

International Perspectives

The Candle Project: Supporting Bereaved Children in London, England

An Interview with Frances Kraus, BA, CQSW

In 1998, St. Christopher's Hospice in London, England launched the Candle Project, a service to support bereaved children in south and east London. The majority of the children served by the project are bereaved by the unexpected death of a parent or other relative, who is, therefore, not under hospice care. The Project also offers training, advice, and consultancy to the Metropolitan police and other social service professionals in the London area. In the following interview with Karen S. Heller, PhD, Ms. Frances Kraus, project leader and principal social worker at the Candle Project, reflects on both the design and implementation of this effort to serve the needs of a diverse group of bereaved children. In addition, Ms. Kraus describes a police training program she and her colleagues are conducting to improve police sensitivity and response to families bereaved through unexpected and often traumatic circumstances.

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Origins of the Candle Project

Please tell us the origins and purpose of the Candle Project.

Barbara Monroe, director of the Candle Project and chief executive of St. Christopher's Hospice in London, had a longtime dream of founding a service to help bereaved children. Before becoming chief executive of the hospice, while she was director of social work, she and the other social workers in the department, including myself, noticed a real need in our area of London for that kind of service.

St. Christopher's Hospice has always provided bereavement services for children whose parent, grandparent, or relative has died under our care. As part of the hospice bereavement program, Barbara produced a little booklet for children called *Someone Special Has Died*.¹ The booklet describes some of the grief experiences that the children might have. Barbara wrote it with the help of some other people in the department, and we got an artist to illustrate it. The booklet has had huge sales and has now been translated into about twelve languages. This tremendous interest, as evidenced by the booklet sales, was one of the things that suggested to Barbara that there's a lot of need out there for bereavement resources for children.

In addition, local general practitioners (GPs) or schools sometimes would approach us for help, because there was no bereavement service for children in the area. There were bereavement services around for adults, but nothing for children. They would say: "We know this child isn't bereaved under your care. However, there was a sudden death, do you think you could help?" If we had the space in our caseload, those of us who were interested would work with these children.

Finally, a major impetus for the project arose from a special grant-funded program we had for about three years, which provided short-term counseling to people who weren't under hospice care, but were referred by GPs because they thought our expertise would be useful. We were astonished that so many GPs referred children with complicated bereavements to us.

So, I was seeing quite a number of children. Barbara, who was on the hospice management team then, persuaded the trustees of the hospice to focus on doing some special fundraising to set up the Candle Project, which was tailored to meet the bereavement needs of these children who were otherwise falling through the gaps in provision. We got the money from a private bank trust in September 1997. I was appointed Project Leader a couple of months later and took up the post in February 1998. We launched the project in March 1998.

Where did you obtain funds for the project?

The hospice went to Lloyd's TSB, a philanthropic trust set up by Lloyd's Bank. They gave us 100,000 pounds over three years. In addition, the hospice conducted an appeal to their Friends. St. Christopher's Hospice is a very large and well-known hospice, with a big donor base. The hospice sends donors a little magazine, called *NewsLink*, in which we printed an appeal for funds. I think we raised about 20,000 pounds just through that appeal. Other money came from another trust, and people send in donations. The funds go into an account that is dedicated for the Candle Project.

Staffing and Population Served

What is your role in the project, and how is it staffed?

I'm the project leader. I do the development work, including fundraising to a certain extent, and I manage the project. I am also responsible for the clinical work and training activities. For the first 18 months, I was the only full time staff person; we also had a couple of sessional workers. [A sessional worker is a self-employed professional contracted to provide services on an hourly basis.] Now, our staff includes not quite two full-time people. I and a colleague each work four days a week, and we also have a sessional worker, and nine volunteers, who help with the group work with children.

Barbara, our sessional worker, and I recruited and trained all the volunteers. The volunteers have been remarkably loyal; nine of the twelve whom we originally recruited have stayed since the beginning of the project, more than three years ago. We don't ask a huge amount of time from the volunteers. We hold only three or four groups a year, on a Saturday. Groups for teenagers are held on an evening. The volunteers only help with the groups; they don't work with individuals.

What is the geographic area and the population your project serves?

It's a huge geographic area covering roughly 200 square miles, with a population of approximately 1.8 million people. We cover seven boroughs in southeast and suburban London. If you imagine London divided into four quadrants, we cover south of the river, and the eastern half. So, it's pretty large, and includes a diverse population. The boroughs of Lambeth, Southwark, and Lewisham are all *inner* London boroughs, which border on the river. Lambeth includes Brixton, which is very multi-racial and multi-ethnic; it's an area that had race riots in the early 1980s. Lambeth, Southwark, and Lewisham are some of the most economically deprived areas of the United Kingdom. Croydon and Bromley are suburban boroughs, as are Greenwich and Bexley, which extend more to the east. The suburban boroughs are much more mixed, ethnically and economically. There are some very wealthy parts of Bromley and Croydon. And these boroughs extend right out into the country side.

In terms of ethnic diversity, the majority of the participants are white, but we also serve a very large

Afro-Caribbean population, as well as a large number of Asian people, including Chinese and Vietnamese. London is host to many refugees and asylum seekers. So, in our areas of London, there are Albanians, Bosnians, Somalis, Ugandans, and people from all parts of the African sub-continent. About one third of our referrals of children are Afro-Caribbean, or dual heritage children. This is similar to the overall proportion of Afro-Caribbeans in the whole geographic region we serve, when you average out the borough differences.

Despite the high number of refugees and asylum-seekers in the city, we see very few of their children. I expect this is because the most important thing for people in those circumstances is whether they can stay in the country. It's more important, sometimes, than dealing with bereavement. When a refugee child (often a teenager, very often orphaned) is referred to us, I sometimes think it's not right for us to start working with them on bereavement issues when they don't know if they're even going to be able to stay in this country. You have to deal with the practical issues first. Where am I going to live? Am I going to be sent back?

Philosophy and Practice

Please describe what the Candle Project's philosophical orientation is toward grief and bereavement, and how you actually work with the children referred to you.

We work on the principle of grief as a normal process, rather than something pathological that needs to be worked through with grief specialists. We want grieving to be understood and experienced as a normal part of life.

I've always operated on the idea that a short-term intervention can be very effective. This belief is based on our experience in providing a short-term counseling service to bereaved children before we actually launched the Candle Project. I found that short-term bereavement intervention worked fine for children, as long as you offered them a chance to come back if and when something comes up in the future.

So, at the Candle Project we offer up to six individual sessions, based on the model of short-term counseling. This schedule works from the point-of-view of the parent and child, because they don't feel they're locked into having to come to sessions forever.

With most children, I tend to only set up three sessions at the start, and then we decide as we go along whether we want to have more. The length of these sessions varies depending upon the development of the child. With some younger children, a six- or seven-year-old, for example, the session wouldn't be longer than half an hour because of their limited attention span. This is comparable to the length of each of their school classes. A teenager will happily talk to you for an hour, if they will talk at all. So, I vary the length of our encounters according to the *emotional* age of the child and what he or she wants to do. We have the flexibility to negotiate the number of sessions up to six.

When are the individual sessions held?

I started by thinking that we should conduct these bereavement sessions after school, but found that the majority of young children are very tired by the end of the school day. What they want to do after school is have something to eat, watch TV for a bit, and kick back; they do not want to go and have bereavement counseling. We'll sometimes see teenagers after school, particularly if they really don't want to miss their classes.

So, generally, we see children during the school day. One advantage of providing a short-term

intervention is that you're not asking the child to miss every Tuesday afternoon for the next year. It's not like going into analysis, or therapy. I have never, ever found a school to be difficult about this. On the contrary, the schools are incredibly supportive of the program. I try to negotiate with the child about the day and time, saying: "Look, what's the best? What do you have on Tuesdays? Oh, it's physical education. And that's the one you don't mind missing?"

Do you see the children at the school or do they come to your offices?

When we started, I actually went to the schools to see some children. Because we cover a very large area, however, the travel time for us to go to various schools cut too much into the day and meant that we would have less time available to see more children. London traffic is horrendous -- going five miles can take you an hour -- and there is very little underground service in south London. The other problem was that the school premises do not always lend themselves to holding bereavement sessions. Old schools generally don't have nice rooms where you can do therapeutic work with a child.

What activities do you do with bereaved children?

We're aiming to facilitate the child's being able to tell their story, to talk about their memories, to ask questions, and to get information. So, the first session is really a bit of an introduction. If I'm at the hospice, I show the child around the hospice a bit because there's lots to see. There's a fish pond and gardens. It's a very bright place for them. We've got a playroom that we can use, which is full of nice things for kids, a sand tray, pictures, toys, etc. So, I begin by introducing our setting, "This is the place we will be working."

During this first session, with young children, I often start by saying, "Let's talk about (whoever just died. Let's say it's Dad) your Daddy. Do you remember things about Daddy you want to tell me? Perhaps for our first session, you could draw me your favorite memory of the time you were with Daddy." That focuses them on a happy memory. You also get an idea, then, of how much memory they've got about the deceased person. Sometimes, the memories are very poor, and the picture is sometimes bleak, and sometimes it's a very full, lovely picture, with lots of color and life in it. Then, I ask them to tell me about the picture and the memory.

What portion of children that you see are under age 12, and what portion are teenagers?

About half and half. When we started, slightly more than half the children were aged 11 and under, what we call primary school children. I've seen very few little ones, not yet school-aged. When I see a little one, I usually see them with Mom. Children in London start school at age four, which is terribly young, I think. So, I would tend to see a four-year-old with Mom, because you can help the parent to be able to respond to the child's needs on a much more immediate level. If the child asks a question, you're really helping the parent to answer that question. At that age, they don't really focus on their grief for very long.

Do you do see some of the older kids with their parents? Or do you see the parents separately?

We always see the parent first, unless the bereaved child is a teenager, in which case it's sometimes not appropriate. With a teenager, you're trying to acknowledge their increasing maturity by seeing them as more autonomous, and reassuring them, "You can tell me the story from your own point of view." But, otherwise, we always see the parent first because since the project began, I've come more and more to believe that the key to the child's ultimate well-being, really, is the surviving parent. This

is consistent with William Worden's work that showed that how the child recovers from grief depends a great deal on how the surviving parent is managing.² I find I agree with him, more and more. The work of the Family Bereavement Program in Arizona, featured in this issue of *Innovations*, has a similar ethos of helping parents to support children. We share much in common with this program, particularly in our group work. If parents are so into their own grief that they can't respond to the child's needs, or have mental health problems, or hated the person who died so much that they can't allow the child to talk about it, then the situation for the child becomes much more problematic. In terms of our own focus in helping a family cope with loss, we have to strike a delicate balance. Although we try to keep a family focus, and help parents cope with their own grief to some extent, our *main* focus has to be on the children, because whereas there are adult bereavement services in our area, there are no other bereavement services for children.

A Self-Help Group for Parents

We do offer a self-help group for parents, which was started by Stewart Sinclair and Angela Paul, whose spouses died in St. Christopher's Hospice about six years ago. They are on the advisory committee of the Candle Project. She's a black woman, and he's a white man, and each is bringing up kids as a single parent now. They provide a nice gender-racial mix in the leadership of the parent self-help group. Their group won an award this year, and Stewart, Angela and I co-authored a paper about the program that we presented at the annual meeting of the European Association of Palliative Care in Palermo this year.³ The paper has been submitted to *Bereavement Care*, an English journal, although we do not have a date for publication at present.

The group is fundamentally for single parents who need some support in getting on with their lives. Many of the participants in this group are parents of children who have been seen in the Candle Project. I informally screen parents of children whom we are seeing who want to join the self-help group, to make sure that their needs and interests are appropriate for that group. I make very plain to them that this is not a bereavement group. The group talks about issues of mutual concern, such as financial issues, childcare, children growing up and how to deal with this as a lone parent, new relationships, and when to tell the children about them. In sum, it focuses on how these individuals cope with their post-bereavement world. The self-help group holds six or seven meetings a year; we provide volunteer child care for three of them. These are Candle Project volunteers, along with other people who want to help out, often hospice nurses and secretarial staff who want to work with children, but cannot undertake the same commitment or lengthy training that our regular volunteers do. So, if they are willing to be police-checked, I recruit them to volunteer to provide child care for three of the parent self-help groups. The parents organize their own child care for the other meetings. The meetings are held at the hospice. In the summer, they have picnics so families can socialize together and they are currently planning a day trip to France.

Individual and Group Sessions for Children and Teens

How many children do you work with, overall?

We get about 150 referrals a year, and we see nearly all of the children referred. Last year, we were unable to contact only about twenty out of that 150. When I say no contact, that means we were unable to reach the parent by telephone or letter. Sometimes the paper referral will come in, sent maybe by a teacher, and we will then have a long conversation with the parent. That may be all that is necessary to empower and enable the parent to support their child. Or we may decide together that now is not the right time to begin the program with the child. We may meet with the parent, and that's all. Or, we may do a little bit of work with the child, and then leave it for later. So, we have individual sessions with approximately 130 children per year.

Please tell us about the group sessions you hold for children and teens.

We usually have two to three group days a year for children in the age range of 8-12 years. We're also going to start doing something for the younger children. Originally, children six years old and up were all together in a group, but that didn't work well because the younger ones really weren't able to participate fully with the older children and needed something different. We do have a large number of children referred who are 7 years old and under, so I hope we can offer something for them, perhaps including their parents working alongside them.

Range of Activities for Children's Groups

What kinds of activities are provided for children during the group?

The day-long groups for children aged 8-12 years are very structured so that the kids are busy the whole time. There is always a high staff to child ratio. We always use as many volunteers as we've got available. The group starts with getting-to-know-you activities, often in small groups, such as name games, who-am-I games, card games about their favorite hobby. Then, we move them into activities that are about sharing slightly more intimate things, such as bringing a photo of the person who died and talking about that photo. They share stories a little bit.

Then, we have a slot in the day during which the children can ask questions of one of our doctors. This physician, a consultant who really likes being with the kids, always takes part in the day and answers their many medical questions about how the person died and what happens to the body after death.

Between 75-80 percent of our kids are bereaved by sudden death, most commonly from heart attack, stroke, or cerebral aneurysm. The next most common cause of unexpected death is traffic accidents. So, the children might ask the doctor, "What's a heart attack?" or "What's a brain hemorrhage?" That's a very important session for the children, and our doctor does it beautifully because he gives them a lot of attention and time. Just hearing the answers to their questions from a doctor is hugely important for the children.

The children have lunch together, which is a sort of break time. We usually do a treasure hunt around the garden, too. Then, in the afternoon, we do some fairly intensive therapeutic things, such as talking to a puppet about what things helped and didn't help when they were feeling sad about their loss. We also do some exercises about how to express anger.

We always finish the day with lighting candles, in a circle, to the loved ones who died. Each child says who he or she is lighting the candle in memory of, and something about that person, if the child wants to. Actually, we use little night lights because they don't fall over. It's very moving. By that time, of course, the kids have really bonded and got to know each other. After the closing circle, they go back to their parents. The parents have the opportunity to come to a separate parent's group in the morning. So, it's a very packed day.

Teen Program

What happens during the group sessions for teenagers?

The interesting thing was that holding a group on Saturday didn't really work for teenagers because they wanted to do other things that day. But holding the group on an evening worked for them. So, once a term, three or four times a year, we do an evening meeting for them, starting at 6:30 pm. This group for teenagers has a much looser structure than the ones for younger children. My colleagues

who have done the teen groups started off trying to organize it in a similar fashion as with the younger group, but found that teenagers don't want such a rigid structure. They wanted a chance to tell their story, and to talk about what's going on for them, and the difficulties that they've had recently. The other difference is that whereas for the younger children, the group meeting is a one-day event, for teenagers, we've established it as an ongoing group, so they can come back. The teen groups have been running for almost two years now, and we've got kids attending them who have been to five individual bereavement sessions, yet still find it helpful to come back to the group. They can drop out when they're no longer interested.

All the teenagers are offered both individual sessions and participation in the group. Some don't take the group. On the other hand, those teens who are children of people who died in hospice care already have individual bereavement counseling through the hospice, so they will often participate only in the group.

The opportunity to come back to an ongoing group, or to reconnect with the Candle Project staff on an as-needed basis is really important for bereaved children. I've always believed that whatever work you do with a child—say, when they're eight—you're probably going to need to see that child again. I find now I *do* end up seeing these kids again. Once they've developed a relationship with us, families will tend to re-access us when there is something going on. Classically, that's when the parent finds another partner, or has another baby, or they move to a new home, or the child changes schools, for example, from junior school (which they finish when they are 10 or 11), to senior school. That is a huge transition for kids, one in which they are often thinking, "Oh, my Dad would've been here to help me through this." So, at those transition points, children often go through a little kind of dip in their feelings and the parent will ring me up and say, "Could Jamie come and see you again, because he's suddenly started behaving badly. I don't know what it is." After we talk, and I get an idea of what is going on, I say, "Of course, I can see them again." When children come back, they usually only need one or two sessions, because they know exactly what to expect.

Evaluation of the Program

Have you measured the impact of the services you're providing?

That is really difficult to do. As Grace Christ, in her book, *Healing Children's Grief*,⁴ asks (and I'm paraphrasing): "How can you distinguish what it was that affected the child in the first place? Was it the bereavement? Or was it all the other things?" Similarly, it's difficult to tell what has *improved* things for a bereaved child: how much is the natural progression of the bereavement, and how much is the intervention? What I *do* know is that families whose children go through our program, and then the parent goes on to participate in Stewart and Angela's parent self-help group, tend to do okay. The parents get connected in the parent self-help group and keep in loose contact with us. I have known kids now, over years, and basically, they are doing okay. They're using the help and are working through the things that happen. Parents have told me that *knowing* that the Candle Project is there, *knowing* that there's someone who is *accessible*, whom they can ring up and talk to about their child, makes a big difference. I think people need that kind of ongoing, if only occasional, support, accessible at their own pace. Not intensive therapeutic stuff, but somebody they can occasionally just talk to about their children.

For example, one mother called me because her son, whom I've seen off and on, was behaving badly. His father died when he was five, and he's now seven. This latest outburst occurred as something really good was happening for this family. They're all going off to Australia. Mom has a new partner, who happens to be the best friend of her husband, who had died suddenly. So, this

man has known the little boy all his life, and the little boy is really happy. When I saw the boy, we talked about how you can feel happy and sad at the same time, because he also feels guilty because he's happy now, and he wouldn't be feeling that way if his Dad were here. How do you cope with that when you're seven? How do you understand feeling both happy and sad at the same time? And it was just one phone call with Mom, and then one session with him, and that was all he needed at that point; the next time I see him may be in a year or so if something else happens. I think you have to leave the door open for people to reconnect with you.

We would love to be able to evaluate our project in a similar way to the Arizona program featured in this edition of *Innovations*, but we simply do not have the resources to do so. We operate on 1.8 FTE (full time equivalent) staff members. We have been able to look at the impact of our work with teachers and over the telephone however, which is a start.

It's hard to measure the impact of this availability, but we know from our experience, that access to services over time can be of great help to families. Even short time-limited visits, can serve to buffer children and families from the ways in which predictable developmental and other life changes (moving, changing schools, leaving home, parental remarriage) can trigger the pain from this earlier loss.

What a Private Service Can Offer in Contrast to Statutory Services

Offering flexibility and access are what the statutory child and adolescent mental health services cannot do because they are financed by the National Health Service (NHS) and have very scarce resources. These statutory child and adolescent mental health services are excellent on the whole, but they tend to have very long waiting lists. Also, they tend to put parents off a bit because there is a stigma attached to having your child going to the psychiatric services. Parents are rather reluctant to access these services because it's going to go on their child's health record. The statutory services also tend to be less flexible. They will offer you an appointment on a certain date and time; if you can't manage that, that's hard.

By contrast, we can be more flexible about appointments and are able to provide transportation for people. The hospice has a volunteer driver service to bring patients into the day center, and those drivers will pick up families for us. The drivers all tend to be retired people, and the kids love them. So, families who have no transport, and little money are able to use our service. Providing transportation makes us much more accessible; without that service, a family may get somewhere once, but never come again. We find that it's much more acceptable to send drivers to pick up families than to reimburse them the money for transportation, because that feels more like being given charity. And, they've got to find us in the first place. Instead, we say, "Oh, we'll send a car for you" and then this nice elderly gentleman arrives to bring them here. The only charge we ever make is to the local authority, for services to children who are "looked after," as we say in this country. These children are in the care of the local borough authority, perhaps similar to children in foster care or wards of the state in the United States. This charge is for the clinical service we provide and we assess it per session.

Cross-cultural and Gender Issues in Grieving

Because you serve a multi-ethnic population, have you had situations in which culture required you to adapt what you normally would do? How does cultural diversity affect your ways of working?

It's difficult, sometimes. Very early on I was asked to see children in a Nigerian family. The children

had been living in Nigeria with their father, who had cancer, but died suddenly and shockingly, in front of the children. Obviously, his death was traumatic for the kids. After his death, they all came over to England to live with Mom, whom they actually hadn't lived with for about five years because she was over here working. And Mom *absolutely* would not allow any grieving. I believe this taboo may be cultural. I was talking recently to another woman who had lost a child. She told me that her mother is very cross with her because she wants to grieve her child, but that in Ghana you are not supposed to grieve if your firstborn child dies because you've got to keep yourself together for the other kids. So, a parent is expected to just get on with life. That philosophy goes completely *counter* to the messages we convey.

So, we often have to alter how we work because there are, definitely, different ways of expressing things. I'd say that each family has their own culture. And some family cultures are very much about minimal expression of sorrow, so in those instances, we'll talk with children about *all* the different ways that you can express grief. We try to open people up a bit to recognize the various ways of grieving, such as feeling sad or being quiet, but we never attack a family's culture.

The British stiff upper lip is still there, I think. Of course, children are allowed to grieve more than adults. But the expectation still is that little boys, in particular, should be big and brave. I think they *feel* that expectation, just as much from their peers as they do from their families. However, that is changing. I see a lot more open expression of grief among families now. But fathers who are left bringing up small children alone often say that what they find most difficult is talking to their children about the emotional aspect of grieving. The practical aspects may be hard, but not as hard as sharing their feelings about the loss with their children or talking with them about it.

Have you found anything that is particularly helpful for these people to enable them to talk about emotional matters?

I think that sometimes a lot of the men that I work with don't want to talk directly about the emotion. They will talk about the issues that come up because of their feelings, but they do not necessarily want to talk about the emotions themselves.³ Some women are like that, too; so this pattern is by no means entirely gender-specific. I do find it more in men than in women, though. My approach is, okay, so we'll talk about whatever you want to talk about. We don't have to talk about crying. So, I'll talk with some fathers about how they manage practical things and cope with the sudden interest in them from women who come around needing their washing machines fixed. Stewart and Angela tell me that the men in the parent self-help groups often raise the issues about how to manage new relationships.

Since you lived for awhile in the United States, can you comment on any differences that you see in the ways in which bereavement is dealt with there versus the way it is in Great Britain?

I was talking about this recently with Phyllis Silverman.⁴ I think that on the whole, in the United States, people are more ready to commit to attending a weekly group session in the evening. British people tend not to do that. The whole idea of therapy is still not as acceptable in Britain as in the US. Even though there are loads of therapists and counselors, and employee assistance programs, the feeling here is, still, if you go to a counselor, there must be something wrong with you. Seeking therapeutic help is still in the process of becoming acceptable.

Another difference is that in the States, you can get these services paid for by different insurance mechanisms. Here, we have mental health services provided through the National Health Service, but those are scarce resources that tend to be reserved for the very mentally ill, and accessed through

a psychiatrist's referral. Alternately, people may seek out private health care services, which are costly. There are few low-cost services. And the people who know how to access the available low-cost services actually tend to be in the middle class, not the people who *truly* cannot afford to pay forty pounds a session to a therapist.

I think, otherwise, the kind of bereavement care available in the two countries can be easily translated from one setting to the other. From most of what I've read about the US programs, I could imagine us doing any of that here.

Barriers to Implementation: Financing and Larger Context

Have you faced any obstacles in getting the Candle Project going, or in sustaining it?

The biggest obstacle is that we cover seven boroughs, with seven separate organizational structures. Within those structures, it is difficult to categorize a bereavement project for kids. You could *say* that we fit under Education, or under Health, or under Social Care. We get referrals from schools, doctors, and social workers, so we're trying to relate to several administrative departments, in terms of our referral base, and also in terms of our potential ongoing funding.

I'm thinking about ongoing funding at the moment because we have money until the end of 2002. Originally, the idea was to sustain the project by going for some sort of statutory funding. But where do we go? Which department—health, education, or social care—do we try to fit into? This is further complicated because they're all going through processes of reorganization at the moment, and everything's in a process of change. Even if we decided which department we were going to fit under, we've still got seven boroughs to negotiate with. With such a tiny little project, I literally do not have the time to try to make the relationships with all the different people in the different funding areas. So, we are going to go back to our original funders, to present them with the problem, and ask for money for some more years to organize this effort.

Children Facing Multiple Challenges, Few Societal Resources

All social care services are really scarce, so we tend to get referrals for children for whom bereavement is really the least of their problems. But a desperate teacher, or a desperate social worker is thinking, "Oh, there was a death in this child's life. Here's a project that we can access quickly and easily, it's cheap and it's very flexible. Good, we'll refer this child." And what the child really needs may be a new home, money, or family therapy, ongoing deep therapeutic work, which we cannot provide.

So, we have to find other resources for these children and that gets very time-consuming. The main difficulty, I think, is that social work is a profession that has been recognized to be in crisis in this country. Social work is very under-funded, and social workers get very bad press in the UK. It's always, "the social workers who didn't stop this child being killed," or "social workers only take your kids away." Social workers are an easy target for blame and they are not well paid. In London, there's a huge shortage of social workers; some boroughs have got a 30 percent vacancy in social work jobs and, therefore, there are children on the register who haven't got a social worker. There is also high job turnover among social workers. So, the work that *should* be there, which would support the sort of children we then get referred, is just not there. Sometimes I say, "Look, hang on. Do you know we can only offer about six sessions of *specifically* bereavement-focused support? This kid needs—" and then I'll reel off a whole list of things. And they'll say, "Well, yes. But we can't provide any of those things."

It's very difficult for us in those circumstances, because you feel for the children, and feel inadequate to meet their needs. I have to say, "Look, our expertise is bereavement support. We'll do that. But you probably still will have a major problem on your hands. Maybe we can help you with a referral." But what is there to refer on to? The child mental health services have long waiting lists, high dropout rates, and insufficient resources. Yet, there isn't anywhere else. So, I think those are the main difficulties we have.

Replication of the Candle Project

Has the Candle Project been replicated elsewhere in the country, to your knowledge?

There are now a lot of children's bereavement projects in the United Kingdom. One of the first, established in 1992, was Winston's Wish, which I believe was based on models in the United States. The person who set that up had done a placement at the Dougy Center in Oregon, which operates camps for bereaved children. The Candle Project came later and there are now many other projects. For example, in Oxfordshire, one project has built on our experience and that of other projects, and adapted it for their own, more rural area. In addition, there is bereavement support for children that goes on in hospices, which may not be separately listed. There is now an umbrella organization in England, called the Childhood Bereavement Project, which has about 150 paid up members, organizations providing bereavement care for kids. The Childhood Bereavement Project holds a yearly, residential conference, and local meetings, where agency staff can get together.

So, all over the UK, there are now services, which differ in how they're set up. That's appropriate, because you provide the service to suit the population that you're serving, and make the best use of the resources and facilities that you've got. For instance, we couldn't provide transport if we were not based within a hospice that already has a transport service. But all the available services tend to subscribe to the idea of bereavement care being available to anybody who wants it, not that there has to be something *wrong* before a child is referred for bereavement care. To my knowledge, all of us in the childhood bereavement field tend to believe that you should not have to demonstrate need; the services should be available to anybody who wants them, so that you're not always working with the pathological end of the spectrum.

Responding to Trauma

Because so many of the children you see in the Candle Project are bereaved suddenly, do you have any insight into how best to help children who've been bereaved by a traumatic death?

The big thing I've learned about helping children cope with traumatic loss is that, to a greater or lesser extent, the shock often delays the grief reaction for a very long time. Also, children who are bereaved suddenly have huge amounts of anger. I work quite closely with William Yule, Professor of Applied Child Psychology at Maudesley Hospital, nearby in South London. Dr. Yule has worked for many years on post-traumatic stress with kids and has written and published widely on this subject.² He runs one of two child traumatic stress clinics in the UK. He's on our advisory group and we work together in training the Metropolitan police to work more effectively with bereaved families following a traumatic and often violent death. We often share cases. He will work on the trauma with children, and then send them over to us for the bereavement work.

I'm working with one family long-term and over a long distance, so I don't see them very often. There are three children whose father killed their mother. I saw them first very soon after Mother died, but before Father, who was the prime suspect, was arrested. These children actually didn't start

to grieve for months and months because they had to go through the whole process of Mom being missing, Mom being found dead, Dad being arrested, not knowing exactly where they were going to be living. They all grieved in stages. The boy has worked through a load of bereavement stuff and is now doing fine. We have been talking now over two years and he came back to see me just before Christmas this year. I've done some bereavement work recently with the middle daughter, but the little one, who is only six or seven, is not yet ready to grieve. She told me, "I want to forget. Nanny and Granddad are my Mom and Dad."

Have you worked at all with children of British citizens who were killed in the September 11 terrorist attacks in the United States?

One or two family members phoned in for advice and information. I sent out some literature and talked things through with them. I also have been involved, as an advisor, to the police and the government department that organized a memorial service for the families of the victims of the attack, which was held at Westminster Abbey on November 29, 2001. The Queen, Prince Philip, and many notables were there. Former President Bush and representatives from the New York City police and fire services also attended.

Several years ago, I helped to develop a training program for members of the Metropolitan police. They have family liaison officers assigned to the bereaved families in London and, given their developing expertise in responding to trauma, they were in charge of organizing this memorial service for September 11. Of course, there are families all over the country who have been bereaved by the events of September 11. Family liaison officers also worked with families outside London but they had not received the specialized training the Metropolitan police receive. Because of the work I do with the police, I was asked to be an advisor/consultant to the department in the government that organized the service. The day was planned to respond to what the families said they wanted—a national service in Westminster Abbey. It has been a real joint effort between the government, the police, and the Abbey staff. The presence of dignitaries was kept to a minimum, because the service was primarily for the families and the police officers and fire fighters. After the service the families were taken to a big hotel for refreshments. Some of the staff members from bereavement services, including the Candle Project, were asked to be there, with red badges on, to assist family members or police officers who wanted information or support. The memorial offered the families a chance to network amongst themselves, to get to know each other, to form their own support system. Later in the day, we had a big debriefing session, and about a week later we met to discuss where we go from there. The government department plans to write up this experience, because we want to benefit from the lessons learned, and not have to reinvent the wheel each time there's a disaster.

Consultation and Training Role:

Improving Police Sensitivity and Knowledge about Traumatic Loss and Grief

How did you begin your work with the police department to help families bereaved by violent deaths?

Our work with them began in October 1999 after the Ladbroke Grove Paddington rail crash, in which about 31 people died. The police, who were coordinating the arrangements for the relatives and survivors found that one of the things that they were asked a lot was, "How do I tell my kids?" The police were seeking guidance about how to respond to those questions. One of the bereavement workers who was around at the time knew about us, and that Barbara Monroe and I had just written a booklet called, *Someone Has Died Suddenly*, for kids bereaved by sudden death.⁸ (The train company subsequently bought 150 copies of this booklet.) This bereavement worker told

police about that, and they contacted me. I then met with some of the police up at Ladbroke Grove, and gave them my details. They said, "Oh, great. We'll tell families to phone you." I had quite a lot of phone contact with a number of families who were bereaved by the crash between Ladbroke Grove and Paddington stations. I didn't actually see any of these children because they all lived outside our area.

At that time, the Metropolitan police were also putting together a training program in response to the McPherson Report, which came out in 1998 as a result of the Steven Lawrence inquiries. Steven Lawrence was a young, black teenager who was killed by five racist white youths in our area, southeast London in 1993. The youths came to trial, but the case had to be dropped. The main problem was that relations completely broke down between the police and Steven Lawrence's family. The police really did *not* handle this bereaved family as they should have. The family was upset because they felt patronized and that they were treated inappropriately by the police.

These events led to a public inquiry, which resulted in the McPherson Report. One of its recommendations was that the police improve their handling of bereaved families. The report called for trained family liaison officers, who would support bereaved families through whatever legal process might take place as a result of a violent or traumatic death. Offering this familial support can be complex since the police recognize that some of the family members may also be suspects. The police responded to this call for change by acknowledging a need for training. When the Paddington crash occurred, the Metropolitan police were in the process of putting together their training for the family liaison officers.

Content of the Police Training Course

After they contacted me following the crash, we held a meeting at St. Christopher's Hospice of representatives of many agencies in the London area. At that meeting, the police asked for input on how to work with bereaved children, and then with bereaved people generally. We did a pilot session with the police on bereavement, after which they asked me to coordinate the training, and provide one day's input, specifically, on bereavement, sudden and traumatic death, and children, during their week-long training course for the family liaison police. I've now been doing this training every three weeks since March 2000. It's a big commitment.

The training course is excellent because the police officers who teach the bulk of the course are also aware of bereavement issues. The person who has "driven" the course lost a child himself, and he uses his own example to talk about such questions as, "How do we work with families? What shape and size are they? What do people need?" The course covers the legal aspects, the coroners, and how they handle families. They bring in people to talk about cot death (referred to as SIDS or Sudden Infant Death Syndrome in the US).

Originally, I did some of the training sessions with Barbara Monroe. I always worked with William Yule on these trainings, and now work with David Olivière, a social worker and our Director of Education at St. Christopher's Hospice, as well. These trainings are booked up to the end of next year. The commissioner at the time of the McPherson Report had said, "I want 500 trained officers by the end of 2001." We've probably got about 500 family liaison officers now. But, with police force attrition, I have a feeling that these trainings will go on for quite some time, so my role in this is continuing.

On the day we teach, we start by talking about bereavement and loss, in a fairly general way. We slide in some theory, but not too much. We conduct an exercise in small groups about a loss that still means something to them, which could be personal, or a professional situation they've worked

with. Then, we move on to sudden and traumatic death. I show a video clip with people talking who've been through that. I use some of Therese A. Rando's work on sudden death, and how that impacts on grief.² Toward the end of the morning, we usually have an open discussion on some of the issues around gender and culture, such as differences in how men and women grieve.

Then, in the afternoon we talk about how children develop understanding of death and loss. I often ask them fairly controversial things, such as, "Do you think children should go to funerals? At what age?" Quite often, the police officers say, "No, no, I don't think so." They respond as members of the public, thinking of what they would choose to do with their own children. Then, we show them a very good, short video in which children themselves talk about their own experiences. The video is moving and really makes them think. We then use these children's comments as a catalyst to talk about what children need.

When I lead that discussion, I link it to my own experiences. For instance, I'll give an example of a child I saw that week. We talk about resources, and I explain what the Candle Project is and invite them to phone me and talk about things, even if they are not working in our area of the city. If William Yule leads this session, he focuses more on the work he's done with children who've been traumatized. He often gives them some fascinating data from his research.

Evaluation and Impact of Police Training

Has the training been evaluated?

Participants evaluate every day of the training. Our sessions have always received high marks. We also get some personal feedback. One of the officers came up and told me, "*Before* I had your day, there's no way I would've taken my kids to a funeral. I have completely changed my thinking." They're clearly moved by the material we present, and they appreciate having the benefit of our experience. They commented on "the wealth of expertise" we brought and said, "We feel honored to have had that shared with us." It's terrific. And they do phone up. They use the ongoing support. I've had lots of calls from officers over the time, whenever they come in contact with bereaved families.

I *know* we are making a difference, because I also work with families who have had contact with the police officers that I've trained. The families don't know that I've trained those officers, but I hear from them how they've been handled and can tell, through that, that we've made an impact. So far, the police want us to continue with the training for the foreseeable future. William Yule and I both feel very committed to it because we really are helping to change police attitudes and behavior, and in that way, to extend the reach of our project.

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