ACLP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

WINTER 2023 | VOL. 41 NO. 1

ACLP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

Winter 2023 | Vol. 41 No. 1

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

Published quarterly in February (Winter issue), May (Spring Issue), August (Summer issue), and November (Fall issue). Submission deadlines for consideration for each issue are as follows: Winter - November 1, Spring - February 1, Summer - May 1, Fall - August 1. For more information on submitting articles, please see Submission Guidelines in the ACLP Bulletin section of the ACLP website.

For information on advertising in ACLP Bulletin, please refer to the Advertising page on the ACLP website.

To contact a board member, please visit the *ACLP Member Directory*

ASSOCIATION OF Child Life Professionals

CONNECT WITH US

Front cover photo provided by Michelle M. O'Hara, CCLS

CONTENTS

CEO Shares

by Alison E. Heron, MBA, CAE

Greetings! The new year of 2023 has started with a renewed energy toward professional and personal goals. For the ACLP team, we continue to work to provide the needed resources and support to our members and the child life community. We are pleased to share a few updates regarding the association and upcoming programming over the next few months. Despite immense challenges that continue to impact the child life profession, we are proud of the resiliency and strength of the community to serve children and families.

Join colleagues from around the world to share challenges, collaborate on solutions, and stay up to date on the latest in the child life community at the 2023 Child Life Conference, June 15-18 at the Gaylord Texan Resort and Convention in Grapevine, Texas. Registration is now open!

We are excited to bring back hospital tours, poster presentations, an all-access pass, and the depth and quality of our sessions focused on gender-affirming care, DEI initiatives, emotional safety, and mental health, such as:

- The ethics of providing care for patients who identify as gender diverse in an uncertain environment
- DEI initiatives within the child life field: Initiating change in ourselves and our teams
- Mind the gap: Assessing children and teens with mental health concerns
- Lessening the trauma: A sensory approach to promoting emotional safety
- Beyond everyday responsibilities: Reconnecting with the power and impact of joy in your work
- Team Medicine: A recipe for psychological safety and team resilience, and much more.

We appreciate the continued support of our exhibitors and sponsors as we begin to bring the profession back together in person. Attending the conference provides an opportunity to broaden your network, meet new people, promote a deeper understanding of essential topics, uncover new learnings, and reinforce existing best practices. Check out the Conference Justification Toolkit to communicate the value of participating in the conference experience to your manager or supervisor.

March is Child Life Month! We celebrate YOU and the child life profession the entire month through learning and raising awareness of all you do. Be on the lookout for resources and a special kick-off message on March 1. Each week we will focus on several topics such as professional development and offering of free webinars, member appreciation, self-care, and celebration and recognition of award winners and members. Our team invites you to participate in all activities and connect with us on social media to share how your hospital is celebrating Child Life Month. We love pictures!

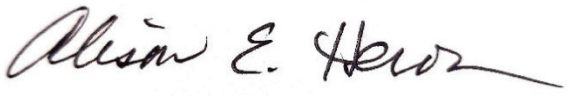
In April, we will launch the reimagined Call for

Volunteers (formerly VIF) with new improvements and streamlined processes. Volunteering with ACLP provides an excellent opportunity to not only give back to the profession but a learning opportunity for oneself to collaborate and share knowledge, keep up to date professionally, and, best of all, positively impact the child life profession. The ACLP Board, volunteer committee leaders, members, and staff continue to stay focused, and the Strategic Plan serves as our guide. However, we can only accomplish these goals and objectives with the insights and dedication of our members, such as yourself.

I encourage everyone to answer the call and share their perspectives and knowledge of the child life profession. Each person has a unique experience that can contribute to the overall growth of ACLP. Contribution to surveys, focus groups, workgroups, or a task force is another avenue to contribute to the direction of ACLP and the development of content and resources for the profession.

Thanks again for all you do and aspire to do in the child life community. Remember to reach out if you need help, please extend grace and mercy, and take care of yourself and your family.

Respectfully,



Alison E. Heron, MBA, CAE

President's Perspective

by Lindsay Heering, MS, CCLS

2023 is off to a strong start for ACLP. The February ACLP Board of Directors meeting was virtual and focused on board reports from the Governance Committee and the Internship Accreditation Oversight Committee (IAOC), along with an update on the upcoming ACLP Think Tank. IAOC presented revisions to the internship accreditation standards establishing congruency with our new Internship Readiness Common Application. The ACLP Board of Directors application process is also under way. Following the November board application deadline, the Nominations Committee reviewed applications and completed interviews this month. The Board of Directors slate will be made public in April for membership vote. Based on consultant recommendations, following the evaluation of our Nominating Committee's working documents and entire process, several improvements were made for the current application round. Moving forward, we'll be developing a road map to guide our continuous process improvement.

ACLP has maintained our intentional focus on building an environment and culture that is inclusive, transparent, and respects our members of every race, identity, and community. To uphold ACLP's commitment to providing a professional, safe, and welcoming environment for all members, the Governance Committee cultivated an ACLP Membership Code of Conduct (the "Code"). The Code outlines expectations for our members to foster a positive environment for one another and our affiliates. Best practices and standards of conduct guidelines informed the development of our Code. When enrolling in and continuing ACLP membership, our members will commit to standards of conduct. An associated Membership Disciplinary Policy and Membership Disciplinary Complaint Form will add procedural parameters to guide the integrity, accountability, and adherence to the Code. Once finalized, these documents will be housed on the ACLP website for transparency to our members.

With the upcoming think tank focused on the staffing crisis and the pathway to our profession, we have identified the following outcomes: 1) increased collaboration between academic and clinical sites, 2) increased support for internship supervisors, and 3) increased program leader engagement. To alleviate the staffing crisis and increase access to our profession, we need to work more collaboratively. This is incredibly complex given the wide-ranging variety in the way that our clinical and academic programs function. We have experienced an exponential amount of turnover in child life across the US and Canada, more than our profession has ever faced in its history. For various reasons,

internship placements have become even more limited than they were before the pandemic, which has led to a downstream impact of job postings remaining open with limited applicants for extended periods of time. These vacancies and continuous onboarding subsequently compound child life specialist fatigue and burnout. This is a complicated and cyclical issue. By bringing our interested parties (academia, internship coordinators, child life specialists, program leaders, and aspiring professionals) together, we will strategize ways to improve our current and future state.

Earlier this month, Alison Heron, ACLP CEO, and I traveled to Hong Kong to learn about their delivery of child life and hospital play services. Our trip was funded by the Hong Kong Jockey Club Charities Trust and Playright Academy to help advocate for child life as an essential service within their pediatric healthcare system. During our time in Hong Kong, we met with healthcare executives, presidents and chairmen of various healthcare associations, government officials, funding sources, their child life specialists, and various medical teams. We spent time at the Hong Kong Children's Hospital and the Prince of Wales Hospital, to understand how pediatric services are delivered within their public hospital system. We were also invited to present at their PLAY for Child Health seminar at the Hong Kong Children's Hospital. Our time in Hong Kong was a fruitful and engaging experience. We were impressed by the quality of work being done by our Hong Kong child life colleagues and the number of champions and advocates for child life and hospital play. We're looking forward to continued partnership to help advance their infrastructure and foster further growth and development of the child life profession within Hong Kong.

Looking ahead to March, we're also looking forward to Child Life Month and celebrating the impact child life has on children, families, and the quality and culture of care within our institutions. I am continually inspired by the talent, skills, and creativity of our child life community. Thank you for bringing continued passion and dedication to your work. We appreciate those serving as first responders for emotional safety, those teaching our next generation of child life professionals, and those in pursuit of a child life career. Thank you for all you do!

From the Executive Editor

by Shannon Dier, MS, CCLS

Self-reflective practice is one of the core competencies of the child life profession (ACLP, 2019), yet I doubt this is something most of us mention in our "elevator speech" explaining what a child life specialist does. Nonetheless, it is foundational to our ability to continue to grow and develop as professionals. Reflection invites us to move beyond *what* happened and to consider *how* our experiences impact the way we think, feel, and act as child life specialists. Research with other health care professionals suggests that reflective practice decreases stress and anxiety, improves professional competence, develops knowledge and application to practice, and increases self-awareness and critical thinking (Choperena et al., 2019; Contreras et al., 2020)

Reflection requires "stepping back from the direct, intense experience of clinical work and exploring the thoughts, feelings, and issues" being managed (ACLP, n.d.). This process is especially clear among child life students, who we require to reflect on all they have seen and done in weekly or daily journals. In the professional world, reflective practices typically involve clinical supervision groups and debriefing with a peer or supervisor. While these externalized processing opportunities are valuable, there seems to be a shift away from individual written reflection as we move from student to professional. Given how valuable writing about clinical experiences is while we are learning, are we missing out when we aren't engaging in writing as reflective practice?

As a doctoral student and child life instructor, I recently rediscovered the benefits of writing about what I was doing and observing. Last fall, I was enrolled in an action research course that required completing weekly journals about my teaching and the actions I had taken to improve student learning. My goal had been to embed content related to diversity, equity, and inclusion throughout the semester to better prepare child life students for the updated ACLP Internship Readiness Knowledge, Skills, and Abilities (KSAs). Not only was I able to evaluate the impact of my changes through reflection, but I was also able to recognize how my actions as an instructor impacted the outcome. For example, I hoped to increase student self-awareness and facilitate collaborative discussions, yet I discovered that my eagerness to share information often turned into more of a passive lecture. Through reflective practice on my teaching, I was able to see beyond what initially felt like lack of engagement from the students to realize I needed to create space for them to more actively engage.

Much like the practicum students with whom I was working, I found that reflective writing

increased my self-awareness, deepened my understanding of the practice, and empowered me to make adjustments to what I doing in real-time. It was also motivating in a way I hadn't considered before: I was writing my own story, and I couldn't wait to update myself next week about the progress I was making toward my goals. In this way, reflective practice through writing facilitates ongoing growth and encourages us to not be complacent or stagnant in our work.

This Winter issue of *ACLP Bulletin* includes several examples of professionals engaging in this important process of reflection. Shelby Strauser discusses how visitor restrictions imposed by the pandemic prompted her to rethink her role in supporting caregivers in the emergency department. In an article about pre-admission phone calls, Elise Huntley reflects on the benefits and challenges of this practice and shares what she has learned. Other articles engage us as readers in reflection about what it means to practice child life and challenge our field to continue to grow and change. Describing the development of an academic mentorship program, Belinda Hammond and Katie Walker discuss the implications of helping to build child life programs at historically Black colleges and universities and Hispanic-serving institutions. Finally, Kristen Brown and her colleagues examine what it might look like for child life specialists to use our skills to address social determinants of health.

As I wrap up this reflection on reflecting, I have a few updates to share. First, I want to welcome everyone to our first open-access issue: *ACLP Bulletin* is now available to be read and shared by anyone! Issues will still be emailed to members, but all articles will also be freely available on the ACLP website. Second, ACLP members will be able to earn 1 PDU for reading the issue, similar to earning PDUs for reading articles in *The Journal of Child Life*.

Finally, with help from our committee members, we are offering more support to interested authors. If you are a first-time writer, unsure where to start, or need a little extra assistance organizing your ideas, we are here to help you get from inspiration to article. So, with reflective practice in mind, I invite you all to reach out to us at bulletin@childlife.org with the lessons you've learned, the cases that have challenged you, and the stories you have to share.

References:

Association of Child Life Professionals. (2019). *Child life competencies*. https://www.childlife.org/docs/default-source/aclp-official-documents/child-life-competencies_november-2019-updates.pdf?sfvrsn=d33e8c4d_2

Association of Child Life Professionals. (n.d.) *Position statement on clinical supervision and reflective practice*. https://www.childlife.org/docs/default-source/aclp-official-documents/clinical-supervision.pdf?sfvrsn=61398c4d_2

Choperena, A., Oroviogoicoechea, C., Zaragoza Salcedo, A., Olza Moreno, I., & Jones, D. (2019). Nursing narratives and reflective practice: A theoretical review. Journal of Advanced Nursing, 75(8), 1637–1647. https://doi.org/10.1111/jan.13955

Contreras, J. A., Edwards-Maddox, S., Hall, A., & Lee, M. A. (2020). Effects of reflective practice on baccalaureate nursing students' stress, anxiety and competency: An integrative review. Worldviews on Evidence-based Nursing, 17(3), 239–245. https://doi.org/10.1111/wvn.12438

WELCOME TO THE BOARD ROOM

November 2022 Board of Directors Meeting Recap

ACLP Board of Directors

Each year, the Association of Child Life Professionals (ACLP) Board of Directors meets on four separate occasions. These meetings include the 9 Board members, 2 liaisons, and ACLP's Chief Executive Officer. The Board has oversight for the association and ultimately makes decisions related to financials, key initiatives, and other important issues that the profession of child life and the association are facing. Each meeting has a robust agenda.

The November board meeting is unique from all the other board meetings because it is the 1st in-person meeting for the year's newest Board members to contribute to the decision-making.

During the previous Board meeting (May 2022), the newly elected Board members observe and learn about the initiatives and parliamentarian procedures, and the August board meeting is virtual. During the November board meeting, time is dedicated to building rapport and understanding each person's strengths.

Each meeting begins with ACLP's inclusivity goals, which are incredibly important when considering the scope of the discussions and the impact of the decisions that may be made within the meeting. In addition, every item on the agenda is directly linked back to the Strategic Plan. One of the exciting elements of the Board's discussion was highlighted by the Strategic Plan Dashboard, presented by ACLP's CEO, where the Board reviewed the progress that was made within each of the five strategic priority areas in Year 1 of the 2022-2024 Strategic Plan. Stay tuned for quarterly updates on the progress and how these efforts connect to your work with children and families.

Each board meeting includes standing agenda items, such as the Headquarters, Committee, and Treasurer's reports. Time is also dedicated to discussion of significant topics facing the child life profession. During the November board meeting these included pre-internship, internship readiness, diversity, equity, and inclusion (DEI), the staffing crisis, and internship accreditation. Below is a summary of the Board's discussion on a few topics and some of the decisions that were made.

Pre-Internship: A work group was charged with evaluating the pre-internship modules (formerly known as practicum modules) from an anti-racist and DEI lens. As their work was unfolding, the Internship Readiness Knowledge, Skills and Abilities (KSAs) were released. The work group enhanced the modules and aligned them with the KSAs. The Board reviewed all of their efforts and approved the content which which will be available to the child life community on the ACLP website in the near future.

Internship Readiness: The Board discussed the insights gained from the pilot of the Internship Readiness Common Application and the progress being made towards the launch. The discussion was rich and robust as the Board considered how best to support this work and each of its stakeholder groups, including aspiring child life professionals. Currently, the internship readiness project is supported by a work group. With every work group or task force, groups with charges that have a specific start and end point, the Board has to make a plan for how best to utilize, disseminate, and/or sustain their efforts.

DEI: The DEI Committee submitted ideas for creating committee-curated DEI resources that will be made available to the membership via the Resource Library. The board approved the DEI Committee moving forward with dedicating time and effort in developing and disseminating these new resources. As the Board discussed aspiring professionals and the impact of the Internship Readiness KSAs and Internship Readiness Common Application, in addition to the release of the Pre-Internship Modules and thus, explored how to continue to address disparities within our membership as well as with the children and families served.

Staffing Crisis: This was brought before the Board for discussion driven by concerns shared across all stakeholder groups related to Certified Child Life Specialists (CCLS) entering into the field of child life. Programs across the country have expressed concerns related to their open positions remaining vacant. Academicians have also shared that they have felt the lack of availability of qualified CCLSs to supervise students. The Board discussed potential options for supporting discussion and brainstorming of solutions. This resulted in the approval of a Staffing Crisis Think Tank which will be held in Spring 2023. Stakeholders will be invited to an in-person meeting to collaborate on steps to take to help address the staffing crisis.

Internship Accreditation: The Internship Accreditation Oversight Committee presented revisions to the Clinical Rotation Supervisor Standard to support greater flexibility in the definition of a clinical rotation supervisor as well as updated Internship Curriculum Modules. Both of these items were approved, and more specific will be made available on the ACLP website in the near future.

ACLP Budget: Unique to the November board meeting is a review and vote on the next calendar year's budget. This budget was presented to the board, voted on, and approved. The budget helps to guide the ACLP staff in planning for the year.

ACLP Awards Committee: Additionally, at the November board meeting, the Awards Committee presents the recipients of the Distinguished Service Award and Mary Barkey Clinical Excellence Award and the Board votes on the upcoming year's award winners. Stay tuned for the announcement of this year's winners during Child Life Month.

The next board meeting is in February (virtual) followed by a meeting at the annual conference (in-person). The Board looks forward to sharing more updates in the *ACLP Bulletin* Summer issue.

BOARD OF DIRECTORS SPOTLIGHT

Meet Alisha Saavedra, MA, CCLS

NAME: Alisha Saavedra, MA, CCLS

PRONOUNS: She/Her/Hers

TITLE: Assistant Professor, Director of Clinical Training

LOCATION: Works at Loma Linda University in the M.S. Child Life Specialist Program and lives in the city of San Bernardino.

ROLE ON THE BOARD: President-elect

Tell us a little bit more about your child life interests or passions.

Throughout my career I have had an interest in the clinical training of students and new professionals. I have grown to really appreciate the opportunity to support students as they navigate entering the field. It is a privilege to walk alongside them in their journeys and champion not only their academic, but their personal growth as well. They have been some of my greatest teachers! I also have a passion for DEI and strive to expand my awareness with an other-oriented perspective. Over the past couple of years, with the increased recognition by healthcare leaders that we are living in a racial pandemic, it prompted me to seek opportunities to deepen my own self-reflection and discovery process. I consider myself a life-long learner and someone who is willing to learn from others. We all have a life story and are worthy of feeling a sense of trust and belonging.

What inspired you to serve as a board member?

Simply said, representation matters. It is important for the communities we serve, the colleagues we welcome into our teams, and the students we educate in our learning spaces to see a reflection of themselves. As I think about the past couple of decades of being in this field, I have not seen anyone who looks like me in a leadership position. As a person of color, I have been privileged to hold space with others who identify as BIPOC (Black, Indigenous, and People of Color), students and colleagues, who have shared

their thoughts or feelings as they navigate the field of child life. Their collective words and sentiments have sat with me over time. With ACLP's recent efforts in the area of antiracism and DEI, I was motivated to serve as a board member. During the nomination process, a consistent question I considered was, "Why not me?" I have a great sense of hope for change in the future and value being in collaboration with others and seeing how far our efforts ripple into the future.

What experiences have you had in your career that have prepared you for serving on the Board?

Having held a clinical coordinator role and now as an academician, I bring my experiences and expertise from both lenses. The focus of my university's mission is community service which has provided me the opportunity to engage in local and global child life work. These experiences have supported my development of project management skills and ability to build relationships with the local and global community as well as clinical partners. I actively engage with processes and procedures as a director of clinical training and have awareness of academic programming while also walking alongside the student experience. This year I reached a milestone of ten years volunteering with the Association of Child Life Professionals (ACLP). My experience with multiple committee initiatives and my passion for supporting aspiring professionals has contributed to my investment as a board member. My combination of experiences has given me a unique perspective, and I have appreciated working in teams that have diverse skills and knowledge.

What is the Board working on right now that you are most excited for?

When ACLP shared a sneak peek into the new common internship application. I had an opportunity to participate in the early stages of the Internship Readiness Project. With continued feedback from all stakeholders about the need for a revised application, the work group considered bias and other barriers that have been consistently reported as challenges. We are grateful that there will be an opportunity to collect ongoing data in the future to gauge its accessibility and effectiveness and discover how all stakeholders are experiencing the new format.

What is one hope you have for the child life profession and where do you see it in the future?

My hope is that we can strengthen our collaborative relationships to withstand current and future challenges. The field of child life has not been immune to the stresses and pressures that have resulted from the pandemic. This has put a strain on all our stakeholders. I think our best work is done in community with each other. And as a community, I know we have the capacity to work in partnership through open communication and thoughtful approaches to identify solutions in response to the crisis at hand. With challenges, there are growth opportunities for the betterment of the field which directly impacts the students who are in our learning spaces, services we provide to patients and their families, and communities we serve.

How do you take time for self-care? What does self-care look like for you?

For me, self-care, or soul care, needs to be restorative. Being in nature helps to ground me and creative expression also helps when I need to release stress. Creativity can be anything from painting or crafting to trying out a new recipe idea. Recently, I joined a book club, and we are reading a book about burnout, and it has been very encouraging to talk with others about how we navigate the stress cycle. Lastly, I am a firm believer that self-care includes supporting my mental health. I regularly engage in therapy so that I can show up as my best self in my personal and professional relationships.

What is ONE thing you would like the child life community to know about the Board of Directors?

We are a group of dedicated volunteers who have various talents and interests. While each of us have our own focus area within child life, we want to hear from you! We learn and grow when we have opportunities to engage with various members and learn about their questions, concerns, and hopes.

ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH CHILD LIFE PRACTICE

by Kristin Brown, CCLS, Nemours Children's Hospital, Florida
Nicole Gandolfo, MA, CCLS, Child Life Manager, Nemours Children's Hospital, Delaware
Jenna Read, MS, CCLS, Supervisor of Child Life and Creative Arts Therapies, Nemours Children's Hospital, Florida
and Jana Teagle, CTRS, CCLS, CBIS, Senior Child Life Specialist, Nemours Children's Hospital, Delaware

As the topic of social determinants of health (SDoH) is becoming a more widespread discussion in healthcare, and clinicians begin to self-reflect and examine their practice to see how they can best address this need while supporting the whole patient, we must do the same in our field. It is a natural step to see the correlation between the skillset of child life specialists (CLS) and providing support for more widespread family psychosocial issues. SDoH include Adverse Childhood Experiences (ACEs), such as divorce, parental mental illness, bullying, substance abuse, emotional neglect and/or abuse, physical neglect and/or abuse and Health-Related Social Needs (HRSNs), like poverty/financial need, homelessness, unemployment, and hunger or food insecurity (Bottino et al., 2019). As child life specialists, we must first ask ourselves what, if anything, are we currently doing to address these crucial psychosocial issues? And second, how can we use the skills and competencies we pride ourselves on to be of better support in building the healthiest generation of children and teens?

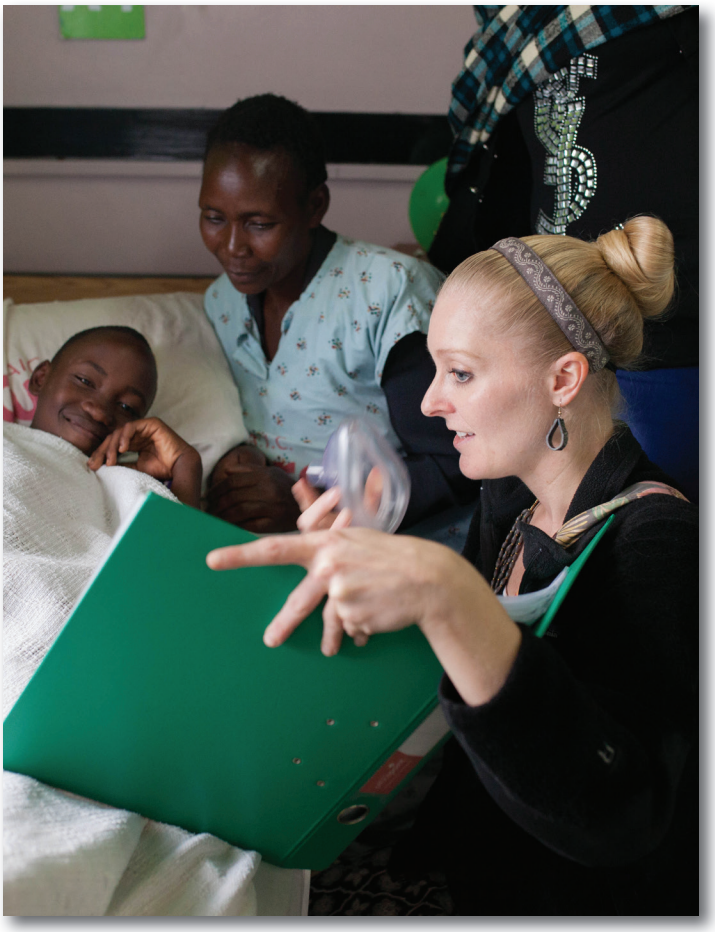


Photo provided by Katie McGinnis

Many of the children and adolescents who receive child life services can be classified as being "at risk" with regards to their physical and emotional health due to previously identified psychosocial stressors, ACEs, and social determinants. Masten and Barnes (2018) noted that singular adversities are rare, as the most severe forms of childhood adversity often reflect chronic, repeated, or combined exposures to traumatic events or hardships. Growing evidence links ACEs and other social determinants to risky health behaviors and other negative outcomes, including chronic health conditions, low life potential, poor learning capacity, and early death (Rollins et al., 2018).

Given the role of CLSs in supporting patients through stressful healthcare experiences, it seemed reasonable to question whether this role extends to family psychosocial issues and SDoH. Bottino et al. (2019) examined the frequency at which CLSs specifically address ACEs and HRSNs and if/how they provide support to patients who experience these. Eighty-five percent of 110 Certified Child Life Specialists (CCLS) surveyed reported addressing these family psychosocial issues at least once a month. CCLS respondents reported providing clinical services to support SDoH including coping strategies, family support, therapeutic play, psychological preparation, and distress management. Most respondents in the study reported that they gave equal or even higher priority to providing SDoH support as they did to medical procedures. One CCLS respondent said "I believe addressing psychosocial issues [SDoH] is an underrated part of the child life scope of field. Many times, the focus is on procedures and coping strategies, but family dynamics can directly affect how a patient does during hospitalization" (Bottino et al., 2019, p 854).

CLSs are astutely aware of how household stressors may impact feelings of shame, anger, worry, or helplessness in children. Additionally, these feelings don't always derive from the stressor itself but instead come from the internalization of parental stress and worry. When harbored, these feelings can directly affect a child's hospitalization and ability to cope with medical stressors not only in their present hospitalization, but also in their future. CLSs can facilitate the necessary emotional expression to learn problem-solving skills and identify coping techniques that children and families can transfer to stressors outside of their healthcare experience, such as homelessness, food insecurity, or other psychosocial concerns.

It can be hypothesized that one reason CLSs are readily able to provide support to patients impacted by social determinants of health is due to their status as a non-billable service. It should be noted that Principle 11 in the Child Life Code of Ethics states, "Certified Child Life Specialists recognize that financial gain should never take precedence over the mission, vision, values, and operating principles of the profession" (Association of Child Life Professionals, 2020). Child life programs do not bill for services provided within the hospital and therefore remain an accessible service to all patients and families, regardless of socioeconomic status. Despite the availability of child life support in most pediatric hospitals, it must be acknowledged that these services may not always be available to all pediatric patients. Limitations in staffing and resources may be potential barriers to accessing child life services, which may have greater impact to communities that are already under-resourced.

Children and families impacted by health disparities and adversity may also benefit from child life services outside of the hospital walls. Just as preventative healthcare is essential, preventative education surrounding psychosocial health and well-being is equally vital to children and their families. CLSs remain in the position to utilize community visits as an opportunity to

encourage and facilitate understanding of the importance of accessing healthcare, while also promoting protective factors, such as resilience, in a variety of ways. The scope of child life practice ideally positions specialists to support families in their caregiving roles and build on caregiver knowledge about their child's health and development. In the primary care setting, CLSs can educate parents on the importance of identifying risk factors and/or stressors in the lives of children and teens, while also nurturing lifelong capacities for health and well-being by identifying and promoting protective factors such as preferred coping techniques and supportive relationships where youth can seek out mentorship and help.

Together, as a profession, we must think beyond the traditional medical setting and envision how we can support patients, families, and providers in community settings to improve long-term patient health outcomes. CLSs can get involved in community outreach opportunities, such as mobile vaccine clinics, where they can teach easily accessible coping techniques to children and adolescents who can implement these strategies to make future healthcare experiences less scary and more comfortable. Additional activities, such as holding a community-based teddy bear clinic in your local library, can increase health literacy by allowing CLSs to provide preparation and medical play, fostering a positive association with healthcare experiences, reducing fear of the unknown, and likely increasing compliance with preventative care. Another non-traditional point of access to provide support to children and their families would be through educational settings where child life specialists can partner with school nurses, health educators, and school counselors. CLSs already conduct school re-entry programs for many patients, and these visits can present opportunities to teach the class basic health literacy.

One example of child life positively impacting SDoH is a grant-funded connection between a hospital child life program and an underserved pediatric primary care population in Wilmington, Delaware. The Children's Hospital Association, in partnership with the Toy Foundation, awarded $25,000 to child life specialists at Nemours Children's Hospital, Delaware with the goal of strengthening the social, emotional, physical, and behavioral development of children by making play more accessible. The grant focused on utilizing play-based opportunities to bridge the health equity gap through the lens of health literacy and increasing coping with stressful medical events in a community setting. The CLS collaborated with a community primary care team to assess the specific needs of their

Photo provided by Katie McGinnis

patient population. Medical play opportunities were provided for children and families to gain comfort and familiarity with stressful healthcare events. The families received kits that were specific to asthma, dental hygiene, eczema, and/or general coping. Each kit had both real and play medical paraphernalia, coping items, tip sheets for caregivers, and a QR code that linked to additional coping strategies and targeted medical play videos. Funding was used to provide developmentally appropriate bibliotherapy resources for the clinic to provide to continue fostering health literacy. Families were provided with contact information for the CLS and asked to share their feedback via simple survey questions. Families responded positively to the kits, with one parent directly reporting that her child coped more positively with her diagnosis after receiving the materials. Other outcomes included better understand of dental hygiene, pinwheels helping children cope with stressful healthcare events, and improved comfort with stethoscope use due to medical play materials.

The importance of establishing a foundational connection between psychosocial care professionals and healthcare providers is paramount. To accept the World Health Organization's definition of health as a state of physical, mental, and social well-being leads to the understanding that health literacy and resilience must derive from stronger health care systems; improved population health; and developing capabilities to sustain physically, mentally, and socially healthy individuals and communities (Wulff et al., 2015). With the combined support of healthcare professionals, families, and other social connections, children and adolescents can appropriately overcome stressful situations (Pettoello-Mantovani et al., 2019). In extending our collaboration to include key community partners, such as pediatric primary care, public libraries, and schools, child life specialists incorporate our training, sometimes without noticing, as we work to mitigate some of the disparities in the current healthcare system. The end goal for child life specialists remains to not only be able to recognize the difficulties and barriers that our patients and families face, but to continue educating, advocating, and collaborating to address the need for protective factors and provide services and resources that have lasting impacts outside of the hospital system.

References:

Association of Child Life Professionals (2020). *Child life code of ethics.* https://www.childlife.org/docs/default-source/aclp-official-documents/child-life-code-of-ethics4232ee9c90156ede9dafff00004f030f.pdf?sfvrsn=5327804d_2

Bottino, C., Daniels, A., Chung, M., & Dumais, C. (2019). Child life specialists' experiences addressing social determinants of health: A web-based survey. *Clinical Pediatrics, 58*(8), 851-856. https://doi.org/10.177/009922819839233

Masten, A. S., & Barnes, A. J. (2018). Resilience in children: Developmental perspectives. *Children, 5*(7), 98.

Pettoello-Mantovani, M., Pop, T. L., Mestrovic, J., Ferrara, P., Giardino, I., Carrasco-Sanz, A., ... & Çokuğraş, F. Ç. (2019). Fostering resilience in children: The essential role of healthcare professionals and families. *The Journal of Pediatrics, 205*, 298-299.

Rollins, J. H., Bolig, R., & Mahan, C. C. (2005). *Meeting children's psychosocial needs across the health-care continuum* (pp. 119-174). Pro-ed.

Romito, B., Jewell, J., Jackson, M., and AAP Committee on Hospital Care; Association of Child life Professionals. (2021). Child life services. *American Academy of Pediatrics, 147*(1). https://doi.org/10.1542/peds.2020-040261

Thompson, R. H. (2018). *The handbook of child life: A guide for pediatric psychosocial care.* Charles C Thomas.

Wulff, K., Donato, D., & Lurie, N. (2015). What is health resilience and how can we build it? Annual Review of Public Health, 36, 361–374. https://doi.org/10.1146/annurev-publhealth-031914-122829

Zolkoski, S. M., & Bullock, L. M. (2012). Resilience in children and youth: A review. *Children and Youth Services Review, 34*(12), 2295-2303.

MORE THAN A HAND TO HOLD

Rethinking Caregiver Support in the Emergency Department

by Shelby Strauser, MA, CCLS, Certified Child Life Specialist II, Texas Children's Hospital, Emergency Center

Imagine receiving a phone call from your significant other that your child is being rushed to the nearest children's hospital emergency room (ER) after getting hit by a car. Your significant other explains that your child was hit by a car and is currently unconscious. You leave your job immediately and drive to the hospital, not knowing what you may encounter once you arrive. You run towards the ER and completely miss the sign plastered to the doors stating, "COVID-19 Protocols only allow each patient to have one caregiver at their bedside at any time." Upon reaching the doors, you are stopped by a hospital staff member, and with a gesture towards the sign, they explain that you will not be let in the hospital. They offer you your only option, waiting in your car to get updates via your cell phone about your child's health from the caregiver already present with them. You turn around, find the nearest bench, and begin to process what has just occurred.

Inside the hospital, the Certified Child Life Specialist (CCLS) quickly assesses that the patient's mental status is not appropriate for bedside support, and turns their attention to the caregiver. They find a sweaty, pacing father alone outside the room. The CCLS introduces themselves and their role, brings them a chair, and begins to assess the parent's understanding. The CCLS explains the trauma room and who is currently working on their child, while continually validating the overwhelming nature of the situation. The CCLS asks about the child's other caregivers and explains the visitation policy in detail to the father. The father expresses how terrified and alone they feel, and the CCLS quickly assures him that the CCLS themselves will be there for support every step of the way.

As a CCLS within the pediatric hospital setting, when I reflect on the pandemic's impacts on my role, these are the kinds of experiences

that come to mind. As the COVID-19 pandemic began, hospitals across the world enforced new guidelines regarding family members and caregivers' presence during appointments, visits, or admissions. Children's hospital administrators were forced to decide whether one or both patient's primary caregivers could be present for a hospital admission, surgery, or even an ER visit. Hospital staff members, like CCLSs, were left to enforce rules they knew would bring additional stress to an already overwhelming experience. At my hospital, patients were limited to one caregiver at their bedside in the ER. Siblings, extended-family members, and friends were not allowed at bedside, unless exceptional circumstances (i.e., end of life) warranted leadership approval. Knowing this, I found myself using my assessment skills to identify the unique needs of the caregivers I met during each shift.

As CCLSs, caregiver support is well within our scope of practice and often an integral part of the role in critical care areas such as the ER. Working at a Level 1 trauma center means that I expect to see patients of all acuities daily. Prior to the pandemic, I provided parental support often during interventions such as intubations, resuscitation, or the new diagnosis process. What has dramatically shifted due to COVID-19 visitation protocols is the role I play in these intense moments. What previously felt like problem-solving, such as assisting caregivers in navigating how to get to the ER or spending time with siblings so that all caregivers could be present at bedside for updates and patient support, switched to

assisting the present caregiver to the ER exit so they could physically update those who could not be in the hospital or ensuring that doctors spoke directly into a cell phone so that other caregivers could hear the newest medical updates. Previous acts of bringing water and blankets to worn out caregivers then became sitting with the child while the caregiver used the restroom or picked up food from the cafeteria. Instead of making sure a family had a card game to play during a long wait, I found myself asking if they needed to borrow a phone charger to extend the FaceTime calls to home to discuss a child's condition or plan of care. Over the past two years, I have had countless moments just like this where I had to step into the role of the "second caregiver" who provided support to the parent or caregiver at bedside.

My assessment priorities changed as the role of the second caregiver came to fruition. Conversations that used to be focused on previous hospital experiences, personality and interests of the patient, and short-term goals shifted to include discussions regarding family make-up, social history, and current stressors or worries of the caregiver. These bits of information would assist me in advocating for how further conversations could be handled with the family, such as ensuring that all doctors could be present at once so the child's other caregiver could be included through video chat and could ask questions themselves. For patients and families who were learning about a suspected new oncological diagnosis, it changed the way I made initial assessments in these situations. Knowing that the caregiver at bedside with their child was going to be alone with the medical team when learning the news of a tumor being found or abnormal bloodwork concerning for leukemia, I made it a priority to build rapport with both the patient and the caregiver early on. I knew how valuable it would be for my face to seem "familiar" when life-changing news was later given.

Fortunately, current protocols at my workplace have changed. Two caregivers are now allowed at bedside during ER visits, and extended family members and siblings can visit a patient within a specific protocol. As a CCLS, I quickly saw the positive impact this change had on my patient's ability to cope through procedures and caregivers' ability to cope with new diagnoses and medical decision-making. Though I now find myself having more typical caregiver support interventions, the experiences I had during the pandemic increased my confidence in how to advocate for the needs of patients and their loved ones, whether present or not. I found myself becoming comfortable in conveying my assessment of not only the patient's needs, but the caregiver's needs as well. For example, when working with new mothers whose young infants were being admitted, I always ensured they knew we had breast pumps available for use in the ER and access to a fridge or freezer for storage. Even something as simple as advocating that our child life team use part of our yearly budget to purchase phone chargers to provide to families in need has made a difference in the ways we can support the caregivers we see daily. Advocacy is a vital part of child life, and I experienced unprecedented growth in my confidence in speaking to members of the medical team and leadership to express the unique needs of each patient and family and to encourage the team to get creative in the support we provided. Just as we look to provide children with appropriate choices to give control, when possible, I learned how I could advocate for the same opportunities for their caregivers and loved ones as well.

ACLP COMMITTEE UPDATES

CLCC TRANSITION TO A 501 (C) (6)

This Work Group will complete the necessary tasks to establish the Child Life Certifying Commission (CLCC) as a 501(c)(6) to work with staff to review documents provided by legal counsel such as bylaws, governing, and resource sharing documents. This status will allow for certification activities to proceed without income tax liability. Certification revenue in the nonprofit space is considered Unrelated Business Income Tax (UBIT). ACLP will still maintain financial and legal oversight of the new Child Life Certification Commission. No impact on programs as a result of this change.

ACADEMIC EXCELLENCE TASK FORCE

AETF found through benchmarking related professions and our own profession that academic institutions and professions value accreditation and recognize it as a valuable process for recognizing academic excellence. We have identified challenges and provided suggestions to the ACLP Board of Directors for increasing diversity related to the process of recognizing high quality educational standards.

ARCHIVES MANAGEMENT

The Archives Committee has updated the online submission for child life program histories. We are looking for histories from both clinical and academic programs. You can submit a program history here: https://www.childlife.org/resources/for-child-life-specialists/aclp-archives

AWARDS

The Awards Committee reviewed applications for the MBA, DSA, and Research Awards. We are excited to share the 2023 winners during Child Life Month.

BOARD DIVERSIFICATION TASK FORCE

This task force is currently observing the new Board of Directors interview process; providing feedback on nominating documents and processes; and making recommendations for changes based on observations and best DEI practices are in the process of being planned.

CLCC

The CLCC is currently working towards National Commission for Certifying Agencies (NCCA) accreditation and turning into a 501c6. We also are currently working with Prometric for item development (question and exam development) and a job analysis.

CONFERENCE PROGRAM

We reviewed 117 abstracts this year, which was a great increase from the past few years. We also had 100% engagement from the review committee. The positive energy is strong around making our next conference the best one yet. We are excited that the new submission system worked well and we are eager to discuss how we can continue to refine our systems for submission and review to ensure that our conference is full of content that reflects our mission and values.

D.E.I.

This year, we've been prioritizing hands-on work from all committee members. In the past, the same individuals took on lead roles; however, this year, with the restructuring of meetings and responsibilities, all members are making individual contributions towards specific tasks that are tied to our priorities. There are subgroups that also allow for more collaborative work. There has been success in identifying presenters for the member-of-color meet ups, developing a robust shared excel document outlining the various Historically Black Colleges and Universities., Hispanic-Serving Institutions, Tribal and Community Colleges/Universities, and presenting on health equity to membership.

PATIENT AND FAMILY EXPERIENCE

The Patient and Family Experience Committee is continuing to work towards planning of the Emotional Safety Summitt II happening in June of 2023.

PRE-INTERNSHIP WORKSHOP

The Pre-Internship Working Group comprehensively reviewed previously created and unreleased pre-internship learning modules, with a particular focus on DEI. DEI topics and resources are now interwoven throughout all five modules. The working group aligned the modules to the KSAs, with curriculum inclusive of pre-internship experiences in healthcare and other community-based settings.

PUBLICATIONS

The committee is currently undergoing an audit of all ACLP publications which will be used to determine and prioritize which publications should be revised or sunsetted in the future.

ACLP COMMITTEE MEMBER SPOTLIGHT

Meet Lauren Holley

Name: Lauren Holley

Pronouns: She/Her/Hers

Title: Professional Development Specialist

Location: Child Life On Call and instructor at the local technical college, Athens, GA

Committee / Committee Role: Education and Training Committee - Committee Member

How long have you been a volunteer with ACLP; have you served on other committees previously?

Volunteer since June 2022, first time ACLP volunteer

Why did you want to become a volunteer with ACLP?

I wanted to help fix things and be a part of the change. I enjoy working with students and in academics and want to give them a voice. I was a clinical CCLS and can bring that perspective to the ACLP as well.

What's your favorite part of volunteering with ACLP?

I enjoy learning from others in the field. There are such various experience levels in my committee, so I enjoy hearing what others are doing, what's going well, what are the challenges, etc. I like to listen to others and learn about different experiences throughout the field.

If you could offer advice to a new volunteer, what would you say?

Do it! There are so many different committees, that there is something that is interesting to everyone and you can meet so many different people from different place and situations.

What is one thing you've learned as a volunteer?

I learned that there are so many people on my committee that are very passionate, and that's been exciting to see how many people are advocating for students and the student experience.

What is one fun fact you would like the child life community to know about you:

In college, I studied in London and had an internship at a daycare.

DIVERSIFYING THE FIELD

Supporting the Development of Child Life Academic Programs at Historically Black Colleges & Universities and Hispanic-Serving Institutions

by Belinda Hammond, EdD, CCLS, CIMI, Eastern Washington, University Lecturer, Children's Studies, Child Life
Katie Walker, PhD, CCLS, Eastern Washington University, Assistant Professor, Children's Studies, Child Life
Jennifer Beasley, PhD, North Carolina A&T State University, Assistant Professor, Family & Consumer Sciences
Chiara Bacigalupa, PhD, Sonoma State University, Chair & Professor, Early Childhood Studies
and Linda M. Platas, PhD, San Francisco State University, Chair & Associate Professor, Child & Adolescent Development

With the current population of Certified Child Life Specialists (CCLS) reflecting 91% Caucasian, 1.5% Black/African American, and 3% Hispanic (ACLP Member Survey, 2018), representation of the diverse populations we serve has not yet been established. This lack of racial diversity has been widely recognized in the field, and several conversations have taken place exploring how to best impact representation. With many clinical supervisors sharing that racial and ethnic diversity is not currently represented in applications received for clinical practicums and internships; as such, we recognized the need for students to begin exploring child life within their community, long before clinical experiences are sought. We realized our child life community was not seeking out racial and ethnic diversity, yet expecting it. Racial and ethnic diversity can be impacted by identifying where racially and ethnically diverse students find their academic community. This means finding students where they are studying and collaborating with Historically Black Colleges and Universities (HBCUs) and Hispanic-Serving Institutions (HSI) to introduce students to the field of child life (Hammond, 2021). In recognition of ACLP'S Diversity, Equity, and Inclusion

(DEI) initiative, Eastern Washington University (EWU) is piloting a mentorship program for the development of child life academic tracks within HBCUs and HSIs to specifically impact the students pursuing degrees through these academic institutions.

Mentorship is described as a "guiding relationship" (Waddell et al., 2016) and is recognized as a valued element of supporting growth in the field of child life (Beltran, 2021). Eastern Washington University's child life mentorship program was created as an action step towards increasing racial and ethnic diversity in the child life field and as a passion project for the faculty involved. To date, the HBCU and HSI academic institutions, North Carolina Agriculture and Technology State University (NC A&T, HBCU), Sonoma State University (SSU,HSI), and San Francisco State University (SFSU,HSI) are collaborating with EWU's child life mentorship team to begin the process of gaining course approvals for child life courses in Fall 2023. Each of these universities had previously explored offering child life courses but found it was difficult to proceed without a CCLS on faculty to provide guidance. Our hope is to continue providing mentorship to HBCUs and HSIs until their child life programs are sustainable without our support.

DEVELOPMENT OF THE MENTORSHIP MODEL

The idea of a mentorship program was initially developed by Belinda Hammond during her doctoral dissertation. One theme identified in thematic analysis was the lack of child life academic options in HBCU programs and how important this felt to the student to not have the option of pursuing her studies within what she felt to be her community. Hammond received feedback on how much child life education was needed at the undergraduate level, how there were no child life academic tracks at HBCUs, and how this could impact DEI within child life. This participant was eager to begin a career in higher education, specifically teaching with her local HBCU, so we started by exploring what was in place and what was needed for the HBCU closest to her to offer a child life track. As a California resident, Hammond was introduced to both of our HSI partner programs after they contacted a local CCLS for guidance. Thus far, our connections with the HBCU and HSI institutions involved have relied on networking with our students and colleagues.

MENTORSHIP STRUCTURE

Currently, each of these three schools are in a different state of program development. This is due to the timeline for getting courses approved through each university's curriculum committee, as well as when the opportunity has existed to pilot classes prior to university curriculum approvals. The mentorship process continues to evolve as we encounter new opportunities and challenges at each collaborating institution. Described below is the general structure of what we strive for the mentorship program to include.

After the EWU mentorship team was established, a meeting was set with the department chairs and other academic stakeholders at each of the institutions. These meetings allowed the mentorship team to meet the key players at each institution and gain a better understanding of the existing collaborative programming available locally to support child life students, as well as the existing faculty in place to support new course development. The mentorship team worked with faculty to determine which ACLP required courses each school was already offering and which may need further development. The teams worked together to complete necessary documentation for the schools' curriculum committees to approve newly developed courses and to determine what local experiences may already exist for students to gain exposure to child life under a CCLS (e.g., hospital settings, medical camps).

Once the initial structure of a child life program was outlined, it was time to recruit students. With two programs actively running, each was offered Q&A sessions for students in both Early Childhood/Child Development, as well as in related majors, such as psychology, education, and various pre-professional programs (e.g., pre-med, nursing, various therapies). Sonoma State University provided the opportunity to participate in the Q&As within an Early Childhood Studies course and for broader interest across the campus, while San Francisco State university had enough interest in the program to ensure the classes would be offered without hosting a Q&A. By offering child life courses to both students pursuing child life as well as those outside of a

MENTORSHIP PROCESS

Identify academic stakeholders (faculty, department chairs, etc) and schedule an initial meeting to discuss mentorship needs

Exploration of ACLP required courses currently offered and those still requiring development

Exploration of local experience opportunities under CCLS (hospital, medical camp, non-traditional setting)

Exploration of needed documentation for curriculum committee approvals for remaining courses

Development of course outline for courses remaining for ACLP academic requirements

Exploration of local potential CCLS faculty (continued throughout program development as needed to staff courses)

Offer a Q&A session about child life for child development and related majors

Ongoing conversation about program needs (i.e. child life elective options, local volunteer opportunities)

Continued exploration of grant funding

Continued exploration of clinical sites providing either housing or student stipend for living expenses

child life major, two goals were achieved: enrolling enough students to ensure the classes would have the required minimum enrollment to move forward and educating others on some essentials of child life practice which could ensure pediatric patients received pediatric friendly care from child life as well as through other related fields. Many students pursuing these other careers never receive specific training in helping children cope with medical experiences. Thus, coursework that focuses on the therapeutic use of skills to support successful coping can benefit students in multiple majors, which can include interacting with children in stressful situations.

Finally, local CCLSs were hired to teach the new child life courses for each of the two HSI programs, with recommendations made for the HBCU campus for their Fall 2023 start. This is an ongoing process as each university continues to expand its course offerings. The mentorship team and each of the universities are currently involved in ongoing conversations regarding additional program needs, exploring grant funding, and looking at potential clinical sites for students to gain field experience.

Though the EWU mentorship program is in its infancy, we are hopeful this is a step toward progress. With three collaborating universities actively developing their child life academic programs this year, we are eager to support an additional three to four programs for a Fall 2023 start, all of whom are actively in discussions to develop their child life academic programming and community collaborations. The lack of awareness of child life in many academic settings, as well as the belief that child life skills are only valuable in hospital, are certainly barriers we hope to remove through education, data, and the mentorship program. We are just beginning to explore affiliation agreements on behalf of these academic institutions and are thrilled with the response so far, especially with those hospitals exploring affiliation with HBCU and HSI campuses without an active offer having been made to a student. The EWU mentorship team is actively exploring grant funding opportunities to support further development of these academic programs as well as to provide stipends for student living expenses during clinical training. Additionally, we plan to pursue funding for original research on the mentorship program itself. While studies have been conducted to explore mentorship for new academic faculty (Law et al., 2014; Waddell et al., 2016; Nowell et al., 2017; Martin et al., 2018), none have been done to study mentorship for establishing new academic programs. Our hope is to further explore the impact of mentorship to establish child life academic programs for students in underrepresented communities.

FEEDBACK FROM PARTNER PROGRAMS

Q: How did you learn about child life?

- *Dr. Jennifer Beasley, NCATSU, HBCU NCATSU:* We first learned of *child life* through a meeting that was set up by Dr. Belinda Hammond with our FCS department chair. Dr. Hammond reached out to our department chair to initiate discussions about the Child Life Specialist Program and our chair invited the Child Development Program area faculty to the meeting.
- *Dr. Chiara Bacigalupa, SSU, HSI:* A faculty member had previous experience as a volunteer in the Child Life Program at UCLA Medical Center.
- *Dr. Linda M. Platas, SFSU, HSI:* Manager and staff from UCSF Benioff asked if they could come and present to students – after that we've invited them back every year.

Q: How did mentorship make adding the needed courses possible?

- *Dr. Beasley, NCATSU:* Two of the main components of mentorship that have been helpful include: 1) Shared knowledge and expertise of our "mentors" regarding the child life program and the curriculum required for the program. For example, Dr. Hammond and Dr. Walker have been able to review our current child development classes and have advised us on what classes needed to be added to our program area to develop the child life specialist program. 2) The second component of mentorship that has been helpful is accountability. Dr. Hammond and Dr. Walker have been quick to respond to our questions and have offered guidance and a gentle push to keep us moving forward despite any obstacles we face.
- *Dr. Bacigalupa, SSU:* We do not have faculty members with recent or extensive experience in this field, so we did not know what students needed to take, and we did not have the expertise to develop the courses on our own.
- *Dr. Platas, SFSU:* I wouldn't have known how to align/create courses without it.

Q: What are the major lessons learned through mentorship so far?

- *Dr. Beasley, NCATSU:* Honestly, we have learned more specifics of the child life specialty field including the priority to diversify the field. We have also learned that the child life field is well-connected (from hospitals to medical camps to academia) and is supportive of the expansion of more child life professionals.
- *Dr. Bacigalupa, SSU:* We have a better understanding of the field and how to support students. We have been able to connect with child life specialists in California who can serve as faculty and advisors for our students. Really, we need a full-time faculty member who can devote some of their time to thinking through how to develop a robust program, but our faculty is currently too small for the number of programs we run and the amount of work that we do.

Q: Did you face any unanticipated challenges so far through the process? How did/are you going about solving them?

- *Dr. Beasley, NCATUS:* The biggest challenge to date has been the time and capacity to develop the program and focus on moving it forward due to faculty overload at our university (and likely many others!). When faculty are on multiple research projects, teaching, advising students, and serving on numerous committees, priority does not necessarily go to development of new programming. However, we are in the process of writing a proposal

to support the development of the child life program and if funded, will allow faculty time and effort to prioritize the challenge of time and capacity of the development of the Child Life Program.

- *Dr. Bacigalupa, SSU:* We want to work on practicum opportunities in the future, but do not currently have the resources to make that happen. We also live in an area that does not have local child life programs, so we are feeling somewhat stuck about how to help our on-campus students with this piece. In addition, if we were to add a formal program, that would require a minimum of one year's time for approvals.
- *Dr. Platas, SFSU:* The academic process takes a long time. Need to be approved at various levels

Q: How do you plan on recruiting students to the newly formed program?

- *Dr. Beasley, NCATUS:* We plan on recruiting students through not only our existing student base here in our department but with a marketing campaign to recruit across our university from other related departments (e.g., Psychology, Nursing, etc.). We also plan to seek the guidance of our mentors on how to market, advertise, and recruit from outside our university.
- *Dr. Bacigalupa, SSU:* We do not currently have a program, but do have individual classes. If we were to put one together, word of mouth and information on our website is often our best recruiting tool. We probably need help deciding on the best way to present this information so that we do not over- or under-promise on what we are able to provide right now.
- *Dr. Platas, SFSU:* Don't have a formal program yet, however we keep track of career goals for all of our students

References:

Association of Child Life Professionals (2018). *ACLP membership survey.* https://www.childlife.org/docs/default-source/default-document-library/aclp-2018-year-in-review.pdf?sfvrsn=454cb24d_4

Association of Child Life Professionals (2020). *2018 year in review.* https://www.childlife.org/docs/default-source/default-document-library/aclp-2018-year-in-review/pdf?sfvrsn=454cb24d_4

Association of Child Life Professionals (nd). ACLP Diversity, Equity & Inclusion (DEI) Action Plan. https://www.childlife.org/about-aclp/diversity-equity-inclusion

Beltran, L. (2021). *Exploring mentoring experiences of child life specialists working with chronically ill children.* [Doctoral dissertation, Capella University]. ProQuest Dissertations.

Hammond, B. (2021). *Development and implementation of a child life community practicum offered virtually,* [Doctoral dissertation, Fresno State University]. ProQuest Dissertations.

Law, A., Bottenberg, M., Brozick, A., Currie, J., DiVall, V., Haines, S., Jolowsky, C., Koh-Knox, C., Leonard, G., Phelps, S., Rao, D., & Yabloshki, E. (2014). A checklist for the development of faculty mentorship programs. *American Journal of Pharmaceutical Education,* 78 (5), 98.

Martin, J., & Douglas, D. (2018). Faculty mentorship: Making it work across the career continuum through development, implementation, and evaluation of a formal mentorship program. *Nursing education perspectives,* 39 (5), 217-218.

Nowell, L., Norris, J., Krklas, K., & White, D. (2017). A literature review of mentorship programs in academic nursing. *Journal of Professional Nursing,* 33, 334-344.

Waddell, J. Martin, J., Schwind, J., & Lapum, J. (2016). A faculty-based mentorship circle: Positioning new faculty for success. *Canadian Journal of Higher Education, 46* (4), 60-75.

MAKING PHONE CALLS PRIOR TO HOSPITALIZATION

by Elise Huntley, MA, CCLS

The outpatient world moves quickly. Your patient comes in for their scheduled appointment, you say hi and provide a brief preparation before the rest of the staff come in to get the procedure started. The procedure or hospital visit ends, the patient and family leave, and you're on to your next appointment. So how can child life specialists optimize the support we provide for these patients and their families? One solution I have found is making phone calls to families.

After working in radiology, surgery, and as a member of the behavioral safety team, I've spent my fair share of time on the phone. I've provided detailed explanations and preparation materials to parents to share with their child prior to an MRI. I've discussed how families may cope with surgery visits and what supports might make their time in pre-op more comfortable. Currently I work with our behavioral safety team discussing patient's behaviors and support needs prior to a visit to keep patients and caregivers safe while getting patients' essential medical care. In all these roles, a phone call has been a valuable tool in helping me assess, prepare, and support before the patient even arrives at the hospital.

WHY MAKE A PRE-ADMISSION PHONE CALL?

A pre-admission phone call gives the Certified Child Life Specialists (CCLSs) a chance to assess the patient and family without the hustle and bustle of the hospital. Assessment is one of the most integral and basic roles of a child life specialist (Turner et al., 2009), and a phone call can be an instrumental tool in the assessment process. A phone call, along with chart review and in-person assessment, can help you best prioritize the patient's needs on your unit. Every child is different, and a phone call to assess ways to support a patient's coping can be helpful in adapting care to the unique needs of a child. This phone call not only helps you assess patient needs, but it is a private conversation with a caregiver where you can be honest about what to expect and allows the caregiver to ask questions or express concerns that they might be hesitant to bring up in front of the child. During a pre-admission phone call, you can begin to plan what resources you might want to have available such as noise-cancelling headphones or other sensory adaptations. This information can also be helpful when evaluating a census and determining priorities for the day.

Preparation lowers fear and anxiety when provided in a developmentally appropriate way and is considered an important element of any child life program (American Academy of Pediatrics, 2021; Official Documents of the Child Life Council, 2011). By calling the family prior to admission, child life specialists can provide some developmentally appropriate preparation before the patient ever arrives at the hospital. Jaaniste et al. (2007) found that children benefit from preparation that starts about a week before their hospital visit. Over multiple studies, Bray et al. (2019; 2021) found that both children and caregivers wanted more preparation and information but didn't seek out the answers to their questions for a variety of reasons, including not knowing where to look or whether the information they found would be applicable to their experiences. A preparation phone call gives CCLSs a chance to provide caregivers and patients with the information they may need to begin preparing for an admission or outpatient procedure. The preparation phone call has also been associated with success in MRI non-sedate programs. Fraser et al. (2019) considered that phone call assessment as the essential first step in a child's participation in the non-sedate MRI program, and Durand et al. (2015) found that the phone call from a CCLS provided a significant reduction in the need for anesthesia for MRI patients.

The pre-admission phone call is also helpful for patients with developmental delays and special needs. Parents and caregivers are the experts on their children, and Taghizadeh et al. (2015) considered it ideal to talk to the caregivers before any procedure. In a study looking at the role of child life specialists in supporting patients with autism, partnering with the family was an essential part of the care provided by these CCLSs, especially when it came to reaching out prior to admission to individualize the care that the patient would receive (Fraatz et al., 2021). Following the individualized plan created prior to a pre-op visit was found to decrease the need for sedation in over 60% of patients with autism (Swartz et al., 2017). When a phone call is made before visiting the hospital, the child life specialist can provide guidance about stressors and address environmental factors that might be adjusted to make the hospital visit easier (McGee, 2003). By calling ahead, the CCLS can have detailed information before the day of the patient's visit to accurately prioritize patient needs.

PREPARING TO MAKE A PHONE CALL

The first step is to gather the relevant

information that you need to make the call, including the patient's name, age, any pertinent diagnoses, reason for their upcoming hospital encounter, and their legal guardian's name and phone number. I sometimes find it helpful to write down how I will introduce myself and what I will share with the caregiver prior to calling the family. I typically focus on my role in the department that the patient will be visiting and why I'm calling. For example, if the patient is going to have an MRI, I would say I'm calling because my role is to provide MRI preparation. If I'm calling because the patient has autism and will be visiting an outpatient clinic, then I would say I'm calling to learn more about their child's needs and discuss ways to make their hospital visit as easy as possible. As you make more and more phone calls, you'll find you become more comfortable, and gradually you won't need the script when you call. If I'm looking to gather information, I will often print out a form with blank areas to fill in during our conversation.

MAKING THE PHONE CALL

When you call and someone answers, the first thing to confirm is that you are speaking to the patient's legal guardian. When they confirm this, you can share who you are and why you are calling. If it's a preparation phone call, then offer to share preparation materials and encourage the caregiver to have conversations with their child about what will happen during their procedure or admission. By providing accurate information, you are empowering the caregiver. This is also a time to clarify common misconceptions, such as that MRI contrast won't make the child feel warm all over like the contrast used for a CT scan or that having an MRI with contrast means the child will need to have an IV. For individualized plans for patients with a development delay or special needs, it can be helpful to discuss the child's likes and dislikes. This will give you information about how to adapt the environment and other ways to support their coping. During the conversation, caregivers might ask things that you don't know the answer to. That's okay – the important thing is that you're giving them a space to share and ask those questions. Just tell them you don't know but that you'll figure out who to talk to and find answers. Write down their questions and follow up with appropriate staff to address these, either during the family visit or in another phone call.

AFTER THE PHONE CALL

After the phone call, make sure you document the conversation. A phone call is an encounter with the patient's caregiver, and you've either shared information with the family or gained information from them that would be helpful for the rest of the team to know. It's essential that you document relevant information to provide continuity of care for your patients. You will also be able to use much of the information gained when planning for future appointments.

POTENTIAL OBSTACLES

Nothing is exempt from obstacles and roadblocks, and making phone calls is no exception. One concern that other staff might bring up is that caregivers won't want yet another

PHONE CALL TIP SHEET

PLAN AHEAD:

- Check the chart to see what you can learn ahead of the phone call.
- Write a script with how to explain your role and what you want to ask.
- Write notes so you don't forget what information you want to chart about.

GIVE YOURSELF TIME:

- Aim to call a week before the appointment, so you can try to call back if you don't reach a caregiver.
- Call early in your shift if possible so caregivers can call you back the same day.

MAKE IT EASY FOR CAREGIVERS:

- Call caregivers from the phone number that you want them to call. Some parents will call right back without listening to the voicemail or what number they should call.
- Speak slowly and give caregivers time to share their questions, worries or concerns.
- If parents ask something that you don't know, that's okay. Write it down to find out the answer or transfer them to someone else more appropriate.

phone call on top of the scheduling and reminder calls they already receive. In my experience, caregivers are typically very appreciative of my phone call when they realize that it's different from the arrival time reminders. Swartz et al. (2017) found that caregivers really appreciated when staff recognized that their child was unique and wanted to provide individualized support to the child. Because child life specialists are trained in family-centered care, the child life phone call is often a chance for parents to ask questions they might not have otherwise mentioned or may have forgotten to ask on an earlier phone call.

But even if they want the call, families might not have time to talk. I always check when they first answer if they can talk at that time, and if not, I'll inquire as to whether another time might be better. Sometimes email is easier for families, especially if you're sending information, so this could be another option for the caregiver that doesn't have time to talk. You can also shorten your information to what's most relevant to the patient and family.

When you call, you won't always reach the guardian. When you leave a voicemail, do not say the patient's name as that is a HIPAA violation. I typically say I'm calling from the hospital name to speak with you about your child's appointment, and then I briefly mention why I'm calling and how that's different from other calls before leaving a call back number. If the family does not speak English, I would encourage utilizing your hospital's interpreting services to reach out to these families.

As child life specialists, time is at a premium, so it's natural for this to be a concern when considering adding phone calls to your to-do list. Depending on the nature of the call, it can be as quick as 10-15 minutes. Another helpful trick that I've found is calling a week in advance for the first call. This gives some wiggle room if you get busy with direct clinical work. It can be hard to prioritize a phone call when there is a patient on your unit needing support now, so planning can allow for you to make important prioritization decisions while also calling caregivers.

A preparation phone call can also shorten in-person preparation time later and potentially decrease the need for direct procedural support. Sometimes the phone call will give you a chance to assess whether a patient needs child life support or will cope well independently, freeing up your time to focus on another patient's needs during their visit. By calling to assess a child's coping and sensory preferences, you can also proactively adjust the environment and set the child up for success to avoid the need for future de-escalation.

It can feel overwhelming trying to figure out how to start the process of making phone calls and identifying what kind of information to obtain or discuss. But the content of the phone call is something you're already trained to do; the only difference is that it's on the phone instead of in person. You know how to assess patients and families and what kind of information you're looking at during your assessment. You know how to prepare patients using developmentally appropriate terms. You know what kinds of questions to ask a caregiver prior to the procedure to make it as successful as possible. The phone call might be new to you, but the support you're providing isn't.

References:

Bray, L., Appleton, V., & Sharpe, A. (2019). 'If I knew what was going to happen, it wouldn't worry me so much': Children's, parents' and health professionals' perspectives on information for children undergoing a procedure. *Journal of Child Health Care, 23*(4), 626–638. https://doi.org/10.1177/1367493519870654

Bray, L., Appleton, V., & Sharpe, A. (2021). 'We should have been told what would happen': Children's and parents' procedural knowledge levels and information-seeking behaviours when coming to hospital for a planned procedure. *Journal of Child Health Care, 26*(1), 96–109. https://doi.org/10.1177/13674935211000929

Durand, D. J., Young, M., Nagy, P., Tekes, A., & Huisman, T. A. (2015). Mandatory child life consultation and its impact on pediatric MRI workflow in an academic medical center. *Journal of the American College of Radiology, 12*(6), 594–598. https://doi.org/10.1016/j.jacr.2014.12.015

Fraatz, E., & Durand, T. M. (2021). Meeting the needs of children with autism spectrum disorder and their families in hospital settings: the perspectives of certified child life specialists and nurses. *The Journal of Child Life: Psychosocial Theory and Practice, 2*(2). https://doi.org/10.55591/001c.27703

Fraser, C., Gray, S. B., & Boles, J. (2019). Patient awake while scanned: program to reduce the need for anesthesia In pediatric MRI. *Pediatric Nursing, 45*(6), 283–288

Jaaniste, T., Hayes, B., & von Baeyer, C. L. (2007). Providing children with information about forthcoming medical procedures: A review and synthesis. *Clinical Psychology: Science and Practice, 14*(2), 124–143. https://doi.org/10.1111/j.1468-2850.2007.00072.x

McGee, K. (2003). The role of a child life specialist in a pediatric radiology department. *Pediatric Radiology, 33*(7), 467–474. https://doi.org/10.1007/s00247-003-0900-2

Child Life Council. (2011). *Official documents of the Child Life Council.*

Romito, B., Jewell, J., Jackson, M., Ernst, K., Hill, V., Hsu, B., Lam, V., Mauro-Small, M., & Vinocur, C. (2021). Child life services. *Pediatrics, 147*(1). https://doi.org/10.1542/peds.2020-040261

Swartz, J. S., Amos, K. E., Brindas, M., Girling, L. G., & Ruth Graham, M. (2017). Benefits of an individualized perioperative plan for children with autism spectrum disorder. *Pediatric Anesthesia, 27*(8), 856–862. https://doi.org/10.1111/pan.13189

Taghizadeh, N., Davidson, A., Williams, K., & Story, D. (2015). Autism spectrum disorder (ASD) and its perioperative management. *Pediatric Anesthesia, 25*(11), 1076–1084. https://doi.org/10.1111/pan.12732

Turner, J. C., & Fralic, J. (2009). Making explicit the implicit: child life specialists talk about their assessment process. *Child & Youth Care Forum, 38*(1), 39–54. https://doi.org/10.1007/s10566-009-9066-x


2023
CHILD LIFE CONFERENCE
REGISTER
JUNE 15-18, 2023
GRAPEVINE, TX
ASSOCIATION OF
Child Life
Professionals

CALENDAR
UPCOMING EVENTS AND IMPORTANT DATES

MARCH 14: Community-Based Affinity Group

MARCH 15: Application Deadline for Fall 2023 Internship

MARCH 15: Certification Exam Window Opens

MARCH 15: Member of Color Affinity Group Meet-Up

MARCH 17: Summer 2023 Diversity Scholarship Applications Open

MARCH 22: LGBTQIA+ Affinity Group

MARCH 24: ACLP Webinar: More Than Just a Bad Day: How CCLSs Can Maintain Professional Well-Being and Create a Coping Plan for Burnout

MARCH 30: Certification Exam Window Closes

MARCH 31: Early Bird Registration Deadline for the 2023 Child Life Conference

APRIL 1: CLPDC Annual Data Entry Opens & CLPDC 2023 Q1 Data Entry Opens

APRIL 3: Summer 2023 Diversity Scholarship Applications Due

APRIL 3: ACLP Call for Volunteers Opens

APRIL 5: ACLP Webinar: Demystifying Research for the Clinical Child Life Specialist

APRIL 13: NICU Affinity Group

APRIL 17: ACLP Webinar: Bridging the Gap: Using Innovation and Technology to Provide Child Life Services Virtually

APRIL 26: LGBTQIA+ Affinity Group

APRIL 28: ACLP Webinar: Supporting the Child with Medical Complexity Following Non-Accidental Trauma

MAY 2: Initial Offer Date for Fall 2023 Internships

MAY 2: ACLP Webinar: Sustainable Self-Care for Clinicians: Utilizing Wellness Champions to Promote Holistic Wellbeing

MAY 3: Acceptance Date for Fall Internship 2023

MAY 4: 2nd Offer Date for Fall 2023 Internship

MAY 8: Fall 2023 Diversity Scholarship Applications Open

MAY 9: Member of Color Affinity Group Meet-Up

MAY 11: NICU Affinity Group

MAY 17: Community Based Affinity Group

MAY 18: ACLP Webinar: Communication and Role Identification Between Child Life Students & Nursing Students During Pediatric Simulations

MAY 23: Fall 2023 Diversity Scholarship Applications Close

MAY 24: LGBTQIA+ Affinity Group