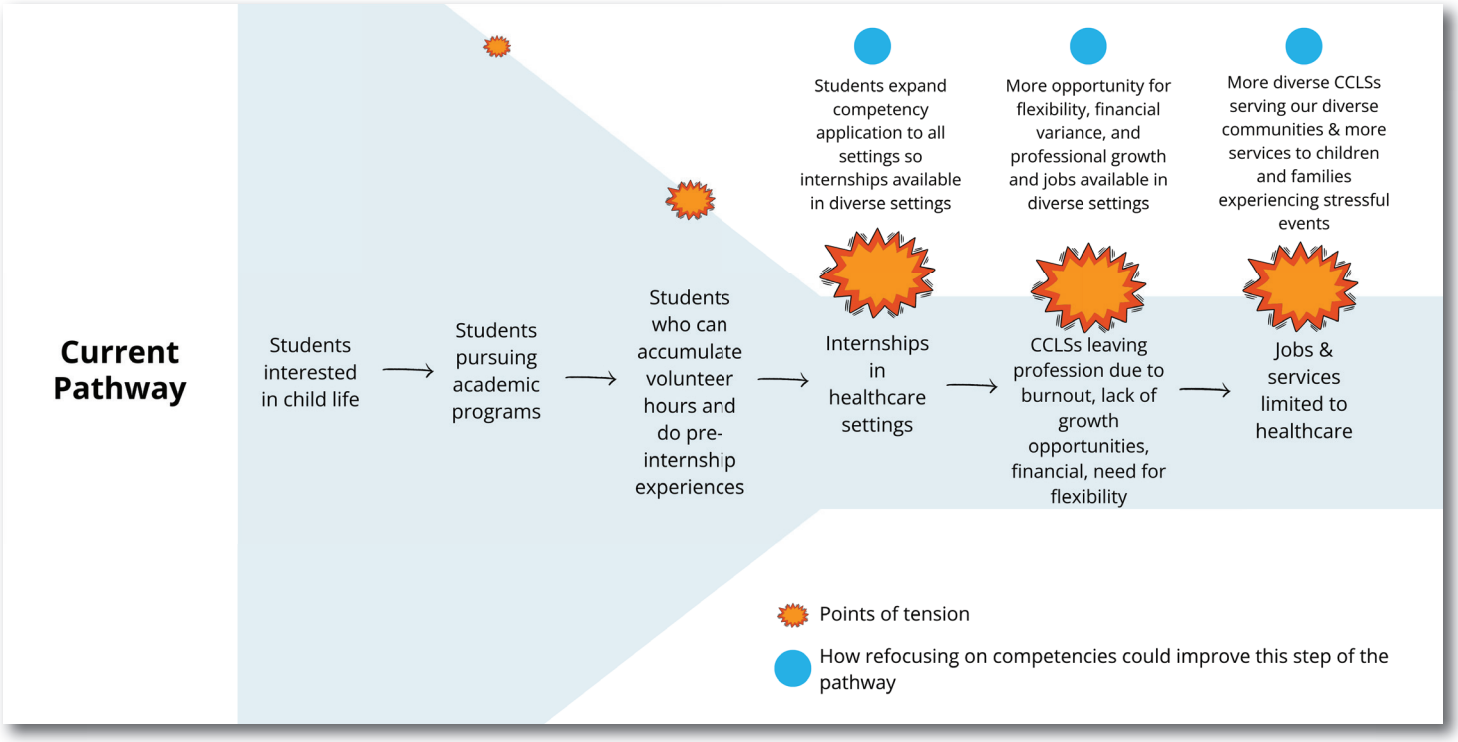
Academic Training

The competitive nature of internship sites (currently centered in healthcare) forces academic programs to largely base their curriculum on "patients", "illness, injury", and "hospitalization." This limits students' application of the competencies in all settings. Courses should always be discussed in the context of diverse settings with diverse populations, not just in relation to healthcare settings and populations. Academic programs struggle to balance the required courses for certification, courses desirable to internship sites (e.g., medical terminology, anatomy and physiology), and additional courses (e.g., trauma-informed care, stress and coping) that prepare students to meet the ever-changing needs of children and families in diverse settings. Child life education and training should focus on the ability to apply theory to practice in all settings where families experience crisis. The competencies guide child life specialists to assess a child and family holistically using all their lived experiences to create meaningful interventions. Even courses focused on illness and disease should use an inclusive lens that recognizes illness does not just happen in a vacuum but in settings within and outside of traditional healthcare.

Clinical Training

Pre-internship and internship training opportunities are extremely limited and grossly disproportionate to the students seeking them. Clinical sites have long reported regularly receiving 50-200 applications for 2-4 clinical positions. Most importantly, these limited clinical training opportunities are restricting the number of CCLSs entering the field and therefore also limiting the settings and populations of children and families receiving child life services who could greatly benefit. As a profession, we must consider what is lost by restricting access to clinical training and limiting employment opportunities by arbitrarily defining the profession to be only situated in healthcare environments.

A shift needs to take place in which diverse training and clinical hours are not just tolerated but valued. Internship hours required for certification eligibility currently state that "some" of the hours must be completed in a hospital setting (CLCC, 2019). While there are no minimum hour requirements attached to this statement, it once again highlights the focus on training students in healthcare settings. Clinical training (pre-internship experiences and internships) should focus on gaining the competencies of a child life specialist,



under the supervision of a CCLS, in any setting the child life specialist practices.

Certification Exam

In addition, the certification exam needs to be reflective and inclusive of child life competencies within all settings. Currently, the exam domains explicitly use language such as "healthcare", "patients", and "illness, injury, and healthcare" rather than "stress", "trauma", "crisis", "children and families." This is a direct result of the content being driven by the job analysis (conducted every 5 years) rather than the competencies. The job analysis "determines the tasks a CCLS performs as well as the knowledge, skills, and abilities needed to perform those tasks competently (CLCC, 2023)." While the latter sounds like competencies, it begs the question, "What drives the definition of a Certified Child Life Specialist?" Is it current practices or the Child Life Competencies? If we solely rely on current practices, the field is at risk of diminishing, or worse eliminating, the very value of the child life specialist outlined by Boles et al. (2020). In addition, the Child Life Certification Commission Clinical Experience Verification Form (2019) centers solely on the child life certification exam, not the child life competencies. Is best practice "teaching to the test" or should we be evaluating "competency" of the student in becoming a CCLS professional?

Adjusting the pathway to certification to be inclusive of community settings opens the door for students to enter the field in whatever setting fits their professional interests and personal needs. Expanding supervision of clinical experiences to community sites creates more diverse and accessible entries into the field for students unable to relocate or meet the requirements for work within a healthcare facility. It validates the role of CCLSs working outside of healthcare and helps them reclaim the title of CCLS in roles currently being identified under other job titles. It is imperative that we continuously reevaluate the requirements to become a CCLS and ground the academic and clinical training required in the core competencies of the profession, not a specific setting.

Valuing Diverse Settings

It is currently recommended that CCLSs complete 6,000 hours of work in healthcare before engaging as a CCLS in a community setting (ACLP, 2022b). The gross assumption here is that somehow healthcare experience provides

competency in and for other settings, whereas community experiences do not provide learning that is useful to healthcare settings. In reality, each setting a CCLS works in requires "on the job" training and specialization. Whether you are a CCLS in the Emergency Department, a Hem/Onc unit, the prison system, or in disaster relief, setting and population-specific training is required to provide the most appropriate and effective services to those served. The same is true for other professionals as well (e.g., social workers, nurses, physical therapists, teachers). They obtain their credentials based on general competency, then gain on the job training specific to the setting and population being served. When the field is recentered on competencies, child life experiences gained in any setting will be applicable to any setting. Diversity of experiences actually adds value that deepens our understanding, assessment, and interventions with children and families enduring stressful situations.

Implications & Conclusions

The current crisis puts the child life profession at risk of losing footholds in the field that have taken decades to establish. With vacant positions and limited opportunities to fill them, child life programs risk losing those positions in future budgets. Shrinking departments unable to provide internships lead to qualified students leaving the field before they get started. Further, the current crisis has exacerbated existing issues of diversity, equity, inclusion, and accessibility within the field (ACLP, 2020).

Child life specialists have historically focused their role in healthcare settings. The goal is not to diminish the healthcare role but to make space for the child life profession in all settings. We must take a "Yes and" approach to child life. Yes, child life specialists play an important role in multidisciplinary teams in healthcare settings AND serve in community settings wherever children, youth, and families encounter stress. By accepting child life specialists in community settings as a "traditional" role of child life, we create a powerful circle of care. Child life services are not limited to those children and families that attain traditional healthcare services, but are expanded to the children who witness a medical emergency but do not require medical attention; to children who need help translating terminology in a court setting; to teens grappling with the effects of school shootings; to youth affected by the any losses that accompany disasters, and to so many more. By connecting and supporting child life specialists in all settings, we create a powerful network of collaboration and enhance continuity of care.

Since the competencies are already inclusive, we must use them more directly to support opportunities for equity, sustainability, and growth in the field. The current ACLP 2022-2024 strategic plan supports the education and clinical training that leads to diversity in the field [3b] and promotes professional opportunities resulting in increased services for children and families[5b] (ACLP, 2022a). The competencies must be the consistent and firm foundation for the entire pathway to the profession - in academics, clinical training, and certification exam. This will "create a more diverse and equitable entry into the field" (Lowry, et al., 2023), mitigate many of the current crises, and ultimately benefit more children and families experiencing stress.

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2023

CHILD LIFE CONFERENCE

530 attendees
85 speakers
48 sessions
61 exhibitors
10 poster presentations


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SUPPORTING AUTISTIC CHILD LIFE STUDENTS

by Mary Ann Gill, MEd, CCLS, Monroe Carell Jr. Children's Hospital at Vanderbilt

Mary Ann Gill in CCLS role with teammates celebrating a large donation.

Many child life specialists have professional interests that stem from personal experience. I have long been passionate about providing child life services to a neurodiverse population. This year, I realized just how much my personal experience informs that interest as I joined the growing ranks of adults being diagnosed with autism. I am generally a high-masking autistic person, meaning that I work hard to pass as neurotypical, and I often succeed. Externally, I may blend in well enough with my neurotypical colleagues, but internally, I learn and process information differently.

I've been intrigued to watch members of our field grapple with issues of diversity, equity, and inclusion, particularly surrounding the question of how we can recruit and support a more diverse pool of child life specialists. I would like to offer my thoughts on how we can make our field more neurodiverse. Specifically, I will share what I found most supportive to my learning process as an autistic child life student. I cannot speak for all autistic or neurodivergent people, but I hope that by describing my personal experiences, I can contribute to building a more disability inclusive profession.

Using inclusive and affirming language surrounding disability.

Language is rapidly evolving; the words that many of us learned in school to describe autism and other disabilities may not reflect the language preferred by the disabled community today. For example, many self-advocates are reclaiming identity-first language, choosing to describe themselves proudly as "autistic people" rather than "people with autism" (Taboas et al., 2023). Groups like the American Psychological Association (APA) and National Institute of Health (NIH) suggest using a mix of person-first and identity-first language until you know whether the individual or group you are speaking about has a clear preference (APA, 2021; Wooldridge, 2023). Personally, I default to identity-first language in my personal conversations but ask individual patients and families what they prefer during clinical care. Additionally, many autistic people find

labels such as "high-functioning/low-functioning" or "mild/moderate/severe" to be unhelpful and even harmful (Kaap & Ne'eman, 2020). Instead, you may hear people describe varied levels of "support needs," which can fluctuate between different environments or phases in an individual's life. Of course, not all autistic or otherwise disabled people agree on language. I feel safest around colleagues who are open to adapting the language they use based on both current trends and individual preferences. Consider whether the language you are using for day-to-day conversations, interview questions, assignments, and chart notes would make an autistic person feel welcome and respected.

Identifying common conversational scripts.

I am constantly analyzing the patterns of neurotypical conversations to improve my masking abilities. As a visual thinker who finds comfort in repetition, I found it helpful to create scripts for common procedural preparations. When my spring 2020 internship was interrupted by the onset of the COVID-19 pandemic, I spent some of my down time writing out detailed verbal scripts. I created different variations for age/developmental stage, including information to address common questions and misconceptions for each stage. I would not suggest that our job is completely formulaic or that we should rely on a script during clinical interventions; one of my favorite things about kids is that they are constantly surprising me with new questions and reactions. However, I think many of us could identify some common phrases and conversational patterns that we hear ourselves repeating multiple times per day, and it helped me to see those in written form. These days, I can still see my script in my head when I'm preparing a child for surgery or an IV start.

Providing access to calming sensory environments.

One morning during my first internship rotation, I was involved in a tough bereavement in the PICU. I lasted about two more hours in clinical care before a meltdown took over. Autistic people can experience meltdowns in different ways. For me, this looked like a burst of uncontrolled tears, an unrelenting loop of negative self-talk in my mind, and a diminished ability to verbally communicate. My rotation supervisor let me sit for a while in her office, lit only by a strand of twinkle lights. I listened to quiet instrumental music and slowly felt myself return to a calm baseline. Later in the semester, the leadership team set up a self-care "spa" in our sensory room to kick off Child Life Month celebrations, and my co-intern and I got to sign up for a time to sit in the room and relax together. I often hear my colleagues talk about better ways to meet our patients' sensory needs, but I love working with people who encourage me to meet my own as well. These days, I'm grateful for my two wonderful officemates who share my aversion to fluorescent lighting and my passion for collecting the latest and greatest fidget toys.

Creating resources for visual learning.

While there is no universal learning style for autistic people, many of us do benefit from having information written down or illustrated. I was able to let my rotation supervisors know that this was an important way for me to learn. I took primary responsibility for this process, but I always appreciated when my supervisors helped me create visual resources. One printed a "face sheet" for me with headshots, names, and titles of various staff on the unit, which I used as a helpful quick reference when trying to decide who to seek out with a question or request. Another

assigned me to build a model pancreas from loose parts. The hands-on, visual process helped me better understand what was happening inside our patients' bodies while also preparing me to deliver high quality, developmentally appropriate diabetes education. Today, when I use a photo prep book, teaching vein, or sample central line for preparation, I see how visual resources can benefit not only children but also their adult caregivers. My visual thinking has inspired me to add new educational resources to my team's collection. For example, when preparing children and families for their first port access, I started placing toothpaste and Tegaderm on the back of my hand to model the proper application of EMLA cream. My teammates and I have seen an increase in patients coming in with their numbing cream applied properly compared to when we were using verbal preparation alone.

Breaking the ice and sharing rapport with medical staff.

I currently see patients on three different inpatient "pods" and a busy outpatient clinic. I spend a lot of mental energy trying to learn the unique personalities and communication styles of each staff member – e.g., figuring out which nurses like to slow down and chitchat versus which ones want me to cut to the chase when I need something. The rotations that students go through are relatively short, so it was helpful when my preceptors shared their rapport with unit staff and gave me specific advice about how best to interact with each person. When I started each rotation, I appreciated my supervisors initiating and modeling interactions with different staff on the unit. As a student, this helped me work through the whole process more quickly and easily. As a Certified Child Life Specialist, I have drawn on my past supervisors' examples to successfully collaborate with a multidisciplinary team of diverse personalities.

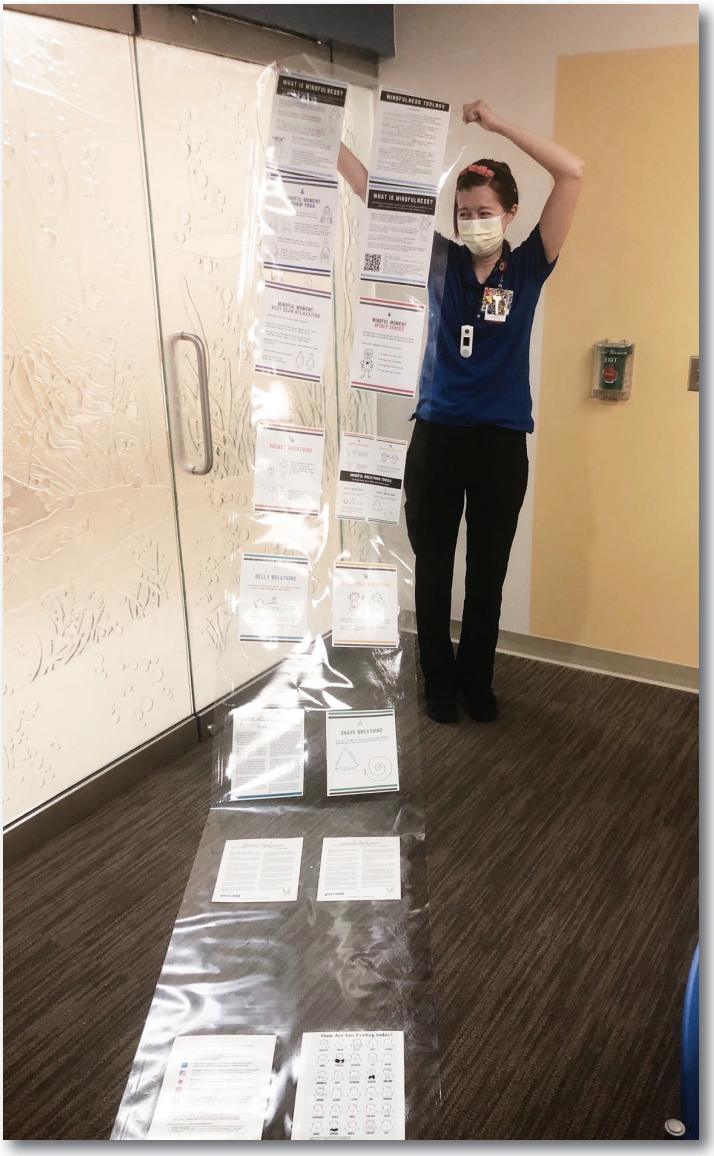
Mary Ann Gill on last day of internship posing with some of her favorite distraction tools.

Giving clear expectations for performance and evaluation.

At the end of my first internship rotation, my supervisor and I both filled out the same form to evaluate my performance, then met to compare answers. The answer scale went from 1 to 6, with 6 representing independent performance. I spent the last week or two of that rotation operating independently on the unit, so I gave myself 4s, 5s, and 6s on some of the items. As we met, my supervisor explained that she used the scale differently, viewing the highest score for someone halfway through their internship as a 3. Although our answers were still relatively comparable, I spent the rest of the evaluation panicking about my failure to follow these previously unexplained rules. I have since learned to be kinder to myself and to ask specific questions until I have a clear understanding of what is expected. Many autistic people value clear, direct, and literal communication (Wilson & Bishop, 2021); supervisors should apply this when communicating expectations for students.

Offering multiple ways to participate in class

Seminar classes are my social anxiety nightmare. I am slow to process auditory information and struggle to keep up with large group conversations. I learned a few seminar survival tactics, including showing up with detailed notes and offering my opinion near the beginning of class before the conversation topic veered too far from what I had prepared for. But I truly thrived in classes with more varied methods of participation: "pair and share" questions, small group work, and even online discussion boards for pre-class and post-class processing. My current department has historically made decisions via large group, spoken, free-for-all conversations. I'm thankful for my colleagues who have been open to workshopping new participation methods, which we hope will be more inclusive of neurodivergent and other marginalized voices.



Mary Ann Gill preparing final internship project.

As you read this article, you may have reflected that many of these recommendations could benefit any child life student, autistic or not. The principle of universal design for learning (UDL) encourages educators to support diverse groups of learners by adopting a flexible teaching style and offering a variety of instructional methods to all (Bernacchio & Mullen, 2007; CAST, 2018). By offering multiple means of engagement, representation, action, and expression for all students, educators will naturally create a more inclusive and supportive environment for neurodivergent learners (CAST, 2018). Koller (2016) also points out that UDL is a helpful framework for offering healthcare education to pediatric patients. UDL can and should be applied to education of adult healthcare students, and our professional colleagues have discussed the use of UDL in educating diverse cohorts of nursing and occupational therapy students (Coffman & Draper, 2022; Davis et al., 2022; Murphy et al., 2020). The child life field would benefit from engagement in similar conversations as we seek to recruit and support a more diverse pool of emerging professionals.

Every Certified Child Life Specialist starts off as a student. As a field, we cannot solve our lack of diversity until we improve our support for students from underrepresented groups. In exploring ways to meet the needs of autistic or otherwise neurodivergent child life students, ongoing research will certainly be helpful in building more empirical support for the above suggestions. However, for student supervisors and educators, the time to act is now. Professionals from related fields, disabled child life specialists, and students themselves have plenty to teach us about how to increase our support for this population. It's time to start listening.

SCENES FROM THE LIFE:

The Effects of Gun Violence on Children and Families as Observed by Three Child Life Specialists in the United States

by Jennifer Fieten, MA, CCLS, Shirley Ryan Ability Lab, Chicago, IL, Concordia University, Ann Arbor, MI, Willow House, Chicago, IL

Interwiewees: Jennifer Fieten, Brielle Swerdlin, MHA, CCLS, Methodist Children's Hospital, San Antonio, TX and Sidney Moreno, MS, CCLS, Shriners Children's of Northern California, Sacramento, CA

Gun violence is a significant human rights issue, one that we as child life specialists encounter with great frequency while serving children and families in the healthcare setting. Our trauma-informed perspective has uniquely contributed to our ability to serve children and families using an evidence-based approach. Below, three Certified Child Life Specialists (CCLSs), working across the United States, share their experiences working with children and families that have been affected by gun violence. Responses were collected via email during Gun Awareness Month in June 2023.

How have you seen families affected by gun violence?

Sidney: Working with the spinal cord injury and rehabilitation population has opened my eyes to the long-term effects gun violence can have on the family unit. My patients are learning to navigate their world with new physical barriers, emotional rollercoasters, and adapting to new expectations of life. Something that I believe is often over looked is the grieving process that these families and children go through while being a survivor. Whether it is grieving the loss of motor function, cognitive impairment, or the loss of what once was. Every person involved in the family unit is learning how to live their new way of life.

"More Americans died of gun-related injuries in 2021 than in any other year on record, according to the latest available statistics from the Centers for Disease Control and Prevention (CDC)" (Gramlich, 2023).

Brielle: In my previous role, I worked as an ED CCLS in a Level One Trauma Center. Unfortunately, the area in which I lived had a very high rate of pediatric patients who were victims of gun violence. The impact this had on not only the patients, families, and immediate community members, but the community at large, other patients in our hospital, and medical team was profound. I think we often downplay or do not realize the ripple effect these events can have on our communities. I have been involved when doctors have told families that they were unable to save the life of their child. I have sat on the dirty ambulance bay floor with crying and hysterical family members. I have been present during loud grieving and quiet grieving. I have been yelled at by other patients and family members that their visit is taking too long and they don't understand why they have not been seen faster, but I have had to keep a polite smile on my face and tell them that the medical team is working as quickly as possible and that I will let the charge RN know they want to be seen sooner while being unable to share with them that the wait is because the medical team is trying to save a kid's life. I have seen hundreds of people show up at the hospital with anger and confusion of these senseless acts as they try to console their community members. I have worked with members of the community on the Trauma Response Team (TRT) to help advocate for the families and get them the support they need. I have stood side-by-side with staff as we bring family members into the trauma room as time of death is called. I have held space for staff who are distraught that their efforts to save these patients were futile. I have participated in debriefings provided to the medical team to assist us in having a better understanding of the situation and to talk through the attempts that were made to save the patient's life. I have gone to the Medical Examiner's Office to be able to provide handprint molds, ink prints and jewelry charms for these families. I have seen my patients talked about on the news and social media sites, with community members

leaving memories and comments about the patient for all to see. I have seen principals release statements to the school community regarding the death of a child and the services that will be available for those who need it. I have spoken with parents of children in the community asking for resources on how they talk to their children about the violence that is happening around them.

Jennifer: As a child life specialist, I have worked in the emergency department, in the ICU, in the rehabilitation setting, and as an organ donation specialist for an organ procurement organization. I have seen the effect of gun violence on families immediately after it has occurred, as families have awaited news in the ICU, as families have had to make the extremely difficult decision regarding whether or not to donate, and now as the patient and family learns to navigate their "new normal." To witness the grief regarding "what was" and "what now is", to hear about the nightmares, to support the patient in processing their experience and in finding the hope to move forward, to create space throughout the process, and to see the impact of gun violence on not just the patient, but on the entire family (and, community); has been both disheartening and life changing. To bear witness as two teenage boys each shared their experiences of being shot, words just do not describe it accurately.

"Gun deaths among children and teens rose 50% in just two years, from 1,732 in 2019 to 2,590 in 2021" (Gramlich, 2023).

What have you found to be the most useful ways to support families affected by gun violence?

Sidney: The most useful way to help families that I have found is to provide them with an open space to explore different questions they come to me with. Having open-ended discussions allows both the families and their child to navigate through their different emotions. I also believe that building rapport with the family and child prior to these conversations creates a safe place for the families to not feel judged or looked at differently based on their experiences. I have found it most helpful to bring my teen patients together for exploration of their own needs and having a person they can relate to.

Brielle: I do not think there has been one most useful way to support families affected by gun violence. Every situation, circumstance, and family is different, thus requiring a different approach for each. I have found that providing families with resources to help them in the future has seemed to make a good impact. Finding book, online, and support resources to provide families has allowed me to connect them with ways to move through this new phase of life. I have also received voicemails from families after they have received their handprint molds/jewelry to their homes, thanking us for providing these materials. Families stating that this has provided them a feeling of closeness with their loved one again.

Jennifer: I do not believe that there is one way that is more useful than another. I find that the best that I can do is to meet the patient and family where they are, to tailor my support to what I assess to be the most important for that patient and family. It is to remember the tenets of trauma-informed care and the influence of trauma on what I am witnessing in front of me, to be that reminder of that to other members of the interdisciplinary team. To create space for the patient to feel however they need to and to be that listening ear; to provide developmentally appropriate information when needed, and to provide encouragement when that is needed too. One cannot discount the importance of creating a place where the patient knows and feels that they are heard.

As a child life professional, what are your thoughts on ways that we can bring awareness to this issue and ways in which we can advocate for those affected?

Sidney: Collaborating with our families and patients that we work with can help bring awareness to gun violence and allow them to share their stories as they wish. I have had patients in the past express their desire to share their stories on social media and have been able to collaborate with our development and media team to assist these patients in sharing their stories appropriately. Giving other children and families stories to relate to brings a sense of community and support in ways we may never be able to fathom on our own. This opens the world for these children and families to be vulnerable and lean on others when they need it the most.

"More than 500 people die every day because of violence committed with firearms" (Amnesty International, 2023).

Brielle: I think the question of as a child life professional, how can we bring awareness to this issue and ways we can advocate for those affected, is multifaceted. Continuing to share the ACLP, AAP, and other organizations stances on gun violence will continue to propel this issue into the limelight. Continuing to provide resources to our communities for when acts of gun violence happen in our direct communities or those nationally is helpful and beneficial to get this information out to the families who are grieving these situations. Sharing our stories and anecdotes so those in our communities- and our local governments- can have a true glimpse of what it looks like in the healthcare setting to be dealing with gun violence. Fighting for increased access to debriefings, counseling and mental health providers for our medical teams is also important, so our providers can protect their mental health to continue to be able to serve our communities. Providing educational opportunities for reporters, news outlets, elected officials and others on how the messaging and news delivery can be better tailored to not harm those in our communities who are seeing these stories. Lastly, making sure our child life education prepares us and provides us the tools we need to be able to support our communities in these times of tragedies.

I think it is important to mention and remind ourselves that gun violence affects us as providers as well. Whether as a CCLS working in a trauma center and directly providing services to these patients or not, we are all still impacted. With the climate across the country and seeing more and more mass shootings and singular shootings (likely many shootings happening in our own communities), it is hard to not see these events on TV and social media. It is important that we focus on taking care of our mental health

so that we are in the best places to support our patients and communities during these events. Having resources available to us to share with our communities is also very important. Conducting research studies and gathering information about these situations will assist us professionally and allow us to contribute to the resources available. Organizations like Child Life Disaster Relief to help provide support is also something that will help us to better provide for our communities.

Jennifer: I think that we have the ability to advocate and to bring awareness on a daily basis,. Whether it be through conversations with our team members, in our interactions with our patients and families, in our conversations with hospital leadership, as we meet with and train students, as we supervise volunteers, and as we interact with others in our community, we have the opportunity to be a voice to talk about the effects that we have seen (while maintaining HIPAA). We also have the ability to advocate on a larger scale, reaching out to our state and federal governments to advocate on a public policy level.

Gun violence remains a human rights issue. As child life specialists, we have the ability to advocate for, and bring awareness to the needs of those affected. Take action by utilizing the ACLP Gun Violence Prevention & Safety Advocacy Toolkit. Child life specialists' advocacy is vital; this toolkit offers resources to make your voice heard.

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USING DATA TO ADVANCE THE FIELD OF CHILD LIFE:

The Child Life Professional Data Center

By Erika Croswhite, MA, CCLS, Children's Hospital Colorado, Aurora, CO

Child life specialists often tell meaningful and heart-warming stories to demonstrate the quality of care provided to the children and families they serve. But quantifying the qualitative nature of child life work is an art. The Child Life Professional Data Center (CLPDC) launched in 2016 to help meet this need. The CLPDC is a grassroots database that holds information about hospitals, nationally and internationally, that employ child life programs, where they exist, how they are funded, and many more granular details. It is a tool that can be used to track child life program capacity and benchmark against other programs, giving child life specialists the power to increase funding, staffing, and credibility for child life programs throughout the world. However, this power depends on our combined efforts to sustain the CLPDC and develop our capabilities to effectively use it. This article provides a brief overview of what the CLPDC can do and why it matters for maintaining the strength and growth of the child life profession.

The CLPDC is the centralized location for child life program data with information from more than 160 child life programs (Romito et al., 2021). Utilization of the CLPDC has varied over time, ranging from 30-50 of child life programs inputting quarterly and annual productivity data. There

are seven service areas distinguished by location of patients and families, including the 6 most common pediatric units (inpatient, outpatient, surgery, radiology, critical care, and the emergency department) and a recently added 7th area (adult high-acuity units), for child life specialists who support children of seriously ill and/or injured adults. The information collected in the database depicts the number of patients and families served

by a child life specialist in the given service area during a certain time frame. The data can be utilized to inform staffing models, patient caseload expectations, and individual and departmental productivity. In addition, the database serves as a reliable resource for child life program benchmarking, enabling programs to compare themselves to other child life programs in their regions to determine opportunities for continued improvement in service delivery.

A direct result of the CLPDC is the best-known metric in the field of child life: the Capacity for Patient and Family Impact (CPFI). CPFI is calculated by dividing the number of patients seen by the hours worked by each clinician. There are myriad child life programs across the country who have utilized the CPFI metric as a resource. For example, a program leader was tracking the CPFI data of her staff in the emergency department and found the overall CPFI for that department was .70, meaning that the child life specialists were seeing less than one patient in an hour in the ED. This statistic inspired the leader to dive into what was happening, and she discovered that her staff were feeling burned out and over-extended. They had too many other responsibilities on their plate and were struggling to see as many kids as they had in the past. This realization caused the team to regroup and reprioritize patient care with a revitalized sense of awareness. As they intentionally sought to "say no" to competing non-patient care requests, they saw their CPFI metric steadily grow to .85 over the course of two years. The input, tracking, and analysis of the data had paid off as the child life staff returned to their roots of doing the work they enjoyed the most: seeing patients!

Another example of how child life leaders have used the data in the datacenter is professional benchmarking. Child life professionals often receive requests from administrators and executives about how they compare to other child life programs. The database serves as a robust resource with detailed, essential information that can guide operational decisions including where, when, and how child life services are delivered, what specific programming is offered, and how the hospital is structured, including number of beds, number of staff, and productivity metrics across cities, states, and countries. For example, child life specialists who work in the surgery department in a free-standing children's hospital can compare their CPFI to child life specialists who work in the surgery department in an adult hospital with pediatric services. This data helps validate the caseloads of child life specialists within specific departments and informs leaders about the approximate number of children who will be served daily. Leaders can then set realistic expectations with hospital administrators when determining child life staffing models.

Front-line child life specialists, program leaders, and educators who serve in both traditional and community settings can all benefit from engaging with the data center. Educators can teach students and colleagues about the details of how child life services are delivered by sharing the results of the quarterly and annual data entered in the CLPDC. When a college instructor is able to demonstrate that the typical caseload of a child life specialist who works in the emergency department at the local freestanding children's hospital is approximately one patient per hour, it helps to accurately prepare the student for what to expect in the field. In another way, if a creative arts or music therapy professional is interested in learning about available collaboration with the child life program at a specific hospital, they can access the CLPDC for more information. Credibility, visibility, and accessibility of child life services continue to grow and evolve through continuously interacting with the data center. This, in turn, elevates professional exchanges between child life professionals, other clinicians, and

administrators in healthcare and community settings.

Databases of this nature are typically found within professional career fields of massive size like nursing, education, and sales. The CLPDC is therefore a commendable achievement in the child life profession, spearheaded by leaders of the child life profession who understood how advantageous the collection of data would be for child life specialists on the ground. They witnessed the impact of data and research for other medical, psychological, and psychosocial professions as they navigated the dynamics of supporting children, teens, adults, and families, whether it be nursing, medicine, social work, or chaplaincy. The common thread in proving the value of each discipline was through telling the story both quantitatively and qualitatively. It is critical that the child life profession strive to do the same.

The CLPDC is operationally supported by the ACLP and upheld by members of the benchmarking committee, but the database needs input, attention, and oversight from child life specialists at every level to survive. Though it might seem intimidating at first to enter and analyze data, confidence and competence increase with frequent utilization and exposure to viewing child life work through a quantitative lens. We must, as a profession, recommit to the purpose and potential of the database. We must collect and input the data for our programs because the CLPDC is only as valid and reliable as the data provided. When we engage with the data center through ongoing review, data entry, and analyses of our own programs as well as others, we demonstrate our commitment to the child life profession because we can articulate the impact of child life services through current data in real time.

The CLPDC exists to serve as an advocacy platform for the rights of children and families who face challenging medical circumstances and deserve emotionally safe care. It is here for the professionals who do the work to document and demonstrate the impact and influence of child life specific support locally, nationally and internationally. The database has untapped potential that we have yet to realize! It is our professional responsibility to give it the attention and support it deserves. In the ever-changing world of healthcare, the child life profession needs the datacenter to remain a top priority as we strive to meet the demands of the patients, children, and organizations we serve.

For more information about how to access the data center, how to enter data, and how to apply the data within your specific organization, please reach out to datacenter@childlife.org, or click here to be connected to the ACLP website.

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A CHILD LIFE SPECIALIST'S BEST FRIEND:

The History of Facility Dog Programming

Lynn McGurgan, MS, CCLS, Inova L.J. Murphy Children's Hospital

Have you ever heard of the saying "dogs are a man's best friend"? This phrase was coined way back in 1789 to describe dogs' close companionship, loyalty, and friendship with humans. The idea that animals could be used as a therapeutic modality to treat hospitalized patients was introduced in the 1970s by a nurse named Elaine Smith, and it is no surprise that dogs won out when deciding between rabbits, pigs, and fish (Howe et al., 2021). With Smith's guidance, trained volunteers and their personally owned therapy dogs would frequently visit children's hospitals to provide comfort and support. Throughout the years the growth of animal-assisted therapy (AAT) and the definition of what that means has grown, allowing specially-trained facility dogs to provide a larger role in the care of pediatric patients and their caregivers. AAT is used today to reduce stress and promote coping by using a trained therapy animal to improve a patient's social, emotional, and cognitive functioning (Howe et al., 2021). Today it is common to see child life specialists utilizing AAT as a part of their clinical duties. This article will explore the history and evolution of facility dogs within the child life profession and how facility dogs are used in child life programs today.

Therapy dogs and facility dogs may not sound very different, but they each provide unique and varied services to a wide array of populations. Therapy dogs are typically pets who provide comfort, affection and companionship (Schoenfeld-Tacher, 2017). These dogs can typically be found in places such as hospitals and nursing homes. Facility dogs are highly trained in tasks to assist professionals working in healthcare, rehabilitation, criminal justice or education settings. Facility dogs receive additional specialized training compared to therapy dogs and have more concrete goals and outcomes when providing services. Facility dogs may assist a child life specialist and physical therapist with a child's goal of walking, while a therapy dog may come visit the

Bartley, facility dog at Inova L.J. Murphy Children's Hospital

hospital with a volunteer to provide comfort.

Fine et al., (2019) found although AAT has been around for many years in some shape or form, until the last 10 or so years, there has been little research supporting the use of dogs in the pediatric healthcare setting.

The History

Many children's hospitals have at least one facility dog as part of their child life department or hospital programming. However, even just 30 years ago, this was not nearly as common. In 1990, the Americans with Disabilities Act (ADA) was passed, which expanded the idea that service dogs could be used for purposes other than blindness and deafness, such as emotional and therapeutic support (Schoenfeld-Tacher, 2017). As many dogs began going through service dog training, it was found that not every dog was qualified to work in this capacity. Many of these dogs ended up failing service dog training for reasons like being too friendly, making them perfect for a facility dog position (Schoenfeld-Tacher, 2017).

Over time, nonprofit organizations began developing programs to support the funding, training, and education of facility dogs within healthcare and community settings. In 1991, Canine Assistants was founded in Milton, Georgia, to train and place working dogs with people who have physical disabilities, type 1 diabetes, seizures, or other types of special needs (Canine Assistants, 2022). These individuals receive a dog that assists them with specific needs related to their health conditions and lives with them in their homes. In 2009, Canine Assistants expanded their programming to children's hospitals, first partnering with Children's Healthcare of Atlanta. Today Canine Assistants has over 80 dogs placed in children's hospitals all over the country.

Growth of Programs

Children's Healthcare of Atlanta (CHOA) had the first documented facility dog program, welcoming their first dog, Casper, in 2009 (Canine Assistants, 2022). Children's Healthcare of Atlanta has grown its program exponentially since creating "Canine for Kids," which now has 14 dogs that work in all hospital areas, including inpatient units, outpatient areas, camp programs, and staff support. Numerous children's hospitals have added facility dogs to provide therapeutic support, comfort, and assistance in treatment goals to pediatric patients and their families, looking towards CHOA and their program for guidance (Canine Assistants, 2022). Several children's hospitals have created specific facility dog positions to oversee the maintenance and daily running of a facility dog program. Many of these positions require duties such as coordinating vet visits, facilitating requests for special/community events, overseeing budgeting and training, and supervising dogs and their handlers.

An informal survey was conducted for this article with 18 child life specialists who are facility dog handlers. This survey asked participants about their clinical and managerial duties specific to being a facility dog handler. Participants overwhelmingly reported the most difficult aspect of being a handler is managing expectations with staff and having staff understand when/how to appropriately consult. Secondary to this, 25% of participants stated managing funding, supplies and scheduling for the facility dogs is challenge. However, every participant in the survey reported that having a facility dog is a very rewarding and impactful part of their job, even with all the challenges.

As the field of animal-assisted therapy has grown, facility dogs have expanded their services to a wide variety of settings, including outside of the hospital. For example, Chicago Children's Advocacy Center added Mac, a two-year-old golden retriever, to their child life department in 2018. Mac was trained with Duo Dogs, a nonprofit organization that specifically trains facility dogs to provide support for people in courtroom settings,

Facility dogs at Norton Children's Hospital "Heel Dog Heal" program.
From left to right: Henry, Yarie, Zeus, Dunkin, Doc, Juno, Holly, Pepper and Finley

forensic interviews, and school districts (Duo Dogs, n.d.). In 2020, Mac participated in over 70 forensic interviews, and it was reported the disclosure rate in cases of suspected sexual abuse was 10% higher when Mac was present (Chicago Children's Advocacy Center, n.d.). Walsh et al.(2018) found that in addition to reducing stress for patients during forensic interviews, facility dog presence reduced staff burnout and long-term secondary traumatic stress. Having a facility dog present during stressful events and procedures may assist in promoting job longevity, especially for child life specialists.

With the rise of social media, many facility dog programs have created social media pages on platforms such as Instagram. These pages show highlights of their programs, provide health information, share patient experience stories, and build a digital community. These social media pages are followed by hospital staff, patients and families, and community members, allowing individuals to learn more about facility dog programming as well as donate to support the facility dog program in their workplace or community. These accounts also provide an opportunity to share accurate and developmentally appropriate information across a wide network, particularly for young adults who use Instagram more than any other social media platform to access healthcare information (Thomas et al., 2022). Social media has also connected facility dog programs across the country, creating annual events such as the secret Santa paws gift exchange, where facility dogs from different programs are assigned another program's dog and send gifts throughout the month. In 2022, 127 dogs from 31 states participated in this event!

As you can see, facility dog programming has evolved significantly over a short period of time. Facility dogs provide a great addition to many children's hospitals and community settings all over the county. With the introduction of facility dogs to child life programming, child life specialists have been able to add another tool to their clinical tool belt when working with children and families.

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CALENDAR

UPCOMING EVENTS AND IMPORTANT DATES

AUGUST 30: Certification exam window closes

SEPTEMBER 7: ACLP Webinar: All Hands on Deck, But It's Only Your Hands: Navigating the Ups and Downs of Being a One-Person Program

SEPTEMBER 17: Applications open for the 2024 ACLP Research Fellows

SEPTEMBER 20: ACLP Webinar: The Skin They Are In: Delivering Racially Conscious Pediatric Psychosocial Care

OCTOBER 2: Applications close for the 2024 ACLP Research Fellows

October 4: CLPDC 2023 Q3 Data Entry opens

October 6: ACLP Webinar: The Other End of the Leash Incorporating Student Programming with a Facility Dog: Harnessing Learning Styles and Discovering the Right Fit

October 10: Offer date for Winter 2023/Spring 2024 Internships

October 17: ACLP Webinar: No One Had to Lose for you to Win: Psychological Safety for the Child Life Student

October 18: Applications open for the Winter/ Spring 2024 ACLP Diversity Scholarships

November 1: Applications close for the Winter/ Spring 2024 ACLP Diversity Scholarship

November 1: Certification exam window opens

November 6: ACLP Webinar: Let's Take a Trip!: Preparing Children for Hospital Transfers

November 15: Certification exam window closes

November 15: ACLP Webinar: Truth Telling Across Cultures: Is Veracity Always a Best Practice