A System of Care

for

Children and Adolescents with Emotional and Behavioural Disorders

by:

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Abstract

The system of care model as outlined by Stroul and Friedman (1986, 1994) has been adopted by the Province of Manitoba in an effort to better meet the needs of children and adolescents with severe emotional and behavioural disorders [EBD] (Manitoba Education, Citizenship and Youth, Manitoba Family Services, Manitoba Health & Manitoba Justice, 1995). This study reports on the Manitoba model, through a case study approach, which includes the perspectives of parents, foster parents, social workers and teachers involved in supporting children and adolescents with EBD. Qualitative data obtained from these participants was used to determine whether or not the system of care was achieving its stated objectives. Several factors that interfered with the realization of a true system of care from the perspectives of key participants in the process are discussed. Suggestions to improve the system of care in Manitoba to make it more responsive to the needs of children and adolescents with EBD and their families are proposed.

Acknowledgments

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Chapter 1

Introduction

The task of attempting to meet the complex needs of children and adolescents with mental illness has challenged service providers for many years. In *Unclaimed Children* (1982), Knitzer describes significant deficiencies in the availability and type of services for children and adolescents with severe emotional disturbance (SED). Knitzer (1982) presented an alarming statistic: that of the 3 million children in the United States with SED, two-thirds were not receiving the services they required and when they were receiving services, they were being provided in a fragmented and poorly coordinated manner. *Unclaimed Children* served as a call to action to social service providers in the United States. In response to the fact that children with SED had been "unclaimed" by the service providers who shared responsibility for meeting their needs, the National Institute of Mental Health [NIMH] developed the Child and Adolescent Service System Program [CASSP] to direct local state agencies in developing systems of care (Stroul & Friedman, 1986, 1994). The system of care model proposed by Stroul and Friedman (1986, 1994) is described as the means by which services can become responsive to the needs of children and adolescents with SED and their families. The intent of a system of care is to coordinate and integrate services for children with SED and their families through a network of community-based, child-centred and family focused supports.

Recognizing that services for children and adolescents with emotional and behavioural disorders [EBD] in the province of Manitoba also were being delivered in a poorly coordinated and fragmented way, the departments of Manitoba Education, Citizenship and Youth, Family Services, Health, and Justice developed an

interdepartmental protocol pilot project between September 1990 and September 1993. The goal of this project was to assess the impact of providing integrated services to children and adolescents with severe EBD (Bartlett & Freeze, 2005). Based on positive feedback from the pilot project, the "Interdepartmental Protocol Agreement for Children and Adolescents with Severe to Profound Emotional and Behavioural Disorders," was developed which supports the development of a system of care in Manitoba (Manitoba Education, Citizenship and Youth, Manitoba Family Services, Manitoba Health & Manitoba Justice, 1995). In this cooperative agreement the aforementioned departments agreed to coordinate and integrate their services in an effort to better meet the needs of children and adolescents with EBD and their families.

In a pilot study (Bartlett, 2004), I found there were significant barriers to the development of a true system of care in the province of Manitoba. This preliminary research led me to believe that a further evaluation of the Manitoba system of care was warranted to determine ways to overcome these barriers and develop an effective and responsive system of care. According to Winer and Ray (1997), the ongoing assessment of the development of a system of care is essential to its survival and maintenance. A first step in the evaluation process should involve obtaining the perspectives of the individuals directly involved in the system to determine if the system of care in Manitoba is achieving its stated objectives.

Thesis Organization

In this chapter, I will define the system of care outlined by Stroul and Friedman (1986, 1994). I will also define the Manitoba system of care. I will then provide a glossary of key terminology used in the literature dealing with children and adolescents

with EBD. Next, I will describe my findings from a pilot study I conducted in the spring of 2004 on the system of care in Manitoba. In chapter two, I provide a review of the literature. Then, in chapter three, I describe my research methodology. In chapter four, I will describe my findings and finally, in chapter five, I will present a conclusion and suggest limitations and implications.

A System of Care. According to Stroul and Friedman (1986, 1994) a system of care is defined as a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed [SED] children and adolescents. The core values of a system of care state that it should be: (1) child centred with the needs of child and family dictating the kind of services provided and, (2) community based with the management and provision of services occurring at the local level. There are also 10 guiding principles of a system of care (Stroul & Friedman, 1986, 1994). The guiding principles state that:

1. Individuals should be provided with access to a comprehensive array of services.

2. Services should be individualized.

3. Services also should be provided in the least restrictive environment.

4. Families should be full participants in all aspects of planning and delivery of services.

5. Services should be integrated with mechanisms for planning, developing and coordinating services.

6. Case management should be provided to ensure multiple services are delivered in a coordinated and therapeutic manner.

7. Early identification and intervention should be promoted.

8. There should be support for a smooth transition to the adult service system.

9. The rights of children should be protected and advocacy should be promoted.

10. Services should be nondiscriminatory and culturally sensitive.

The Manitoba System of Care. In order to address the gaps and inadequacies in the provision of services for children and adolescents with EBD in Manitoba, the "Interdepartmental Protocol Agreement for Children and Adolescents with Severe to Profound Emotional and Behavioural Disorders," directs the departments of Manitoba Health, Family Services, Justice and Education to implement a system of care (Manitoba Education and Training, Manitoba Family Services, Manitoba Health & Manitoba Justice, 1995). The Provincial Coordination of Services Committee in Manitoba which has representation from Manitoba Health, Family Services, Justice, and Education is the committee responsible for the development of integrated, province-wide strategies for the provision of services to children with complex, exceptional needs (Manitoba Health, 1999). In Manitoba, the system of care is defined as a consensual process for coordinating multi-system services and developing individualized, shared service plans for children and adolescents with severe to profound EBD. It is described as a process that is respectful of the experience of all team members and involves all participants in sharing information, resources and expertise (Government of Manitoba, 2000). The target population for whom the Manitoba system of care is intended is identified as children and adolescents with severe to profound EBD. They are described further as children and

adolescents who are: (a) are a danger to themselves or others, (b) display impulsive, aggressive and violent behaviour, (c) have emotional and behavioural difficulties that are chronic, long-standing, pervasive and consistent, and (d) require a combination of services (Manitoba Education, Citizenship and Youth, 2005).

Definition of Terms

In this section I briefly review the terminology that is used when supporting children and adolescents with mental health issues.

Emotionally behaviourally disordered [EBD]. Emotionally behaviourally disordered is defined by Manitoba Education, Citizenship and Youth (2005) as a student with a profound emotional/behavioural disorder and associated learning difficulties requiring highly individualized programming and intensive support services at school and in the community. This applies to the student: (a) who is a danger to self and/or others and whose actions are marked by impulsive, aggressive, and violent behavior, (b) whose behaviour is chronic, (c) whose behaviour is pervasive and persistent and negatively affects all environments including home, school, and community and, (d) requires or receives a combination of statutory and non-statutory services (Manitoba Education, Citizenship and Youth, 2005).

Emotional or behaviour disorder. On the other hand, [EBD] is defined by the National Mental Health and Special Education Coalition in the United States as a disability characterized by behavioural or emotional responses in school so different from appropriate, age, cultural, or ethnic norms that they adversely affect educational performance. Educational performance includes academic, social, vocational, and personal skills. Such a disability (a) is more than a temporary, expected response to

stressful events in the environment, (b) is consistently exhibited in two different settings, at least one of which is school related, and (c) is unresponsive to direct intervention in general education or the child's condition is such that general interventions would be insufficient (Forness & Knitzer, 1992).

Emotionally disturbed. Currently, the term emotionally disturbed [ED] is the label that is used in the United States to define a child as having mental health needs and children that fit this definition are eligible for support. According to Public Law 94-142, ED is defined as conditions exhibiting one or more of the following characteristics over a long period of time to a marked degree which adversely affects educational performance and: (a) an inability to learn which cannot be explained by intellectual, sensory and health factors, (b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers, (c) inappropriate types of behaviour or feelings under normal circumstances, (d) a general pervasive mood of unhappiness or depression or, (e) a tendency to develop physical symptoms or fears associated with personal or school problems (Federal Register, 42 (163), August 23, 1977, p. 42478 as amended in Federal Register. Vol. 46, 1981, p. 3866).

A System of Care. There are not only variations in the way children and adolescents with mental health needs are labeled, but there are also variations in the way the system of care or the means by which supports are provided to this population are defined. According to the Government of Manitoba (2000), a system of care is defined as a consensual process for coordinating multi-system services and developing individualized, shared service plans for children and adolescents with severe to profound

EBD. It is further described as a process that is respectful of the experience of all team members and involves all participants in sharing information, resources and expertise.

A System of Care. While the Province of Manitoba has adopted the system of care model, it does not exactly follow the definition outlined by Stroul and Friedman (1986, 1994). Stroul and Friedman (1986, 1994) refer to a system of care as "a comprehensive spectrum of mental health and other necessary services which are organized into a network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents" (p. vi).

Categorical Funding. The term categorical funding is used by many social service providers and other agencies to describe how resources and supports are provided to designated individuals. According to the Manitoba Teacher's Society categorical funding consists of entitlements to provincial funds in relation to a designated series of education programs and services. The package of entitlements varies from year to year (Manitoba Teachers' Society Research Office, 2001).

Description of Pilot Study

In this next section I describe why and how I did a pilot study in preparation for this thesis. Through my review of the literature on the system of care model I came to learn that while the Province of Manitoba had the expectation that multidisciplinary teaming would occur, the models of professional practice and systemic supports that support a system of care, as outlined by Stroul and Friedman (1998, 1994) for example were not in place (Bartlett & Freeze, 2005).

To that end, I conducted a beginning study on the system of care in Manitoba in the spring of 2004 (Bartlett, 2004). A "Human Subject Research Ethics Protocol

Submission Form" was submitted (see Appendix A) and approval was granted for this research by the Education and Nursing Research Ethics Board (see Appendix B). Also, "Approval to Research Records" was granted by Child and Family Services (see Appendix C).

In my capacity as a behaviour and learning support resource teacher I support children with EBD in regular school settings. I work also with teachers, resource teachers, school counselors and teaching assistants to help identify and implement strategies designed to help children with severe EBD to be successful at school. In most cases, children with EBD have very complex needs. Often, they have multiple diagnoses, are on several different medications, and may be so physically aggressive that they pose a threat to the safety of themselves or others.

As a behaviour and learning support resource teacher, I became interested in the challenges associated with teaching students with EBD. In particular, I wanted to explore how broad arrays of services were provided to them and to explore how the provision of those services could be improved. To do this, I wanted to obtain the perspectives of parents, foster parents, social workers and school personnel to learn about the factors that they felt influenced the effectiveness of support for children with EBD. Through this process I hoped to give voice to the key participants in the system of care and draw attention to gaps in service provision.

In my beginning study (Bartlett, 2004), I interviewed 5 individuals involved in supporting children with EBD. I interviewed a parent, 2 social workers and 2 teachers. Based on my research I identified 4 themes that I felt warranted further investigation. The themes were: (a) the importance of the relationships between service providers and with

parents, (b) the difficulties that appeared to be related to limited resources, (c) the frustration of parents and service providers in constantly having to justify or prove need to funding agencies, and (d) the conflicts that appeared to arise due to a lack of clarity over roles and responsibilities.

Relationships. I was surprised to learn that all of the informants in my pilot study felt the relationships that they had with other members of the multidisciplinary team directly affected their perceptions of the success of the children's programs. In other words, when the team of adults was getting along, all participants expressed greater satisfaction with the program supports and reported greater success and gains by the child. The social worker Donna (pseudonym) talked about the fact that it was a priority for her to build relationships with the families she supports. She said,

> I think that one of the things I probably do is just listening
>
> to people and trying to really hear what they're saying.
>
> Sometimes it takes getting to know them and building trust
>
> before I can really help. That's where I focus a lot of my
>
> energy (Bartlett, 2004, p. 5).

Sometimes it appeared, especially in the parent's case, that the personal support that she received from the members of the multidisciplinary team was just as important as the material support she received. This came through in her comments about one of her mental health supports,

> Or just phoning him and having a nervous breakdown and
>
> telling him what's happening, and asking for help. Even if
>
> it's just me in a frantic thing because I've just had enough

and I'm overwhelmed, to have him giving me the support

and I know that he knows his stuff (Bartlett, 2004, p. 21).

The relationships between the members of the multidisciplinary team also had an

impact on their perceptions of the effectiveness of the team. The parent referred to

conflict between her child's classroom teacher and teaching assistant and said that she

felt she had to help resolve their personal conflict because if she didn't, she was worried

that it might adversely affect her child. Jackie said, "But I have to live it, so I have to be

involved. So then I try to manage all those things to try to keep everybody happy and

remind them that this is about the kid" (Bartlett, 2004, p. 15).

The classroom teacher was less specific, but she too referenced how conflict

between team members was a factor that was interfering with the coordination of services

for this child, she said, "The only thing that I can think of that might have hindered [the

receipt of services] is sometimes you have personal conflicts" (Bartlett, 2004, p. 14).

Limited resources. Participants also identified several obstacles that they felt

interfered with their attempts to meet the best interests of the child and family involved in

a system of care. All participants felt that budgetary restrictions had limited the creativity

and flexibility they were able to employ when attempting to support children with EBD.

The participants also reported that having their own separate bureaucratic structures for

obtaining support sometimes led to competition as opposed to cooperation over much

needed resources. The parent Jackie explained that she had to fight with service

providers in order to receive basic necessities for her son. She shared that it if she gave

up her child to government care it would cost significantly more than the amount of

money she receives to support her child. She said, "If I quit right now it's going to cost

them $250, 000 per year, when I get $10, 000 a year from welfare to supply this kid with everything here … so why not put some of the funds into the home so that he can still stay at home as long as I can possibly keep him" (Bartlett, 2004, p.17-18).

The availability of resources was essential to the success of the team. The teacher described the funding process to obtain teaching assistant support as, "Horrible! You are at the depths of despair because you can't celebrate any successes. I wish you could but you really can't" (Bartlett, 2004, p.10). The social worker "Ruth" talked about how the child in question had developed an interest in the arts. Then "Ruth" described a dispute over payment for lessons that was preventing the child from being able to participate in such a positive activity. She said:

> I don't think that it's always a good use of time on
>
> anybody's part to be fighting for funds of $150.00 when we
>
> look at the big picture that if we do not help this child to be
>
> functional, we know what the future for him is, and that's a
>
> future of institutionalization in a mental facility or
>
> incarceration (Bartlett, 2004, p. 19).

Proving need. Most of the informants talked about constantly having to prove that an individual in their care needed the services and supports that they said they needed. The social worker Ruth put it aptly when she said, "I'm not prepared to have to justify over and over again and be treated with a suspicious attitude when I'm doing a professional function" (Bartlett, 2004, p.18). Ruth was the only person to use the term "suspicious attitude," but that really seemed to be the way professionals and parents felt that they were being treated by agencies when they made requests for

support. The parent Jackie described her struggle to obtain support for her son as an

ongoing battle. She expressed her frustration by saying:

> It sucks though that it has to come down to that. It
>
> shouldn't have to come down to me always fighting for
>
> things that are so minute that he deserves. If he could say
>
> these things then everybody would be listening. But
>
> because he can't and I am his voice, I have to fight on a
>
> daily basis to get the things that he deserves as a human
>
> being, which is not right (Bartlett, 2004, p. 18).

I don't think any of the informants had an objection with having to make a request

for support, their complaint was having to constantly prove that it was needed through

lengthy paperwork, and then encounter a complex bureaucratic approval process, and

then still face the possibility of being denied support. Professional staff described the

process of proving that an individual needed a particular support as so time consuming,

that it was taking away a significant amount of their contact time with the individuals

they were supposed to be supporting. According to the parent "Jackie," the bureaucratic

approval process was creating significant stress in her life and causing her to become

disillusioned with the system. Obtaining support for her son had become like a full-time

job and she described that over the years she had been forced to become skilled at

navigating her way through the system in order to obtain necessary supports.

Roles and responsibilities. When there are so many people and agencies involved

with a child and family and each agency is accountable to an entirely separate authority,

the coordination of services becomes challenging. The confusion created by the presence

of so many different and sometimes competing interests can interfere with the provision

of supports (Bartlett & Freeze, 2005). The social worker "Ruth" talked about a dispute

between her agency and the school system over who was going to pay to supervise a

child with EBD over the lunch hour. She said:

> I'm still receiving difficulty on the approval on a monthly
>
> basis for this lunch coverage to be done, because there's a
>
> dispute between the school system and our agency about
>
> whose responsibility it is, but because that period of the day
>
> is not considered part of the school day from their
>
> perspective. Somebody has to take responsibility for what
>
> happens with … during the lunch hour, so we can debate
>
> about whose responsibility it is (Bartlett, 2004, p. 10).

The parent also talked about how the services she received were uncoordinated

and if she received support from one agency, it could preclude her from receiving support

from another agency. When asked about how the agencies come together to support her

child she said:

> They really aren't. They are a separate unit. You'll have
>
> … saying, "well, you get thirty-nine hours already from …
>
> so we don't see why you need our assistance when we
>
> could be giving it to someone else" … it's politics
>
> (Bartlett, 2004, p. 7).

The social worker Donna reiterated the concern about a lack of coordination of

services. She said, "Administratively, we and … are going to be under the same umbrella,

we are supposed to work together, we are *supposed* [italics added] to work cooperatively.

Really, though, I don't think that our communication is really good with … (Bartlett,

2004. p. 11). She went on to say that she felt that all services should really be under the

same coordinated body, "So we're not so protective of our own dollars" (Bartlett, 2004,

p. 13).

At the same time, there was the feeling that some agencies were doing more than

others and some agencies were not doing what they should be doing.   Since the roles and

responsibilities of agencies are not clearly defined in the Manitoba system of care, and

may not be discussed at multidisciplinary meetings, there may be cross-disciplinary stress

between partnering agencies (Bartlett & Freeze, 2005). For example, the teacher

"Michelle" said that the medical profession did not provide assistance in developing

plans for her students with complex medical needs. She felt that she had to do her own

research on the Internet to learn about how to address complex health issues and that she

did not receive any guidance or support from the medical profession. When asked if she

could change anything about the system of care process she said:

> I think I'd have more help from the medical field. There's
>
> a lot of guessing going on that I don't think it's necessary.
>
> I think that there's information out there. It's a pretty big
>
> onus sometimes to figure out some of the medical things
>
> that are happening with some of my students. That's the
>
> area I find the hardest … I just find the medical part of it
>
> really hit and miss, and just really what I figure out on my
>
> own (Bartlett, 2004, p. 15-16).

It may be that as long as the agencies involved in supporting children and families in

need are accountable to entirely separate authorities, there will continue to be confusion

over roles and responsibilities and competition over resources.

<u>Purpose of the Study</u>

In this study that followed the pilot, I wanted to extend my research and obtain the

perspectives of key participants involved in parenting and supporting children with EBD.

Approval to continue my research was granted by the Education/Nursing Research Ethics

Board (see Appendix D). I wanted to investigate additional cases to determine whether

or not the system of care in Manitoba was achieving its stated objectives from the

perspectives of key participants in this process. I also wanted to learn from the

perspectives of key participants about the conditions that might facilitate

multidisciplinary teaming for children with EBD. Furthermore, I wanted to explore the

factors that the key participants believed were interfering with the identification and

provision of supports for children and adolescents with EBD. Ultimately, by telling the

stories of individuals involved in the system of care in Manitoba there will be heightened

awareness about this issue and the needs of children and adolescents with EBD and their

families will be heightened.

Chapter 2

Literature Review

In this chapter, I am going to begin by discussing the impact of insufficient and inadequate mental health supports for children and adolescents with EBD and their families. Next, I am going to explore the confusion that has been created because of a poorly defined and inconsistently applied categorical approach to labeling children and adolescents with mental health disorders. Then, I will discuss how the absence of accurate prevalence statistics has interfered with the provision of support for children and adolescents with EBD and their families. While these issues are not the primary focus of this study, they provide a context for the inconsistencies and conflicts that exist in the Manitoba system of care and, in part, help to explain why the implementation of a system of care has been so problematic. Although there is a need for quantitative studies to explore these systemic issues in greater depth, I am going to surrender to a different research method. I am going to conduct a qualitative study on the system of care to give voice to the individuals who support and care for children and adolescents with EBD. To that end, I will conclude this chapter by exploring the conflicts that exist in the Manitoba system of care model. Behind the labels and the statistics are real people whose lives are directly affected by the conflicts that exist in the system of care and it is their stories that provide additional and important voices within the system of care.

Limited Mental Health Supports

"If mental illness were an infectious disease, it would constitute an epidemic in Canada. The number of people affected is overwhelming" (Upshall, 2003, p 4). Mental illness is not just an adult condition, nor is it only an issue for low income or at risk

families. Increasingly, children and adolescents from what could be described as the larger, low risk populations are presenting with mental health disorders. Prevalence rates of mental disorders in children and youth in Canada have been estimated to be as high as 15% (The Standing Senate Committee on Social Affairs, Science And Technology, 2004). The Canadian Institute of Child Health (2000) reports that approximately 1 in 5 children aged 4-11 has some form of behavioural disturbance requiring clinical care. Of even greater concern, is an Ontario Child Health Survey that found that of all children with mental disorders, 68% had two or more coexisting mental disorders (The Standing Senate Committee on Social Affairs, Science And Technology, 2004). Mental disorders are also extremely problematic in adolescents. According to the 2002 Canadian Community Health Survey (CCHS), adolescents and young adults aged between 15 and 24 were more likely to report suffering from mental illness and/or substance abuse disorders than any other age group in Canada (Statistics Canada, 2003).

While the prevalence of EBD in children and adolescents is growing, the services and supports for this segment of the population have not increased to accommodate their needs. A Canadian Council of Social Development [CCSD] survey of 112 Canadian agencies found that children and adolescents with special needs were not being adequately served. Furthermore, the survey found that children and adolescents with mental health problems and behavioural difficulties were the most under served population (Hanvey, 2002). According to Watters and Robeson (1999) there is a critical shortage of mental health professionals to meet the needs of children and adolescents with mental health disorders. Due to this critical shortage it is not uncommon to face waiting lists of two years. According to the Canadian Institute of Child Health (2001) in

Toronto, children and adolescents may wait approximately 18 months to receive a diagnosis in the publicly funded system. Mental health services are available in the private system within a week or two, but the cost is approximately $2000.00 per patient per assessment, which may preclude many families from receiving timely services (Standing Senate Committee on Social Affairs, Science And Technology, 2004). In addition to limited diagnostic supports, there are a limited number of treatment programs designed to address the needs of young children with EBD (Burns & Goldman, 1999). Children and adolescents with unmet mental health needs are often highly visible in schools and in the community and may cause high levels of stress in families (Postl, 1995). The social and economic costs of inadequately addressing the mental health needs of children and adolescents should not be underestimated. According to a national longitudinal study, individuals characterized as having EBD had the highest unemployment, the poorest work history and the greatest number of social adjustment problems (Wagner & Shaver, 1989). Wagner (1989) also found that more than 50% of students with emotional disorders are arrested within 3 years of leaving school.

Due to the shortage of mental health supports and a lack of service coordination, parents and schools may be given the task of managing and attempting to treat children and adolescents with EBD. For many children and adolescents with EBD, the only long-term, consistent support they receive is provided by the educational system. While most service systems struggle with diagnosing and treating children and adolescents with EBD, an inappropriate share of the responsibility for supporting school age individuals with EBD may have been placed on the educational system in the absence of essential resources elsewhere; for instance in family, justice, health or aboriginal services.

Traditionally, it has not been the purview of schools to provide treatment for children with EBD.

Wolfensberger and Glenn's (1975) notion of Model Coherency can be used to assess the appropriateness of the systemic supports for children and adolescents with EBD. Program analysis can be conducted by asking the following questions, "are the right people working with the right clients, who are properly grouped, doing the right thing, using the right methods, and consistently so?" (Wolfensberger & Glenn, 1975, p. 35). The answer to these questions appears to be no on all accounts. Increasingly, schools are not only responsible for providing an education to children and adolescents, but defacto, they are expected to provide and coordinate mental health services (U.S. Department of Health and Human Services, 1999). The school might seem to be a logical place to provide mental health services, were it not for the fact that the educational system also has experienced reductions in areas such as special education, guidance, social workers and psychologists that may assist children and adolescents with mental health disorders (Hanvey, 2002). It is also important to note, that most schools are not treatment facilities and while supports may be available to assist with the implementation of mental health programming, schools cannot be expected to lead such programming unless there are profound changes in the type of mental health supports that are currently available in schools and profound changes in the model of mental health service delivery.

Categorical Labels

Research in the area of mental illness yields a multitude of labels that can confuse and mislead and ultimately interfere with the implementation of a system of care. Terms such as "seriously emotionally disturbed, behaviourally disordered, socially maladjusted,

emotionally deviant, socially emotionally disabled, psychologically impaired, emotionally handicapped and most recently emotionally behaviourally disordered" are found throughout the literature (Kauffman & Kneedler, 1981). The term seriously emotionally disturbed [SED] is the label that was used in the United States federal "Individuals with Disabilities Act" (IDEA, 1975). However, there was a great deal of debate about the appropriateness of this label because it was the only disability that used a modifier to describe the disability (Knitzer, Steinberg, & Fleisch, 1990) and because the term "emotional disturbance" was thought to be stigmatizing (Smith, Wood, & Grimes, 1988). In the early 1990s, as dissatisfaction with the SED label grew, the National Mental Health and Special Education Coalition, an organization of 30 mental health and education organizations led by Forness and Knitzer proposed the use of the term emotional or behavioral disorder [EBD] (Forness & Knitzer, 1992; Merrell & Walker, 2004). Various organizations lobbied to have the label EBD and its corresponding definition proposed by Knitzer and Forness adopted in two different reauthorizations of IDEA. However, their attempts to have the term EBD formally adopted in the United States have been unsuccessful. In 1997, Public Law 105-17 amended IDEA and changed serious emotional disturbance [SED] to emotional disturbance [ED]. Despite the fact that federal legislation in the United States now uses the label ED, there continues to be widespread preference for the term EBD among professional organizations (Forness & Kavale 2000).

<u>Categorical Labels in Canada</u>

The provision of services to children and adolescents with mental illness in Canada is further complicated by the fact that the Canadian federal government has not

established a definition for children with mental disorders. Variations in how children and adolescents with mental illness are defined and how these definitions are used to determine eligibility for services may in turn interfere with the receipt of services. According to Upshall (2003), "A respectful, common language to discuss mental illness and mental health is lacking between disciplines and sectors" (p. 8). The classification of mental illness in Canada follows the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV-TR] (American Psychiatric Association, 2000) or the *International Classification of Diseases* [ICD] (World Health Organization, 2004). Both classification systems list more than 300 mental disorders (The Standing Senate Committee on Social Affairs, 2004). Mental disorders or illness generally refer to "clinically significant patterns of behavioural or emotional function that are associated with some level of distress, suffering (even to the point of pain and death), or impairment in one or more functional areas (e.g., school, work, social and family interactions" (World Health Organization, 2004, p.68).

Since education in Canada is a provincial responsibility and there is no federal legislation that defines children and adolescents with mental illness, each province and territory has adopted its own definitions and policies with respect to children with mental disorders. As a result, there is a lack of consistency across Canada with respect to the terminology that is used to identify and provide services to children and adolescents with mental disorders. For a comparison of special education labels and approaches to funding children with behavioural difficulties in Canada (see Table 1).

Table 1

A Comparison of Special Education Labels and Funding for Students with Behaviour

Disorders in Canada

Province	Label	Funding
Manitoba	Very severe emotional behavioural disorder	Categorical
	Severe to profound emotional behavioural disorder	Categorical
	Mild to moderate emotional behavioural disorder	Non-Categorical
Saskatchewan	Social, emotional behavioural disorder	Non-categorical
	Intensive social, emotional and behavioural needs	Categorical
Alberta	Mild to moderate emotional/behavioural disability	Non-categorical
	Severe emotional/behavioural disability	Categorical
British Columbia	Students who require moderate behaviour supports or students with mental illness	Non-categorical
	Students requiring intensive behaviour interventions or students with serious mental illness.	Categorical
Ontario	Behavioural and/or emotional disorder	Non-categorical
	Severe behavioural disorder	Categorical

Table 2 (continued)

Province	Label	Funding
Quebec	At risk students	Non-categorical
	Students with severe behaviour disorders	Categorical
Newfoundland	Mild/moderate emotional/behavioural disorder	Non-categorical
	Severe emotional/behavioural disorder	Categorical
Nova Scotia	Emotional Impairments	Categorical
Nunavut	Students with minor to moderate social/emotional needs (Level 2)	Non-Categorical
	Students with high needs	Categorical
New Brunswick	No labels	Individualized
Prince Edward Island	No labels	Individualized

Manitoba. The province of Manitoba in its provincial special education funding

documentation uses the term "very severely emotionally/ behaviourally disordered" to

describe children with mental disorders. This categorical approach also identifies the

extent or degree of the disorder with the descriptor level II EBD and level III EBD. A

child whose needs are categorized as level II EBD is described as having "very severe

EDB" and a child whose needs are categorized as level III EBD is described as having

"severe or profound EBD" (Manitoba Education, Citizenship & Youth, 2005). In order to

receive student specific support, the child or adolescent must meet the criteria that are

outlined in one of the aforementioned categories. A non-categorical or "block funding"

approach for students with level II EBD is being piloted in the province of Manitoba in a

small number of school divisions (Manitoba Education, Citizenship and Youth, 2002).

Saskatchewan. Saskatchewan Learning (2004) uses the label social, emotional,

behavioural disorders. Saskatchewan provides block or diversity factor recognition for

this segment of the student population. In other words, students in Saskatchewan do not

have to meet the criteria of having a social, emotional, behavioural disorder to receive

support. Instead, funding is allocated based on student enrollment and projected need. A

block of funds are allocated for students with social, emotional, behavioural disorders,

learning disabilities, gifted learners and speech and language disabilities collectively, and

it is up to individual school divisions to allocate these resources based on the needs of the

students (Saskatchewan Learning, 2004). Saskatchewan Learning does, however, have a

separate funding category for Children with Intensive Needs in the Care of the

Department of Community Resources and Employment who have intense social,

emotional and behavioural needs and are placed in a therapeutic foster home. Children

and adolescents in foster care with intensive social, emotional and behavioural needs receive categorical funding if they meet the criteria that are outlined by the province of Saskatchewan (Saskatchewan Learning, 2004).

Alberta. Alberta Learning (2004) uses the label emotional/behavioural disability. They also specify the extent of the disability using the descriptors mild to moderate and severe. Children and adolescents with a severe emotional/behavioural disability must meet categorical funding criteria in order to receive student specific funding. Alberta is the only province that uses the label "disability" to define students with mental health disorders.

British Columbia. The Government of British Columbia Ministry of Education (2002) uses a descriptor that is the most consistent with the Canadian mental health community. The label used identifies students requiring behaviour supports or students with mental illness, and students requiring intensive behaviour support interventions or students with serious mental illness. Mental illness is a broad category that can include any number of mental disorders. Students must meet the criteria that are listed in these categories in order to receive student specific support.

Ontario. The province of Ontario identifies children and adolescents as having a behavioural/emotional disorder under the broad category of behaviour when determining a child or adolescent's eligibility for special educational supports. Students with severe behavioural/emotional disorders must meet pre-set criteria in order to receive student specific support (Ministry of Education, Ministry of Training, Colleges and Universities, 2001).

Quebec. The Province of Quebec uses the broad category of students with social maladjustment to describe children with EBD. The category of social maladjustment is then divided into two groups: (a) at risk students and, (b) students with severe behavioural disorders. At risk students include students who require special support because they may have an emotional disorder, a behavioural disorder, exhibit learning delays, or have a developmental delay or mild intellectual impairment. Support for these students is not dependent on a formal diagnosis instead it is based on students' needs. The second category of students with severe behavioural disorders has very specific diagnostic criteria and is categorically funded (Quebec Ministere de L'Education, 2004).

Newfoundland and Labrador. The province of Newfoundland and Labrador use the label emotional/behavioural disorder and they specify the degree of the disorder, using the terminology mild, moderate and severe (Government of Newfoundland and Labrador Education, 2004). This label is then used to determine a student's eligibility to receive special educational supports.

Nova Scotia. The Province of Nova Scotia uses the label emotional impairments to categorize students and determine eligibility for special educational supports (Special Needs Information Service Directory Online, 2004).

Nunavut. The Nunavut Department of Education uses a categorical approach to funding. Level 1 students are students identified as having the highest or most severe level of needs, level 2 students are described as students with moderate needs and level 3 students are students who may occasionally require additional supports to participate in the mainstream programming. In the level 2 and 3 descriptors students with

social/emotional needs are identified as a group who must qualify for special educational

support (Data Probe Economic Consulting, 2002).

Prince Edward Island and New Brunswick. Prince Edward Island and New

Brunswick do not use a categorical approach to fund students in the educational system.

In Prince Edward Island, if a student is found to have "special educational needs" they

will receive support. In the Minister's Directive NO. MD 2001-08 Special Education, the

province of Prince Edward Island describes special educational needs as the needs of

students who have significant difficulties in learning. The directive then goes on to say

that the difficulties in learning do not need to be attributable to a particular cause or

diagnosis (Government of Prince Edward Island, 2001). In other words, students do not

have to meet categorical criteria in order to receive support in the educational system. In

New Brunswick, Bill 85 emphasizes individual programming. It defines a special

education program as based on an individual pupil's specific needs rather than on a

specific category or handicap (New Brunswick Department of Education 1988).

Despite the research that indicates categorical approaches to the provision of

supports for children and adolescents with EBD are inadequate and inappropriate

(Feldman, 1993; Knitzer, 1982), categorical approaches continue to be used in a majority

of the Canadian provinces and territories. Prince Edward Island and New Brunswick are

the only two Canadian provinces that do not use a categorical approach to supporting

students with EBD. According to Stroul and Friedman (1986), the categorical nature of

support interferes with the seamless provision of child-centered, individualized services.

When a categorical model is used agencies may end up focusing on the services the child

or adolescent is eligible to receive, instead of focusing on the services the child or adolescent needs (Bartlett & Freeze, 2005).

Prevalence of EBD in Canada

A lack of agreement in Canada about a label and a definition for children and adolescents with EBD leads to difficulty in identifying the prevalence of emotional and behavioural difficulties. Presently, there is no national data base in Canada that can provide information about the prevalence of mental disorders for any age group, nor has there ever been a national survey to determine the prevalence of mental disorders in children and adolescents (The Standing Senate Committee on Social Affairs, Science and Technology, 2004). While some school divisions may collect their own data on the segment of their school population with EBD who are receiving special education services, these surveys have been highly unreliable due to the variability in definitions and eligibility criteria used in each province and territory. According to a survey conducted by Csapo (1981) to determine the number of children in each province and territory with emotional and behavioural problems, Saskatchewan reported 2%, Manitoba reported 3-5% and the Yukon reported 12 to 20%. As a follow up to this study, Dworet and Rathgeber (1990) conducted a provincial survey to determine the number of "behaviourally disordered" students who were receiving school services. According to this survey only .0002% of students in Saskatchewan and 1% in Alberta, New Brunswick and Newfoundland were identified as behaviourally disordered and receiving school services. These results do not seem to accurately reflect the number of children with EBD in the educational system.

More recently, Waddell and Shepherd (2002) estimated overall and disorder specific prevalence rates of mental disorders in children and adolescents in British Columbia. Their study was used to estimate the overall prevalence of mental disorders in children and adolescents in Canada and it was found that approximately 15% experience mental illness/addiction severe enough to cause significant distress and impaired functioning. The most common disorders among children and adolescents were anxiety (6.5%), conduct (3.3%), attention deficit (3.3%) and depressive (2.1%) (The Standing Senate Committee on Social Affairs, Science And Technology, 2004). These results appear to be consistent with the work of Postl (1995) who found that 18 – 30 % of children in Manitoba had mental health needs that warranted intervention, of those children 3 % had severe psychiatric disorders that required intensive support. In the absence of accurate information about the prevalence of mental disorders it is difficult to develop appropriate public policies. Furthermore, it is difficult to allocate resources to a segment of the population that can be underestimated because of confusion over terminology.

There are contested definitions for children and adolescents with EBD, contested models of service delivery and an increasing number of children and adolescents requiring support. Amidst this confusion, the province of Manitoba has elected to adopt a system of care policy to improve services for children and adolescents with EBD. Due to the fact that there are so many competing models, it is not surprising that the system of care in Manitoba has not been effectively implemented.

Conflict in the Manitoba System of Care

The province of Manitoba has imposed the system of care model in the absence of

the organizational structures and models of professional practice that make the

coordination of services possible (Bartlett & Freeze, 2005). Despite the existence of a

protocol which states that a system of care will be implemented, a comprehensive plan of

how services can be coordinated to better meet the needs of children and adolescents with

multi-system needs has not been developed (Manitoba Children & Youth Secretariat,

1997a; 1997b; Proactive Information Services, 1998; Manitoba Education, Citizenship &

Youth, 2001).

A lack of clarity over roles and responsibilities. The system of care policy in

Manitoba has not been accompanied by clear directives outlining the roles and

responsibilities of the partnered service providers. While a memorandum of

understanding does exist as the "Interdepartmental Protocol Agreement for Children and

Adolescents with Severe to Profound Emotional and Behavioural Disorders" (Manitoba

Education and Training, Manitoba Family Services, Manitoba Health & Manitoba

Justice, 1995), this document does not outline how the implementation of a system of

care will occur.

Changes in leadership, staffing and political support. Changes in political

leadership and staffing can effect the implementation of a system of care (Hernandez &

Hodges, 2003; Lourie, 1994). While the system of care may have been foremost in the

minds of decision-makers in the early 1990s in the province of Manitoba, individuals

involved in the conceptualization of the policy may no longer be involved in the

implementation of the plan. The implementation of a system of care may no longer be a

priority and its original intent may have become overshadowed by other issues. This

might account for the absence of multi-disciplinary training in the system of care concept

in the province of Manitoba since the late 1990s.

Interdependence. Competing and contradictory agency mandates about who is

responsible for a child or adolescent with EBD may interfere with collaboration and the

development of a comprehensive system of care. For example, when educators are

unable to manage children with extremely aggressive behaviours, they may have no

other option but to suspend them from school which, in turn, puts significant stress on

their families and communities. Due to the limited number of therapeutic educational

settings that are available for children and adolescents in crisis, parents may be forced to

take time off work or not work at all because of their child's behaviour. This is only one

example of the significant stress that families of children with EBD may face (Bartlett &

Freeze, 2005). When social service agencies are asked to provide assistance to families

during school hours, families may be told that it is outside of that agency's mandate. In

this regard, social service agencies are coupled only loosely (Mintzberg, 1979) and,

consequently; may give a higher priority to their own mandates than those of other

agencies (Hodges, Nesman & Hernandez, 1998). Thus, inter-agency collaboration is

replaced with isolation at best and competition at worst, which contradicts the philosophy

of a system of care for the child.

Funding. Most social service providers have separate funding and administrative

structures which may interfere with collaboration. Furthermore, the funding systems

used by social service agencies seem to encourage cost shifting. Cost shifting is defined

as, "trying to move children to different agencies so the services are funded out of

somebody else's budget" (Anderson, McIntyre, Rotto & Robertson, 2002: p.7). The

absence of flexible funding may lead agencies to become protective of their own dollars

and may cause unnecessary delays in the receipt of services. At times disputes about who

will pay for support may even prevent children and adolescents from receiving the

services they need.

Information sharing. Another barrier to collaboration may involve poor

communications between service providers. There may be a lack of understanding on the

part of mental health providers about how the educational system works, while educators

may not understand the legal mandates of the child welfare system (Anderson, 2000).

Furthermore, there is no single agency in Manitoba with the responsibility of managing

the records of children and adolescents with multi-system needs. Rules about privacy can

further interfere with collaboration, as agencies may be apprehensive about sharing

information.

Shared responsibility. According to Eber, Osuch and Redditt (1996), when

schools have participated in a system of care they have rarely acted as the lead agency.

Traditionally, systems of care have been initiated and managed by family services and

mental health. However, in Manitoba, Manitoba Education, Citizenship and Youth is

described as the lead agency responsible for ensuring the integration of services for

children and adolescents with multi-service needs (Manitoba Health, 1999). The

educational system may have been inappropriately given the responsibility of developing

and coordinating treatment plans for children and adolescents with EBD. Education is

the only service provider whose student specific funding is directly dependent on

multidisciplinary teaming in the development of 24-hour plans and the identification of

shared treatment goals for children and adolescents with EBD. In Manitoba, children, families and schools may be the only real stakeholders in the development multidisciplinary plans. All other service providers have their own bureaucratic procedures for obtaining support. In the absence of a multidisciplinary plan, the school is the only agency who will not receive student specific funding to meet the child's needs (Bartlett & Freeze, 2005).

Case management. One of the added roles of special educators, resource teachers, counselors and parents has been to serve as case managers for children with EBD, even though case management for children with EBD may require mental health training (Evans, Armstrong & Kuppinger, 1996). In order for case management to improve the quality and quantity of services available to the child or adolescent with EBD, this function may need to be performed by an individual who is independent of the service providers, like a clinical case manager (Shulman & Athey & 1993). In the Manitoba system of care, educators and other social service providers serve as case managers without the freedom to act independently in the best interests of the child. Case management is not the sole function of educators or social service providers, but rather it is an added responsibility and as such it may not receive the attention that it should (Bartlett & Freeze, 2005).

Treatment options. The educational system does not have a continuum of services for children and adolescents with EBD (Kauffmann, 2003; Walker, Zeller, Close, Webber & Gresham, 1999). According to Merrell and Walker (2004),

> In some instances, nothing exists in terms of service options
>
> beyond some additional time in the resource room, or some

occasional monitoring by an assigned case manager. In other

instances, the only options for special education students

identified as emotionally disturbed [ED] are a self-contained

classroom with other ED students or nothing at all. Neither

extreme is appropriate but they are all too common in our

schools (p. 904-905).

While some school divisions may employ psychiatrists, their support may be

limited to the diagnosis and assessment of the presenting difficulties. The treatment

component may be limited to the prescription of medication, while the monitoring of

medication is often left up to the child's family doctor. School divisions also may

employ school psychologists but due to large caseloads the direct therapeutic services

may not be available. Once the child or adolescent receives has received a formal

diagnosis from a psychiatrist, the school professionals may be forced to rely on their own

knowledge of the disorder and their knowledge of the child to develop a behaviour

intervention plan and a 24-hour plan. This may mean presenting mental health

professionals and family services professionals with a "multi-system" plan that was

developed by school personnel and parents in the absence of support from the other

service providers.

Some children in Manitoba who are under the care of a psychiatrist will receive

services from a mental health clinician. The mental health clinician is supposed to

provide treatment and case management (Manitoba Health, 1999). One of the additional

roles of the mental health clinician is to act as the liaison between the psychiatrist and

other agencies. As schools and families struggle on a daily basis to meet the needs of

children and adolescents with severe EBD, they may look to mental health clinicians to provide direction and expertise in the area of mental health. However, schools become increasingly frustrated when they hear comments like, "The child is not ready for therapy." "I have put the child on a waiting list for a social skills group." The child's home life is not stable, so now is not the time to intervene." "The parents are not actively engaged so we will not provide additional resources at this time." Educators cannot opt out of providing service because the child is not stable or because parents do not want to engage. This is the time when services are most needed. What children and adolescents with EBD and their families need are individualized services, clarity of roles among participants and a collaborative team that is focused on meeting their needs.

Equality among participants. The provision of services to children with EBD in the province of Manitoba seems to favour children and families of children who are in foster care. Parents of children with EBD may be blamed for their child's disability and forced to make significant financial sacrifices (Kaufmann, in press). Frequent calls from the school to their place of employment and frequent absenteeism because of their child's behavioural issues may make it extremely difficult for a parent of a child with EBD to maintain a job. In spite of the stress on families, the current system in Manitoba may not provide support to families of children with EBD during school hours. Therapeutic foster care is extremely costly, however, there does not seem to be a comparable level of support provided to families who struggle with parenting a child with EBD. Regrettably, the current system in Manitoba may force families of children with EBD to place their children in foster care in order to obtain the level of support that they and their child need (Bartlett & Freeze, 2005).

Chapter 3

Method

Design of the Study

The purpose of this study was to obtain the perspectives of teachers, parents and social workers about whether or not the system of care in Manitoba is achieving its stated objectives. In this study I wanted to learn how teachers, parents and social workers felt about multidisciplinary teaming for children and adolescents with EBD. Specifically, I wanted the participants to share their perspectives about the supports and services that are available for children and adolescents with EBD. In addition, I was interested in finding out what kinds of supports were available for children and adolescents with EBD and whether or not these supports were meeting their needs and the needs of their families from the perspectives of the individuals directly involved in the process.

I elected to use qualitative methods for this study because I wanted to give participants who were directly involved in supporting children and adolescents with EBD an opportunity to tell their stories. I wanted to "give voice" to the people involved in the day to day challenges of supporting children and adolescents with EBD. The phrase "giving voice" is associated with qualitative research and refers to empowering people who may not have had an opportunity to tell their stories, to share their insights and ultimately promote social change (Bogdan & Knopp Biklen, 2003). It is important to obtain the perspectives of the individuals involved in supporting children and adolescents with EBD because their first hand experiences with the system of care will provide evidence of its strengths and weaknesses and may provide suggestions to improve services.

I chose to conduct a multi-case study using semi-structured interviews of parents, social workers and teachers of children with EBD. "An interview is a purposeful conversation, usually between two people but sometimes involving more" (Bogdan & Knopp Biklen, 2003). Qualitative interviews provide considerable latitude in that they allow the interviewer to pursue a range of topics and provide the subject with the opportunity to shape the content of the interview (Bogdan & Knopp Biklen, 2003). I chose to conduct semi-structured interviews because I wanted to give the participants the opportunity to tell their stories, but at the same time, I wanted to obtain some comparable data across cases.

I chose a multi-case study to demonstrate the generalizability or diversity of my findings. A multi-case study involves two or more subjects, settings or depositories of data (Bogdan & Knopp Biklen, 2003). Qualitative, in depth, semistructured interviews were conducted.

Recruiting the Participants

I obtained permission from the program manager of Child and Family Services to conduct my research (see Appendix C). In order to build upon my pilot study, I also obtained an amendment approval from the Education and Nursing Research Ethics Board [ENREB] (see Appendix D). Purposeful sampling was then used to identify 2-4 cases involving children or adolescents who were currently being supported by a system of care (see Appendix E). Purposeful sampling involves selecting informants who will facilitate the explanation of a developing theory (Bogdan & Knopp Biklen, 2003). The children who were identified were to be receiving level III funding support from the province of Manitoba under the category profoundly emotionally behaviourally disordered. I also

requested that the children who were identified be enrolled in the same school division.

Four cases were identified of which two cases were used for the present study. Once the

cases were identified, I obtained the parents' and guardians' telephone numbers from

Child and Family Services and contacted them by telephone. At this point, I confirmed

the parents' and guardians' consent for their children's cases to be used in my study. I

also obtained consent from the parent or guardian to participate in an interview and for

their child's teachers and social worker to also be interviewed (see Appendix F). Once

parental consent was obtained, I provided the child's social worker with a copy of the

"Approval to Research Records Application" that was granted by Child and Family

Services and a copy of the signed parental consent form which indicated the parent had

agreed to have their child's social worker interviewed. At that point, I obtained consent

from the social worker to participate in the study (see Appendix G).

Next, I contacted the superintendent of the school division to obtain permission to

conduct research (see Appendix H). I provided the school division with the names of the

children and adolescents who were identified to participate in my study as well a copy of

the signed parental consent letter in which the parents/guardians granted me permission

to interview school personnel. I also asked the school division for the telephone numbers

of the school personnel who were supporting these children. Then I contacted the school

personnel by telephone and provided them with a copy of the signed parental consent

letter and requested their participation in my study (see Appendix I). As a result, I

recruited and interviewed a total of 6 female participants. There were three participants

identified in each case. Three participants were identified in each case in order to provide

the perspective of a parent, a family services social worker and school personnel about

the system of care. Case 1 involved a nine year-old boy and I elected to interview his

mother, his social worker and his school based social worker. Case 2 involved a thirteen

year-old girl and I elected to interview her foster mother, her social worker and her

resource teacher/counselor at school. I had met one of the six selected participants

professionally prior to the study. The other five participants were unknown to me. The

goal of this study was to interview the participants about their experiences with the

system of care. During the interview, the participants were asked to reflect on the

identified child or adolescent's case when responding to questions about the system of

care.

The Participants

The participants in the study all lived in a western Canadian urban centre. They

also were all involved in supporting children and adolescents with severe emotional and

behavioural disorders but in different capacities. The children identified in both cases

attended school in the same school division. The school division has a student population

of approximately 15 000 students consisting of approximately 40 schools. The

population of the school division is diverse and has both an urban and suburban

component. The division provides some specialized "cluster" programs for students with

behavioural difficulties however, the children in this study were not enrolled in this type

of segregated program. All participants and any individuals who were referred to during

interviews were given pseudonyms. First, a brief synopsis introducing the child in case

one is provided, followed by an introduction of his support providers in alphabetical

order. Second, a brief synopsis introducing the adolescent in case two is provided,

followed by an introduction of her support providers in alphabetical order.

Case 1. Josh was a 7- year-old boy who was in grade 4. Josh was Aboriginal and lived with his biological mother, her partner, his brother and two step-siblings. At the time of the study, Josh had limited contact with his biological father. As an infant and toddler Josh's mother described him as having been restless, impulsive and prone to anger outbursts. As Josh grew older his mother described his behaviour as getting progressively worse. Josh was prone to aggressive and oppositional behaviour at both home and school. He had been diagnosed with Attention Deficit Hyperactivity Disorder and had taken stimulant medication in the past however, at the time of the study he was not currently being treated for his difficulties. Josh was described as having some learning difficulties and functioning approximately two years behind his same age peers in mathematics and language arts.

Alisa was a parent of four children ranging in age from 2 months to nine years. She was the biological mother of Josh a nine-year-old boy with severe emotional and behavioural difficulties that was the focus of this study. The first and second interviews were conducted in her home. She was eager to share her perspectives, but was somewhat distracted during the interviews by the presence of her younger children. During the first interview Alisa had assistance with her children from a support worker and during second interview she had assistance from a relative.

Margaret was a school-based social worker at Josh's school. She had been a social worker for two years. Margaret has a Bachelor of Social Work degree. She had also been a foster parent of a child with special needs for many years. Margaret was eager to participate in both interviews. The first interview took place in Margaret's office at her school and the second interview took place over the phone. It appeared that Margaret

had an excellent rapport with the students in her school by the way they greeted her as she walked down the hallway.

Page, Josh's social worker, has been a social worker for 11 years. She has worked in child protection, in foster care and has also been involved in adoption home studies. Page has a Bachelor of Social Work and a Masters in Social Work degree. Page thoughtfully considered each question. The first interview was conducted at my office and the second interview was conducted over the phone. Page changed employers after the first interview so she was difficult to contact. Eventually, contact was made and Page willingly participated in the second interview.

Case 2. Tina was a thirteen-year-old girl in grade 7. Tina was Aboriginal and in foster care. She was a permanent ward of a child welfare agency and had been in the same foster home for the past two years. Tina was apprehended from her family and had suffered much trauma. Tina lived in a foster home with two foster parents, their two biological children and one other teenage foster child. Tina had been diagnosed with a Severe Attachment Disorder, Oppositional Defiant Disorder and according to her foster mother she was waiting to have a number of other disorders explored. At the time of the study she was being prescribed Concerta, Clonadine and Olanzapine. Tina was prone to extremely aggressive, oppositional and self-destructive behaviour. She had significant learning difficulties and both the school personnel and foster parent described her as functioning academically at a grade one level.

Tina's social worker is Cheryl who works with a family services agency. She had been a social worker for 14 years and had a Bachelor of Social Work degree and a Bachelor of Arts degree. Cheryl had worked in child protection, as a kinship worker and

with permanent wards. She was very accommodative in setting up the interviews. The first interview was conducted in her office and the second interview was conducted over the phone. Initially, Cheryl seemed nervous and the presence of the tape recorder bothered her however, after the interview began she was more at ease and gave very thorough answers.

Connie was a resource teacher and counselor at Tina's K-8 school. She had been a middle years teacher for ten years. She had a Bachelor of Education and a Bachelor of Arts degree. This was Connie's second year in a resource/guidance role and she has taken a couple of courses in her Post-Baccalaureate Certificate in counseling. The first interview took place at Connie's school and she did not respond to requests for a second interview. Connie was very friendly and seemed eager to share her experiences. She was quite candid and felt comfortable expressing her opinions on many issues.

Lee-Ann was Tina's foster parent. She was also the foster parent of another teenage girl. Lee-Ann was married and had two biological children who also reside with her. Lee-Ann had been a foster parent for two years and had a background working with children in the foster care system. She had worked in shelters with children who had recently been apprehended. The first interview took place at Lee-Ann's home and the second interview took place over the phone. Lee-Ann had many stories to tell. She spoke very passionately about the issues raised during the interview process and seemed to appreciate being given the opportunity to tell her story and the story of her foster child.

Data Collection

  The data for this study were collected through in depth, semistructured interviews of six individuals involved in supporting 2 children with EBD who were receiving services through a system of care. In case 1 the parent, social worker and school-based social worker were interviewed. In case 2 the foster parent, social worker and resource teacher/counselor were interviewed. Each participant was asked to participate in two interviews of approximately one hour each. After the initial interview, member checking was used. That is, each participant was sent a copy of the interview transcript to review and during the second interview they were asked if they felt the transcript accurately reflected what they had said. They also were also asked if there was anything they would like to add, clarify or change.

  The interviews were conducted during the months of March, April, May, June, and July 2005 at a time and place of the participants' choosing. Two participants chose to have the initial interviews in their homes, two chose to have the interviews at their schools, one participant chose to come to my office and one participant wanted to meet at her office. All of the second interviews were conducted over the phone, with the exception of one, which was conducted in the participant's home. The first round of interviews ranged from 55 minutes to 115 minutes in duration with the average length being 85 minutes. The second round of interviews ranged from 25 minutes to 70 minutes in duration with the average length being 48 minutes. During the interviews I tried to make the participants feel at ease. I maintained a relaxed posture and tried to use my body language and eye contact to encourage the participants to expand on their ideas.

When the interviews were held at the participants' home, office or school I brought a box of doughnuts, which I left with them at the end of the interview. When the interview was conducted at my office, I offered the participant a cup of coffee or water and a doughnut. I began each interview by thanking the participants for their time and inviting them to share anything that they felt was relevant to the study. Then, I asked the participants about their experience and/or training in teaching, parenting and supporting children and adolescents with EBD who were being supported by a system of care. I also asked about their experiences with multidisciplinary teaming and their experiences in obtaining home, school and community supports for children and adolescents with EBD. After some data analysis, the questions that were asked of the parent and foster parent (see Appendix J), the social worker (see Appendix K), and the school personnel (see Appendix L) were followed up with individualized probing question during the second interview. Each participant was asked approximately eight individualized probing questions. In the first case, the parent (see Appendix M), the school based social worker (see Appendix N), the social worker (see Appendix O), and in the second case, the foster parent (see Appendix P), and the social worker (see Appendix Q), were asked to expand on their responses from the initial interview. In addition, the participants were asked to share their thoughts on some emerging themes, as well as their thoughts about some alternative models for supporting children and adolescents with EBD and their families.

The interviews were audiotape recorded and transcribed by a professional transcriptionist as soon as possible after the interviews. The transcriptionist adhered to a code of ethics and was held to a strict standard of confidentiality. A total of 215 pages were transcribed from the 11 interviews. The audiotapes were stored in a locked secure

location and the confidentiality of all participants was respected at all times. Deception was not used at all throughout the course of this study. There were no apparent risks to the subjects or third parties. Some of the participants in the study commented that it had been helpful for them to reflect on their experiences in supporting children and adolescents with EBD. In this regard, they felt that participation in this study had heightened their awareness about some of the needs of children, families and support providers involved in a system of care. At the conclusion of the interviews, the participants were reminded that they would receive a summary of the findings of the study.

<u>Data Analysis</u>

According to Bogden and Knopp Biklen (2003) data analysis means "the process of systematically searching and arranging the interview transcripts, field notes and other materials that you accumulate to enable you to come up with findings" (p. 147). As I came up with an idea or an understanding in my research I made detailed notes and comments on my field notes. I also drew diagrams to help sketch out relationships that I noticed (Miles & Huberman, 1994). In addition, I recorded my thoughts and observations as observer comments to provide me with the opportunity to express my emerging ideas and look for themes. A theme can be defined as a concept or theory that emerges from your data (Bogden & Knopp Biklen, 2003, p. 187). Then, I analyzed my data by developing a coding system. Developing a coding system involves searching through one's data for patterns and regularities. Often key words or phrases from the data become coding categories, in other words, the key words or phrases become the means by which the descriptive data will be sorted (Bogden and Knopp Biklen, 2003).

As I reviewed my data I highlighted key words and phrases to look for patterns and regularities. Since codes can be used to categorize information at various levels, I identified major codes for broad sweeping concepts and subcodes for data that could be broken down further. After I developed my coding categories I assigned each one a number. Then I grouped the quotes from my data in the appropriate coding category by using the "cut-up-and-put-in-folders-approach" (Bogdan & Knopp Biklen, 1992). Ultimately, I used a within case analysis and a cross case analysis to determine the perspectives and implications of the data that was collected.

Role of the Researcher

As an educator, who is directly involved in the provision of services to children and adolescents with severe EBD I have a vested interest in this issue. My direct involvement in systems of care in Manitoba helped me to build a rapport with the participants. I also kept a research diary that I used to record my thoughts and ideas related to my advocacy role. In order to reduce the potential for bias, my advisor read my field notes and ensured that I was accurately interpreting what the informants were saying. Furthermore, I elected to conduct my research outside the school division in which I work, so that I would not be in a position of power vis-à-vis the interviewees in my study.

Chapter 4

<u>Findings</u>

After extensive data analysis several themes emerged. The themes were: (a) support providers perspectives about resources, (b) the significance of relationships between service providers and with children and families, (c) confusion over roles and responsibilities on the part of service providers and families, (d) the impact of collaboration, (e) the role of case management, (f) outcomes for children and adolescents with EBD and, (g) the impact on families.

In this chapter each theme will be presented separately. I will use quotes from the participants in order for their "voices" to be heard. I will quote the participants verbatim except in cases where the grammar comprises the clarity of the point being made. In those cases I will make a few minor changes to enhance the clarity of what is being said. I may also use "…" to indicate that part of the quotation has been omitted. Observer comments that have been added are enclosed in square brackets. Since 2 cases are being presented, and each case involves 2 parents (1 biological and 1 foster), 2 social workers from a child welfare agency, and 2 school based personnel, the frequency of similar responses are indicated in the following way: If the question is specific to a particular role/discipline "both" means that both of the support providers, who have a similar role in each case had similar observations. As a way of comparing and contrasting the two cases I have indicated when a particular idea is present in one case more than the other. For instance, "All" is used to indicate all 6 participants in both cases and all 3 participants in one case responded in a similar way. "Most" is used to indicate that 4-5 participants in

both cases, or 2 participants in one case shared similar ideas. I have also indicated when

only 1 participant expressed a particular perspective or experience.

Theme One: Perspectives about Resources

All of the participants felt that accessing resources and support was problematic,

and if access to a particular support was granted, the amount of support that was then

made available was often described as insufficient to meet the needs of the child,

adolescent, and or family in need.

Limited resources. In both cases, all of the participants talked about a lack of

resources for children and adolescents with EBD and their families. The resources that

were described as inadequate included resources in the educational system, resources

provided by child welfare and resources provided by mental health. Page, the social

worker in case one raised concerns about the lack of resources for children and

adolescents with EBD, she said, "There definitely needs to be more in that area. I think

that there's a lot of short term, quick fixes almost, or attempted quick fixes that aren't

really that effective."

In both cases, all participants shared that often the school's response to extreme

behavioural issues involved sending the child home. While sending the child home from

school may have helped to address an immediate safety concern, the participants reported

that it did not seem to lead to improvements in the child's behaviour. In response to this

issue, the school based social worker Margaret in the first case, wondered why

opportunities for community based learning were not available when a child or

adolescent's behaviour was problematic at school. Lee Ann the foster mother in the

second case also wondered why there were not more options available when a child's

behaviour escalated at school. For instance, Lee Ann wondered why support like a specialized day care service was not available for children with EBD.

The parent in the first case and the foster parent in the second case reported that when their child was sent home from school there was a significant increase in stress within the family. Alisa, the parent in the first case described how difficult it was when the school would call her about her son's behaviour, "It was very hard on me when the school would call. It was very hard. I kept on telling the school, "You have to WANT to deal with him, I can't obviously run out if he causes a little bit of trouble, I can't constantly run out and pick him up."

Lee Ann, the foster parent in the second case, said that she had been more than willing to come when the school had called her, but that it had gotten to the point that she felt her foster child was acting out because she wanted to be sent home. She was also beginning to feel that she was being taken advantage of because of her willingness to take "Tina" home. She said:

> I'm calling them on the 29th of August when their school
>
> opens and I'm indicating that we need a quick brief meeting,
>
> because do not call me, do not tell me she's having a bad day,
>
> do not tell me she's off, do not question whether she's had her
>
> meds, do not phone me for anything unless you are suspending,
>
> expelling, or have the police involved, because last year I bailed
>
> them out at least one day a week [voice raised].

All participants in both cases also felt that like the educational system, child welfare services were insufficient and inadequate to meet the needs of children,

adolescents with EBD and their families. In the second case, Tina was described as having very significant mental health difficulties and all of her support providers felt she needed intensive long-term therapy. As a result, Tina had started weekly therapy and had begun to develop a connection with her psychologist, when suddenly the sessions were terminated. As a permanent ward of a child welfare agency, Tina's therapy was being paid for by the child welfare agency. According to her foster mother, Tina's case was transferred to another child welfare agency that did not have the resources to support the therapy plan. Lee Ann said that the family services provider had, "$907 per year for therapy for Tina." She continued, "This is not going to cover Dr. Jackson's bill. It's a lot more than that. That will cover maybe four hours." When the foster mother tried to advocate for the therapy to be continued she was repeatedly told that the funding was no longer available. Lee Ann said the support provider, "….has dug in their heels and said they don't have provincial funding…therefore Tina's therapy will be ending." Tina, who has multiple diagnoses, one of which is a Severe Attachment Disorder, had begun to develop a relationship with her psychologist. The appointments were occurring weekly and according to the foster mother, Tina had begun to make some progress. When the therapy sessions abruptly ended, Lee Ann described Tina as unable to cope with the news. She went on to describe Tina's extreme reaction. Lee Ann said, "Tina has just freaked out a week ago, carved "fuck you" into her arm, smashed all the drawers in her room, put holes in her wall, holes in her door, and said, "nobody loves me, nobody likes me…""

Mental health was also seen by most participants as having insufficient resources. In the first case, the social worker and the school based social worker felt that more input

was needed from mental health in the development of the child's program. Page the

social worker in case 1 said:

> Do we see medical presence there? No. Not normally.
>
> There are some doctors in the city that are really open to that
>
> and I think it's part of their practice approach, that they want
>
> to be involved in the planning for the child, and will call me
>
> if they feel that they need to see the child. I think I can think
>
> of three." Out of a caseload of ?" Forty-something.

In the second case, all of the participants also reported frustration over long

waiting lists to access mental health supports. Lee Ann, the foster parent, described

extremely long waiting lists to access support. Tina had been on a waiting list for several

months to see a psychologist and begin therapy and then once the therapy finally started

it was terminated. Lee Ann describes her difficulties in accessing this much needed

therapeutic support:

> The other agency should have been informed that this is
>
> a commitment that has to follow through. They weren't
>
> and they tell me "Too bad. We'll see about it next fall".
>
> Not next fall. You know it took a long time on a waiting list
>
> to get into see him. It took us finagling all these different
>
> schedules to accommodate this, I've done everything in my power,
>
> and now you leave us high and dry. So no, that's not been a good
>
> change, and Tina has suffered the consequences, and as a result,
>
> so have we.

Cheryl, the social worker, in the second case also explained that in order for "Tina" to have a psychological assessment, the support providers needed to stop arguing over who would pay for it. According to Cheryl, the school is saying, "There's a wait list of two years, she needs to have it done. Is there any way your system can do it?" At the same time, because Tina is a permanent ward of a family services agency, and the foster mother Lee Ann said that she has been told by a family services agency, "We're not paying for this assessment. It's $1500 we would have to take out of somebody else's budget, we're not doing this, we're not helping with that, we're not doing that, and we're going to make an example out of Tina."

Child specific funding. The process of applying for funding was described as arduous and confusing to most participants involved in supporting children with EBD. In both cases, the children were characterized as having extreme emotional and behavioural needs by most of their support providers. Due to safety issues, both children were also described by school personnel as needing constant one to one support at school. In spite of their needs, neither child was receiving level III funding from the educational system under the category severe to profound emotional and behavioural disorder.

In the case of Josh, the school personnel had not applied for level III support, and in the case of Tina the school had applied for level level II support and been denied. The foster mother described the situation, "… we submitted an application and it was actually denied. Then I went and sat downtown at the Board of Education." When asked why Tina's support was denied, Lee Ann, the foster mother, went on to say, "She didn't meet the needs. It's like I challenge you. Spend ten minutes alone in a room with her…" When asked if she felt like the "Board of Education" listened to her she said, "They

didn't want to talk to me, they approved it." After this struggle to receive level II support

under the category severe EBD, level III support under the category severe to profound

EBD was applied for and it too was denied. As a result, in both cases the school

divisions were receiving level II funding under the category severely emotionally

behaviourally disordered.

According to Margaret, the school based social worker involved in the first case,

there were inequities in the receipt of support for children with EBD. When asked why

Josh wasn't receiving level III funding she said, "From personal experience, I find that if

children are wards of a family services agency they tend to have their level III funding,

you know. It doesn't help as easily or readily for children living in their biological

homes." She went on to talk about the fact that in order to be eligible for level III support

at school children must be receiving support from outside agencies. However, she said

that some families have difficulty accepting support from outside agencies and that

resistance should not preclude their child from receiving support at school. She said:

> Because one of our kids was rejected for a level III even
>
> though we thought he'd met the criteria. So, you know, I think
>
> the more agencies that are involved, the higher the leveling.
>
> But sometimes families aren't comfortable with having everybody
>
> and their brother right with them. Or, personal experiences, their
>
> history with different types of agencies, like mental health and
>
> stuff like that [interfere with their willingness to receive support].

In case 2, Cheryl, the social worker, described her experience in trying to access support for children with EBD, "...the receiving school should not have to fight tooth and nail to access funds." Connie, the resource teacher/counselor, expressed frustration with the funding system. She described her experience:

> ... and you know what, I was invited to take the role with
>
> student services so I knew that this would be happening, but
>
> I had absolutely no training either. So, you know, it's on the job
>
> training almost. Like that's kind of my feeling... And when
>
> you're writing a funding application you don't want, pardon
>
> me, but you don't want average or below average, you want
>
> deficient. As bad as that sounds, that's what's best for her. This
>
> might not be appropriate to add now, and you can do with it
>
> what you want after...she's level II, but people really think she
>
> should meet that level III, well so does the school.

In the second case, level III funding was applied for but it was denied. The resource teacher/counselor frequently mentioned her inexperience in writing funding applications and her lack of training in student services. Connie said:

> You know, we don't only have to prove, but we have to
>
> stand on our heads, because, I'm sorry, but the documentation
>
> is all there. There's nothing more to put. There's not a situation
>
> that is more dire than hers, but you know what, the chances
>
> of getting it are very slim – and I do understand that it's a lot
>
> of money, but that's the frustrating piece. Every person that

I talk to that are involved in her kind of circle of care, any

agencies that are involved, they're saying, "Well why isn't she

funded?" Well you know what, it comes back down to me, really.

That's who it comes to. How can I wield my pen to have somebody

believe?

In both the first and second case, the school based personnel talked about having

to take resources away from other areas so that the safety of the staff and students in their

school could be ensured. Margaret, the school based social worker in the first case talked

about the need for the school to provide full-time support for Josh. She explained that in

the absence of level III support, they were using their Level I support system to make

sure that Josh was constantly monitored. Connie, the school based resource

teacher/counselor, described a similar situation at her school. Connie said:

We also have a level I support system, like, a support person

in the school for the middle years, and we've ended up as

the last few months have that have gone by, taking more of

our level I coverage to cover this child because with all of the

allegations, with her behaviours, having her loose, I always say,

in the general population, is not always a good thing.

There's a real safety concern for herself and for others, and so

our level I coverage is also being eaten up by this four foot

nothing child.

Labels and criteria to prove need. The educational system, child welfare and other social service providers were described as having specific criteria for determining a child's eligibility to receive services. Most participants described the use of labels and categorical approaches to determine individuals' eligibility to receive services as problematic. They described that the use of inconsistent labels and criteria across service providers had led to duplication when applying for support. In addition, labels and criteria were also described as being so narrow that they were excluding individuals from receiving much needed support.

Duplication. Even if a child with EBD met the criteria of one social service provider, paperwork and documentation also would have to be completed and an additional application for support would have to be made with other social service providers. Cheryl, the social worker in the second case, described the complex process that is used to apply for support in the child welfare system. Cheryl said:

> Well it's not a form. They tell us what we have to include –
>
> there's nine categories and we have to address them all and
>
> say what the child's needs are under each. There's health,
>
> medical and mental health, family, socialization, nurturance,
>
> boundaries, supervision. It's requesting level V and we
>
> basically do a social history on the kid addressing all the needs…
>
> A level IV is in-house, basically and level V we send out to the
>
> government. There's a level V committee and there's a specific
>
> draft – and under each category there's numbers assigned to the
>
> different needs of the child and he or she is scored that way.

Connie, the resource teacher/counselor, also described the process that she must use to apply for support for a child like Tina even though the child welfare system has already assessed her complex needs. Connie said:

> I love to write, so the challenge of writing is never a problem
> for me, I find it, if anything, a challenge. However, what I'm
> writing about sometimes doesn't make an awful lot of sense,
> and I don't mean that, it doesn't make sense to write it for the
> child, but the process doesn't make sense to me sometimes.
> The amount of documentation that you need to get appropriate
> funding for a child. For example, my very first funding application
> that I wrote last year was a level III EBD, which had to have a
> 24-hour plan. It was a massive, massive document,

In Tina's case, she is classified by child welfare as having level IV needs. However, in the educational system she is classified as meeting the criteria of a level II severe emotional and behavioural disorder. When asked about this difference, Cheryl, the social worker, felt that it would be great if the systems could come together and work more closely in terms of having the same leveling system. She thought that part of the problem had to do with the fact that different disciplines may not know how other systems work.

In the second case, Page, the social worker, also commented on the inconsistencies and overlap that occurs in the leveling system used by provincial agencies. She said:

> I mean, because really it's the province leveling these children.

So if the province has leveled a child a V, it's the province that's

delivering the education as well so it would not seem to make

sense to have different coding for children in different systems.

Labels leading to exclusion from services. Interestingly, if a child meets the

criteria of one social service provider and is receiving services, they may become

ineligible to receive services from another support provider. In addition, a particular

label or diagnosis may also preclude a child or adolescent with EBD from receiving

services.

In the first case, the school based social worker and the family services social

worker described labels and criteria were being used as a way to exclude children and

adolescents from receiving support. For example, Page, the social worker in the first case

said, "A child who has been diagnosed with a mental health disorder may not be eligible

for a behavioural program." Page also talked about her experiences in trying to access

support from other social services providers, she said:

A social services provider will take cases where the child's

IQ is below a certain level. That's almost the eligibility

requirement. That, as well as some other issue like developmental

delay, or whatever the case might be. But that's sort of their

primary criteria, is around the IQ levels. So we have lots of

kids that could benefit from a social services provider's services,

but we can't access that service for them.

Children that are in care are not eligible for their services either

because it's expected that we're going to pick up whatever

supports are required and do the planning.

Non-categorical funding. The participants were asked about their thoughts about

the use of labels and categorical funding. In both cases, most of the participants saw both

advantages and disadvantages to the use of a label to determine a child's eligibility to

receive services. Margaret, the school based social worker in the first case said:

> Sometimes it can be helpful to have labels because teachers
>
> say, "Oh okay, I get it," right. They know to look at this
>
> child maybe there's an attachment disorder, but then again,
>
> on the flip side, staff in the system may look at a child and
>
> limit their expectations too if there is that label. So there
>
> may not be as much growth as there could have been because
>
> they have that particular label...

When asked about her thoughts on categorical funding Margaret went on to say, "Labels

have been good for funding purposes. Money talks, right, which is too bad."

Most of the participants felt there were advantages to using a needs based funding

model in the educational system, but wondered what it might look like in areas like

mental health and the medical field. Margaret, the school based social worker, said:

> It sounds very positive because it's not the preconceived
>
> deficit model, right. You're not focusing on the negative
>
> so much either...Schools have to really talk up the negativity
>
> in order to meet this criteria. In fact, I've known cases
>
> where they're really stretching it. You know that pressure
>
> and so they are doing everything they can to meet that

criteria. So I think needs based funding could be a good

thing

When asked about her thoughts on a needs based funding model, Cheryl, the social

worker in the second case, said, "For getting funding in the school that might be a very

good thing." Cheryl continued:

"Yeah and I think that would work so much better for

the child because then their needs would be met before –

you know, sometimes it can take a long time to get a referral

to get seen at the clinic for alcohol or drug exposed children or

to get into to see child development, or you know, get in to see

the school psychologist. So I think their needs would be being

met and the teachers would have the help.

Page, the social worker in the first case, saw some advantages and disadvantages

to using the needs based funding model, she explained:

Well it would be interesting to see it in practice. I think that

makes sense in some ways because a lot of the kids that are

struggling aren't diagnosed nor should they be necessarily

because that often follows kids for a long time and can be a

hindrance for them. It would be interesting to see if it would

work. Where it might not work is other systems like where

they might need a diagnosis to get service in other areas like

mental health services or whatever the case might be.

Theme Two: Relationships

As in the pilot study, all of the participants mentioned that the relationships that existed between the participants in a system of care had an impact on how they felt about the team. Most of participants in both cases felt that the team was more effective when the team members liked and respected each other. Furthermore, most of the participants in both cases also reported a greater willingness to collaborate when they felt they were being listened to, when they felt the lines of communication were open and when they saw members of the team providing support that was above and beyond what was required by their role.

Liking and respecting team members. Most participants reported that the relationships that they had with other members of the team affected proactive planning for the child and family in need. Page the social worker in the first case talked about how Josh's parents had been excluded from school meetings and how their exclusion had affected their relationship with the school. Page described the situation, "I really think it would have been helpful for the parents to be a part of those meetings. It really created a gap." Page continued, "It created a gap for them and also their relationship with the school at that time wasn't good. They weren't trusting of school representatives." Ultimately, Josh's parents moved and enrolled him in another school. Margaret, the school based social worker, in the first case, also talked about the importance of building a relationship with other team members. Margaret said:

> I find if I have families that are at the connected to the office
>
> right across he street, and I've worked hard to develop a
>
> relationship with those workers, then we tend to share things

a lot more freely. If the families are with agencies that

aren't community based, so let's say they're connected to

another office somewhere else, it's really hard to build that

relationship. I know one particular child, we don't have that

good relationship at all…It affects proactive planning. I don't

know if it's just a different philosophy that this particular worker

has than what I have, but it's basically – yuck, you know, which is

unfortunate. It's really unfortunate because we all have to be on

the same page.

Cheryl, the social worker in the second case, talked about how she felt that it was easier to develop relationships with other members of the team in smaller communities. She said, "In my experience, in smaller towns a lot of the foster parents have dealt with the school on many occasions, and most of them have a fairly good relationships with the school." She continued, "I think foster parents stay away from schools that they haven't had good relationships with." Lee Ann, the foster parent in case 2, also talked about how important it was to have a positive relationship with support providers. Lee Ann described a situation in which another foster parent was considering taking on some new foster children and she went to her for some advice. Lee Ann recounts her conversation:

Well, the most important thing is tell me about the social worker."

I said, "Oh, he's really nice". And she goes, "Well what do you

know about him?" And I talked to her – I had to sell her on the

social worker otherwise she wouldn't have taken the kids. It

had nothing to do with the kids, it's who the worker is.

Communication. Most participants talked about the importance of open communication between all team members. Page, the social worker in the first case, said she valued, "...the openness of all the professionals involved, being able to update each other, and keeping those lines of communication open all the time." Lee Ann, the foster parent in the second case, talked about how important it was for her to feel she could call Cheryl her social worker anytime to discuss an issue. Lee Ann said, "Like I can phone Cheryl directly anytime and say, "Okay this is a problem." Cheryl is really personable and easygoing..." In both cases most of the participants also talked about the value of informal communication. Cheryl the social worker in the second case said, "I think sharing information comes gradually. Like in a more informal way rather than sitting down at a first meeting with a group of people." Cheryl talked about how she preferred to share information at meetings with fewer people. She said, "...having smaller groups and getting to know the resource teacher or counselor and working together to help the kids." Margaret the social worker in the first case also said, "...so it's lots of informal stuff because you're connected, or at least I find I'm connected with the psychologist and speech pathologist."

Being heard. Most of the participants in both cases felt that the team functioned best when they felt comfortable sharing their ideas and concerns and felt that the other members of the team were responsive to their needs. Page, the social worker in the first case, said:

> In cases like this it's really important to know that the
>
> follow-through is going to happen. Like if a behaviour plan
>
> is in place, and the goals are identified, that's what's going

to be worked on at the school, and the school knows in this

case that if they call with a concern I will respond, and just

that sort of support to each other is there.

Alisa, the parent in the first case, also talked about how she had been able to

provide input into her son's program at his new school. She said, "Like we sat down and

had this talk about what we can do in different situations ... I gave them ideas and

suggestions about what to do with him when he's feeling like that, and they try all those

things ..."

Lee Ann, the foster parent, talked about how she feels when she calls Tina's

social worker about an issue and she gets an immediate response. Lee Ann said, "I know

I can count on Cheryl turning around and working it out ... So she's there in all those

aspects. She contrasted this situation with the response she gets from her other foster

child's social worker. She said:

> Tina and my other foster child are going to camp with school
>
> for two nights. Cheryl said, "Oh leave it with me," and then she
>
> wrote on the permission slip, you know, "Full payment will be
>
> provided by a family services provider." My other foster child's
>
> social worker said, "No." Cheryl says it falls under education.
>
> The other social worker says, "No, it's not my problem. She
>
> doesn't need to go." Well, I could be a real shit disturber and
>
> go to the children's advocate and I can promise you that they
>
> shouldn't be different.

Support that is beyond what might be prescribed by one's role. Most of the

participants in both cases described situations in which members of the team offered

support that was above and beyond what might be prescribed by their role. Alisa, the

parent in the first case, talked about how she appreciated the support her social worker

had provided to her and her family. Even though her case was being transferred to a new

social worker, Page continued to offer support to the family. Alisa said, "The worker is

being changed on me...but my worker is still the one who originally took my case and I

can still contact her. She said, "If I need her I can still contact her."

Connie, the resource teacher/counselor in the second case, talked about how she

had provided a lot of support that was not traditionally part of her role, in an effort to

preserve a strong working relationship with the foster mother. Connie said:

> I know last year her foster mom complained an awful lot about
>
> this school and about how they treated her, how they treated
>
> the child, how they treated situations, and you know what,
>
> I've made it a real goal of mine to not repeat – and I'm not going
>
> to say their mistakes, because everybody has their own strategies
>
> and ways they deal with things – I've put her to bed some
>
> afternoons because she's exhausted. If she gets over stimulated
>
> sometimes she needs to crash and so instead of whereas we
>
> might have called the foster mom to come and pick her up.
>
> Sometimes we take care of the things on our own. I would never
>
> not tell the foster mother what we've done, but there have been times . . .
>
> like yesterday I tried. She just had spun out. She's got a lot of things

happening in her life right now that are causing her some real emotional

upheaval, but I put her to bed. And sometimes it works.

Margaret, the school based social worker, in the first case talked about how

teachers need to be supported when they are trying to teach some of the most challenging

children in the educational system. She talked about how one of her administrators had

supported a teacher who was teaching Josh. Margaret said, "You know, quite honestly a

teacher that was at a particular school that I'm at took a stress day every month because

of this particular kid with administration saying "go for it" because they recognized the

challenges…"

Theme Three: Roles

When children are involved in a system of care, the child, their family and several

disciplines need to coordinate and integrate their services in the best interest of the child

and family. Most of the participants in both cases identified several obstacles to the

coordination and integration of services. They felt that roles of the partnering agencies

were sometimes unclear, professional barriers and territorialism existed, and status and

perceptions of power dictated decision-making.

Clarity of roles. In both cases most of the participants shared that there was often

confusion over the roles and responsibilities of the individuals involved in a system of

care. Cheryl, the social worker, in the second case said, "You know as long as everybody

knows their roles and responsibilities, it's when things get blurred that it can cause

complications…and personalities come into play and different experiences, and I guess

different ideas of what the role should be." Lee Ann, the foster parent in the second case,

talked about the fact that there were two social workers involved with Tina. One social

worker, Cheryl was the legal guardian and the other social worker Linda, had been

contracted out to perform other duties. Lee Ann described the situation, "I'm totally

comfortable with both Cheryl and Linda. I don't know that Cheryl and Linda completely

understand where each of their roles is supposed to fit in. The bad thing is that I'm

taking direction from them."

In the second case, Connie, the resource teacher/counselor, sometimes wondered

what her role was in supporting children with EBD. Connie explained that she felt

overwhelmed by her responsibilities:

> What I find is being only my second year and being completely
>
> kind of overwhelmed with what's going on, it varies because
>
> it's such an umbrella term that student services model that the
>
> job here as compared to the school I was in last year are night
>
> and day different – the jobs that I was doing. So that's difficult…
>
> and there's no book to tell you what your job is necessarily, the job
>
> description isn't there.

In the first case, Page, the social worker, talked about how it was really up to the

service providers themselves to clarify their roles unless they were contracting a specific

service. Page said:

> There's certainly not a guide to defining roles but I think
>
> you work it out between you and the collateral and sort of
>
> try and designate who is going to do what, and for the most
>
> part I think that a lot of the agencies have a defined role in
>
> that you might be contracting out a therapist for a child or you

might be contracting out some addictions treatment for

a child. So in that sense their roles are designated.

She went onto say that roles became more blurred and tended to overlap when social

work duties were shared with another social worker from a different agency.

Professional barriers. Some of the participants talked about the issue of

professional barriers and how at times a lack of information about other systems or

disciplines prevented collaborative planning for children with EBD and their families.

Cheryl, the social worker in the second case, shared that she felt that there needed to be

greater familiarity on the part of all stake holders about how other disciplines operate.

Cheryl said:

> I think also just learning about other systems would be
>
> very helpful, and I don't know whether this can be done
>
> because sometimes you learn as you work . . . for the social
>
> worker and school administration staff to know how each other's
>
> system works. You know, I've learned a lot just working with
>
> kids in the school system and now that my own kids are in school
>
> too, that has helped. So you have to have knowledge base – how
>
> the level III and level II funding works, and vice versa from
>
> the school.

Margaret, the school based social worker, in the first case, shared that she had

concerns about some of the programming for students with mental health issues. She

said, "Unfortunately, when it comes to the educational system they don't necessarily

understand mental health issues and programming may not meet the needs of the

child..." Margaret felt that educators needed more support from mental health professionals when trying to support children with EBD.

Page, the social worker in the first case, had a suggestion about how professional barriers might be broken down and several disciplines might come together in a non-threatening environment to support one another when dealing with children with complex needs:

> I think I would like to see, people available on a consultation
>
> basis more often. Why I say that is because I think that there
>
> are times that resources could be helpful and we haven't
>
> identified it. So, for example, if we had systems available
>
> where I could bring up a case and I sit down with the consultation
>
> team and that consultation team might be made up of numerous
>
> representatives from different organizations across the city,
>
> medical professionals, mental health, social services – you know,
>
> being able to just very quickly bring a case that maybe – I'm not
>
> saying every case, but if I had a case where I was struggling to
>
> determine what type of resources might be appropriate then I could
>
> bring it to a consultation team and have a discussion about a case
>
> and get some ideas. That would be an innovative idea that I don't
>
> think anyone has tried. People bring committees together for
>
> different reasons but we don't do that with consultations.

Status and perceived power. The issue of status and power was mentioned by most of the participants in both cases. The participants felt that when multidisciplinary teams met to plan for a child there was a hierarchy and specific individuals and professions seemed to have more power and authority over decisions that were being made.

In the first case, Alisa the parent talked about how she had been excluded from meetings at her son's school. Alisa said, "I liked meetings because at least – well at first when they would always include me in the meetings. I felt like I was trying to be a part in helping them, like trying to work at home with the school." Alisa went on to say how the situation changed, "Then they stopped inviting me to the meetings and that's why I felt I was being treated poorly. Like, I'm the parent here you know. If anyone knows the kids, I think I would know my own kids." Margaret, the school based social worker, who is also the foster parent of a special needs child talked about how she was treated prior to becoming a social worker herself:

> I lived with my foster child and the strategies that I suggested
>
> were not deemed as relevant because I was the MOM as they
>
> called it. That's one of the reasons why I went and got my
>
> BSW because I had the knowledge but I felt my role was
>
> de-valued. I wasn't a professional in the system and so I would
>
> say "these are some strategies that would work at home and
>
> maybe we can try and do them in the classroom," and it was
>
> really looked upon as not a useful tool for them to use.

In the second case, Connie, the resource teacher/counselor, also referred to the

hierarchy that exists at interdisciplinary meetings. Connie shared, "I think the school is

pretty much at the bottom, which is the funny part because we see her the most. But we

really don't have a lot of authority." Connie went onto share her thoughts on the funding

process, "There is something wrong there because frankly I'm just the lowly

teacher...there are so many people above me who understand those other pieces. They

should have a bigger part..." Connie then questioned why mental health professionals did

not have a bigger role in the funding application process. She said, "But it just seems like

if the doctor that we're working with is the be-all and end-all of people in his field, then

shouldn't he be allowed to bring something on behalf of the child?"

Theme Four: Collaboration

Most of the participants in both cases identified effective collaboration as

essential when supporting a child with multi-system needs. When asked to reflect on their

experiences with collaboration, several factors that interfered with developing a truly

collaborative team to support children and adolescents with EBD and their families were

also identified.

Elements that contribute to collaboration. Page, the social worker in the first case,

described how the team that was supporting Josh had begun to collaborate effectively.

Page said:

> We update the school when there's something that we've
>
> noticed. The school updates us about behaviours that they're
>
> seeing. We try to coordinate resources and just brainstorm
>
> together about what might be helpful. And the principal is

very well aware of this child and just what's going on there.

Through the whole family situation, I know the school has had

the parents in just to discuss – even just to update even when

there's not a problem, which I think is something that has

re-engaged the parents with the school because they had so

much conflict before, it was really important to just start out

with positive focus for them.

Information sharing. Page, the social worker in the first case, talked about her

frustration with not being able to speak to medical professionals and obtain pertinent

medical information. She described her experience:

Sometimes it's difficult to get a doctor on the phone to talk

about a case though, or a psychiatrist on the phone, or whatever

the case might be. I mean, and, sometimes reading a report doesn't

give you the information that you need. Because you know, medical

terminology, and it might be very brief. For example, if we're

getting a report from psych health about an admission a child

had there, sometimes the information just isn't very detailed...

so we are calling over trying to get the psychiatrist on the phone, or

even talk to a psych nurse or whoever might have been involved in

the case at time. Sometimes we do need to rely on the family

though and just ask them more information about the case and what

their experience was at psych health, and they'll tell us what

medication the child is prescribed, or you know, their understanding

about why the child is taking the medication.

Connie, the resource teacher/counselor, talked about collaborating with different agencies and said, "We are an island almost unto ourselves." She then went on to say that in spite of the level of Tina's needs they have not had a multidisciplinary team meeting with all of the partnering service providers present. She said, "I've never been in a million dollar meeting where there's been a ton of people around the table. I would imagine that I would be very intimidated by the whole process because the school seems to be last."

When services are contracted out, Cheryl, the social worker in the second case, talked about how she did not always receive the necessary documentation from other service providers. She described that there was a lack of familiarity with the procedures for documentation:

> When the contracted out service provider sends out a
>
> referral on Tina's behalf and on our behalf, we are supposed
>
> to get a copy of that. Does that happen? No. And it's not
>
> a deliberate thing, it's just lack of knowledge like, "Oh, I'm
>
> supposed to have a copy of that, oh, thirteen years later and
>
> I still don't . . .

When it came to applying for funding in the educational system, Connie, the resource teacher/counselor in the second case, also talked about the difficulties she experienced in trying to access information. She said, "There were definitely things missing because when I went to do the funding application I had to be a detective and I had to track all kinds of things down." Lee Ann, the foster parent in the second case, also

referred to inadequate record keeping and incomplete files. Lee Ann was talking to her

social worker's supervisor about some of Tina's extreme behavioural needs and was

asked about some forms that were missing from Tina's file. Lee Ann recounted her

conversation with Tina's social worker's supervisor. The social worker's supervisor

asked:

> Lee Ann, how come I don't know any of these things about her [Tina]?"
>
> [Lee Ann answered] "Well what do you mean you don't know?" And
>
> then the supervisor was looking through some forms and then she told
>
> me [Lee Ann] there's a four-page form that I'm supposed to fill out on
>
> both of my foster children every six months… and she [the social worker's
>
> supervisor] said [to Lee Ann], "Yes, and I'm looking through Tina's file
>
> and I don't see them, and they need to be done every six months and in a
>
> couple months Tina will have been there two years." And I [Lee Anne]
>
> said, "Yeah," and she [the social worker's supervisor] goes, "Well you
>
> don't have these." I [Lee Ann] said, "How the hell was I supposed to
>
> know, I only know what I'm told by my case manager."

Lee Ann, the foster parent, also talked about how Tina's case was going to be

transferred to a new social worker and when she inquired about sitting down and having a

transition meeting with Tina's new social worker to share pertinent information she was

told by Tina's social worker, "Oh, Lee Ann, I don't have time for stuff like that…" Then

when Lee Ann asked how she was supposed to facilitate the transition she was told, "Oh,

I'm sure you'll manage."

Cheryl, the social worker in the second case, also talked about how rules about confidentiality had made her and her colleagues apprehensive to share information. She talked about how professionals had become uncertain about what they could and could not share. Cheryl shared, "I think that with the new PHIA and FIPPA regulations it has put people on edge about what we can share and what we can't share, and sometimes it really works against our kids."

Accountability to separate authorities. Most participants in both cases talked about how accountability to separate authorities led to conflict between the partnering service providers. Page, the social worker in the first case, pointed out that agencies often ended up in conflict when a child could not attend school because of aggressive behaviour. She said, "How the province sees that is it's the parent's responsibility to ensure that the child's cared for when they're not in school, be that at 4:00 or midday ... it's not the school's responsibility...it's not family services responsibility because the parents are the guardians." Margaret, the social worker, in the first case also talked about a similar challenge when dealing with separate authorities. She talked about a mother whose son was repeatedly "kicked out" of day care because of his behaviour. Struggling to provide care for her son, and to maintain her job, the mother was told by a family services agency to quit her job and stay home with him herself. Margaret described the situation, "... so she's not willing to go on assistance, but yet if she's not working she's not bringing in enough money, and so it's becoming a vicious circle for this family." In this case neither the day care nor family services were willing to provide support.

The foster mother in the second case, Lee Ann also talked about the difficulties associated with dealing with support providers who are accountable to separate

authorities. Even when a child is a ward of a child welfare agency, conflict about who is

going to pay for support exists. The school and a family services provider had been in

conflict over who should pay for supervision for Tina over the noon hour. Lee Ann

described the situation, " I was hiring Maxine, who was her support worker at the time

and I was using 15 hours out of my 20 hours a week of respite for lunch because

technically you don't hire anybody for less than three hours." Eventually, Lee Ann

refused to continue to use her support at lunchtime because she did not perceive it as fair

on her and her family to have to sacrifice their respite hours. As a result, the school

started to provide some support, however, the support was meant to be temporary as

Connie, the resource teacher/counselor, described the response from the school division,

"… our consultant came in yesterday and says, "Where the hell is the foster mom at

lunch hour?"

Theme Five: Case Management

Case management is a term that is frequently used when referring to the

coordination services for children and adolescents with EBD. However, there appears to

be confusion among service provider about what case management means and what the

role and responsibilities of the case manger should be when supporting a child with EBD.

Definitions of case management. Page, the social worker in the first case, defined

case management in the following way:

> Case management for me is assessing the family first off,
>
> determining what resources are required, determining what
>
> resources are already involved, looking at what informal
>
> resources the family has as well and pulling all that together,

accessing whatever resources we might need, you know,

trying to connect everyone that's involved so that there's

not duplication of service, so that we can brainstorm about

what we might be able to do collectively, and then, just on

an ongoing basis, dealing with whatever issues might arise

for the family and pulling in maybe a – even updating all

of the parties involved, and I think just keeping the service

running smoothly.

In the first case, Josh and his family also have another social worker with whom they have more direct contact. When asked how the involvement of another social worker affects case management Page said, "… I mean sometimes I think in terms of case management there can be layers of case management as well." Page explained, "For example, we often deal with contracted out services … so although I'm the case manager, I'm placing this child within their organization so they might have a case manager overseeing that placement. So, it's almost a team approach to case management."

In the first case, Margaret, the school based social worker, described the vice-principal of the school as the case manager because he was connecting with the family and coordinating meetings. When asked if there was another person involved who could be described as a case manager Margaret said, "Well, Page is supposed to be but then she said to me, you know I should be calling the other social worker because she's working directly with the family. So you know, I guess the other social worker is."

In the second case, the social worker, Cheryl, described what she perceived as the definition of case management:

I look at it as, I'm the guardian of the child, I need to know

what's happening with the child … I need to have contact with

the school and contact with the foster parents and contact

with you know, whether it be the doctor, mental health. I need

to have involvement in the child's life and plan for the child with

other people.

When asked about the involvement of other support providers, Cheryl described

the case management of Tina in the following way, "Co-case, I think that's the agreement

we've come to…and it does get blurred at times."

When the resource/counselor in the second case, was asked about case

management she also said, "I am the case manager for sure." She then went onto

describe what case management meant for her:

We were all given a certain amount of people that we were

going to work with and Tina happened to fall into my caseload.

Her team consists of two IA's that work with her, the principal

and the vice-principal, her classroom teachers, and our consultant,

who I will often chat with if there are different things that we're

considering or worried about.

In spite of the fact that Cheryl, the social worker in the second case, described

herself and the other social worker as co-case mangers of Tina, the foster mother,

identified the other social worker as her case manager in name only. She described

herself as performing most of what she saw as case management functions. Lee Ann

said:

I do all of it. I go to all of her appointments with Dr. Jackson.

I sit in on them. Her IEP meetings at school, Cheryl was too

busy to show up and Lisa phoned me an hour later and said,

"It slipped my mind." I sat there and I dealt with all of it myself.

I've been doing it all.

Advocacy. Most of the participants in both cases felt that children with EBD

needed someone to advocate for them who was independent of the service providers.

When asked about the idea of using an independent case clinical case manager in a case

like Tina's, Cheryl, the social worker in case two, said, "You know they could be the

unbiased voice instead of dealing with budgets and in-house squabbling ... people don't

always agree but they have to follow it anyway. In the case of Josh, Margaret, the school

based social worker, said, the idea of an independent case manager might be better able

to advocate for the child. She said, "Sometimes we get caught up in the day to day

barriers or the day to day emotions of the situation ... I think sometimes the educational

system needs to hear somebody independent ... somebody independent could say

something without having a conflict of interest with their employer."

While most participants felt that, in theory, an independent case manager would

be beneficial, some of the participants had questions about how this model would be

implemented given the current bureaucratic structures. Cheryl, the social worker in the

second case, explained her concerns, "They [referring to a clinical case manager] could

recommend but if the other agencies don't have the budget for that, it could be very

frustrating for all people involved." Page, the social worker in the first case, also had

concerns about adding a clinical case manager to the team of people who support children

with EBD because of the number of people who are already involved in working with children with EBD. Page said, "… My concern would be about the number of professionals that the child has to deal with on a regular basis … It's a lot for parents and children to add another person into the mix, or really it would be another system."

Lee Ann, the foster parent, thought the idea of an independent case manager made sense, but what she felt was needed was not necessarily someone who was independent, but rather, someone who really cared about what happened to Tina. She wanted a support provider to take the time to get to know her and to commit to helping her for an extended period of time. Lee Ann felt that her case manager really didn't care about what happened to Tina and her lack of caring and commitment was interfering with the receipt of services. Lee Ann explained, "I said to my case manager who for all intents and purposes really doesn't give a crap because she's done as of tomorrow. She's taken an extreme amount of time off and so basically we're left high and dry. Tina's had two or three social workers go through." Connie, the resource teacher/counselor in case two, had similar concerns she said, "What it looks to me like is that sometimes there's not an awful lot of care taking of the child sometimes when that job is being moved to someone else."

Theme Six: Outcomes for Children and Adolescents with EBD

When asked about the whether or not the needs of children and adolescents with EBD were being met by the current system of care, most participants in both cases felt that there were significant disparities. They went onto describe what they characterized as the shortcomings of the current system of care which included limited resources, a lack of consistent support services and personnel and an over reliance on segregated placements.

Limited resources. In both the first and the second case, all of the participants felt there was a lack of sufficient resources for children and adolescents with EBD. Margaret, the school based social worker in the first case, described how a lack of sufficient resources had taken a toll on Josh and his family. Margaret said:

It's a domino effect. You know, you have one of your systems

shaken and then they all start. And that's what was happening in this

particular household. You know, and then mom becomes stressed and

the other siblings become stressed because of this child with mental

health issues, you know, and the only place they can go for help is

a family services agency. You know, well that's not a good enough

resource. Like, there has to be more opportunities out there.

In the case of Josh, he was unable to attend a segregated educational program for children with EBD because of a limited number of spaces. Margaret, the school based social worker, described the situation, "He was actually accepted but he got bumped and he got bumped because there was another child at our school who was really, really high risk ... so it was which one do we pick, you know." If there had been more spaces in this program Josh would have been bused to a new school. In spite of the need for Josh to change schools to attend this program the school team felt that this program might be better equipped to meet his needs.

In the case of Tina, the lack of availability of specialized foster placements meant that she had to be separated from her brother. Cheryl, the social worker in the second case, described the situation, "If at the time that they were moving from their previous foster home...if there was a foster home that was able to take two high needs children,

then they would have been placed together." Even though Tina suffered and continues to suffer a significant loss being separated from her brother the system has been unable to find a foster home where she can live with her brother.

In addition, in both the first and the second case, the children were placed on lengthy waiting lists to receive support. In the case of Josh, he was on a waiting list for a support worker. Margaret, the school based social worker in case one, described the situation, "… staffing is a big thing, proactive staffing. You know when families are experiencing challenges, like, why wait? Let's get them supports now before the kids are possibly apprehended or something serious happens." In the case of Tina, she remains on a lengthy waiting list for a psychological assessment. According to the Cheryl, the social worker, there is a two year waiting list to have the assessment done by school personnel.

Inconsistent supports. Most of the support providers in both cases described how children with EBD had to deal with a lot of changes and transitions in their lives. In the first case, Josh's behaviour had become extremely aggressive at school and the school was having difficulty managing his aggression. The parents disagreed with the school's approach to managing Josh's behaviour, which led to a strained relationship between Josh's parents and the school personnel. Ultimately, the parents chose to remove Josh from his school and transfer him to another school. Page, the social worker in case one, explained that the parents, "Just wanted to start fresh."

In Tina's case, the situation in her former school was similar. Her behaviour also had put a strain on the relationship between her foster parents and the school. Lee Ann, the foster parent in the second case, described the situation, "She wasn't wanted there

[referring to her former school]. She wasn't liked there. She had a lot of difficulties with the school, the principal and the administration." Ultimately, Tina was transferred to another school mid-year where it was hoped the school would be more accommodating.

In both cases, most of the support providers talked about how difficult it was for children with EBD to develop social connections. In the first case, Josh's mother talked about the fact that Josh did not really have any friends at school. She then went on to say that it also had been difficult for Josh to make friends with the children in his neighbourhood. Josh lived in a subsidized government housing complex and his mother described the transient nature of the neighbourhood, "... kids are here and then they're not so it's kind of hared for the kids around here to actually make friends ..." In the case of Tina, her foster mother explained that her peers feared her so it had been difficult for her to develop any social connections at her new school. Lee Ann said, "Tina doesn't have a friend in the world." She described Tina's relationship with her peers, "...they're scared of her. She has outbursts. She screams and yells in class. She hits her instructional assistant. She freaks right out."

In both cases, not only did the children's schools change, but so did their support providers in both the home and the school environment. In the second case, the foster parent Lee Ann, talked about how Tina's support worker had changed because of Tina's challenging behaviours. She described Tina's behaviour toward her support worker, "...Tina was yelling at her, hitting her and throwing things at her ..." Tina now has a new support worker but her foster mother constantly worries about how long the current support worker will last before she burns out. Connie, the resource/teacher counselor, talked about how difficult it was to develop a consistent program for Tina at school. She

explained that every time the school had tried to provide Tina with an opportunity to

interact with others, her inappropriate behaviour resulted in the cancellation of the

activity. Connie said:

> She actually started the year and it was beautiful because she
>
> was working with the custodian but for two reasons it had to stop:
>
> one, he's a man and couldn't be alone with her, and two, she was
>
> just stealing from every classroom left, right and center. Then
>
> she went and spent some time with the music teacher, but then
>
> she stole from the music teacher and accused the music teacher of
>
> doing something. Then she was coming to homework club ... but she
>
> was just so disruptive to everybody, and now that the weather's a bit
>
> nicer she's going outside, but she's just a hindrance to herself and
>
> others.

In spite of numerous attempts to provide services and supports that foster social

emotional development, and an increase in appropriate behaviour, the participants,

particularly in the case of Tina, felt that she was not making progress. The participants'

observations about Tina relate to the notion of Model Coherency (Wolfensberger &

Glenn, 1975) and require further exploration. Questions about the appropriateness of the

support being provided and whether or not it is being provided by the right people come

to mind.

Segregated placements. In both the first and second case, most of the

participants mentioned the need for the Josh and Tina to be placed in segregated settings.

The idea that these children would benefit from placement in a segregated setting

pervaded. In the first case, the school tried to have Josh placed in a segregated program, which was not located in his neighborhood school. In the case of Tina, the support providers mentioned looking for segregated placements for her as well. Connie, the resource teacher/counselor, talked about some of the segregated programs that had been explored, "You know, we even looked at different programming for her in the division ... we looked at a program at another school, but they won't take EBD kids because they're afraid of what might happen ..." Connie, the resource teacher/counselor, also talked about discussions that had been initiated by other personnel from the school division about Tina's future in the school division. The school division was wondering if it was safe for Tina to be in the school. Connie expressed concern that the school division might say, "No, we're not going to give you the funding. We don't want her in our building, we don't want that to happen to our staff, and so she needs to go somewhere else." The foster parent, Lee Ann, also wondered how long she and her family would be able to maintain Tina in their home. According to Lee Ann, one of Tina's doctors had said, "... she needs to be in an institution or in a specialized group home, and she needs to have staffing because her attachment disorder is so severe she can't attach to anybody."

<u>Theme Seven: Impact on Families</u>

The parent in the first case, and the foster parent in the second case, described caring for a child with EBD as extremely stressful. They both described their child's behaviour as having an adverse affect on all of the members of the family. Both parents felt they needed more support from the educational system, child welfare and mental health in order to meet the needs of their child.

Stress on families. In the first case, Alisa, the parent, talked about how her son's

behaviour led her to feel overwhelmed and unable to cope. Alisa described her feelings,

"Just a lot of things happened … and I just couldn't handle it. It's really hard for me to

stretch 24 ways. Sometimes I wonder how I do it." Alisa went on to provide an example

of one of Josh's "episodes" which highlights the kind of incidents that parents and

families of children and adolescents with EBD experience on a regular basis. She said:

> There was an incident where Josh was stuck in a room for –
>
> he had an episode and he totally lost it, and got really angry,
>
> frustrated, and they [the school personnel] locked him in a room,
>
> and he was still locked in the room when I got to the school I
>
> said I wanted to see him, and they refused to let me see him. As
>
> soon as I opened up the door I could hear him screaming and I
>
> could hear the fear in his voice, and they wouldn't let me see him…
>
> I didn't know what my rights were. I never did find out what my
>
> rights were…When they [mental health supports] arrived somebody else
>
> mentioned to me that he was in there for three hours in that little
>
> room, for three hours just crying and scared.

Lee Ann, the foster parent in the second case, also described the stress that she

and her family were experiencing because of Tina's behaviour. While there was clearly a

lot of emotional stress, there was also a lot of financial stress. Lee Ann frequently

referred to the financial cost associated with being a foster parent of a child like Tina.

Lee Ann said,

> We've sat down and we've thought about it as a family,

you know, my husband and I, how much you know, like,

a water bill goes up, heating, and everything, and actually

it's substantial. With Tina wetting the bed and stuff like that,

you go through a lot laundry, and Tina destroying furniture,

Tina kicking a hole in her door, painting her room because she

drew swastika's all over the walls, ripping curtains off the wall,

which I don't have any curtains in my house. I don't like curtains.

She begged for curtains. We had curtains made for her room and

she ripped them off the wall two days later. There's big holes in the

drywall. That kind of thing we've sat down and figured out how

much all of that has cost and, so if we really want to stay on track

of a budget it's tough. It's really, really tough.

Access to support. Access to support was identified as extremely important to

both the biological parent and the foster parent when trying to care for a child with EBD.

In the first case, the parent, Alisa, described that the support that she had received from

her family had been the most valuable. Alisa had recently moved into a government-

housing complex and was only a few doors away from her foster brother and his wife and

their family. She described how family support had helped her,

My stress level is a little bit easier to control when I know

I got somebody close by. Like my sister-in-law has helped me

so much I can't even pay her back for everything she's

ever done for me [with tears in her eyes]. Because she's gone above and

beyond to help me.

The other support system that Alisa was relying on to help her to cope with parenting a child with EBD consisted of supports that were available in her housing complex. Page, the social worker, described some of the supports that were available on site, "Well with this family they did end up moving into an area where there was a community centre within walking distance. There are some areas of the city that don't have that kind of resource though … there's sort of a gap in services for clients and they end up feeling pretty isolated." Alisa talked about attending parenting sessions and having access to free childcare right in her housing complex. She also mentioned some of the activities that had been beneficial for Josh, she said, "They have things for the kids too, in the summer we have field trips and there's actually family field trips. We have a big old school bus that comes and picks us all up…we had a hay ride over the winter." These supports had helped to reduce Alisa's feelings of isolation and allowed her and her children to engage positive activities that otherwise might have been unavailable to them. Page, the social worker in the first case, went on to describe some of the benefits of having community based support. Page said, "I think for this particular parent, there are – for the mother – she deals with so much of her own issues in terms of self-esteem, so going to some of these programs gives her that sense of confidence with her kids …"

In spite of the fact that Alisa felt very supported by her family and her community resources she talked about how she had still been unable to follow through on much needed appointments with a mental health service provider. Alisa doesn't have a car and she described how difficult it was for her to take Josh to appointments. She said:

> Josh started receiving [mental health support] but we didn't finish …
>
> at that point in my life everything was just too out of control

for me. Yeah, I couldn't keep appointments ... I'm still finding

it overwhelming for me. For me, someone coming to my house

seems to work better form me than me actually going out to

appointments.

Lee Ann, the foster parent, talked about her need for a support system,

particularly a backup support system. Lee Ann described her primary support as being

her respite worker who is also Tina's one to one support worker. She felt as though this

support worker was the only other person who really understood the extent of Tina's

needs and really had made a commitment to help Tina. However, Lee Ann described it

as a delicate balance. Tina's behaviours can be so challenging that she constantly

worried about when she would lose this essential support. She said that the one thing that

she needs as a foster parent and Tina needs as a foster child, is a back-up support system.

Lee Ann said:

> I'm sure if I phoned a family services provider and said,
>
> "Find me somebody!" They'll get somebody to fill in, but
>
> that's not the consistency that Tina needs. So then that's me
>
> [going without a break] and that takes its toll. And the support
>
> worker is entitled to a vacation. She's entitled to a break.
>
> Everybody is, but then that leaves always somebody else
>
> picking up the pieces you know.

According to Lee Ann, the biggest obstacle to accessing support involved the

complex bureaucratic approval process. She described a reluctance on the part of child

welfare to disclose to her what she and her foster child were entitled to in terms of

support. Lee Ann explained that she was never able to get a direct answer about what she should spend on her foster child out of her own pocket and what the child welfare agency would cover. Lee Ann described some of the questions that she has asked her support providers. She said "...I want a break down. What do I cover? What do I ask you for? What are we entitled to ask for?" However, Lee Ann said that she has been unable to get a consistent answer to these questions. One of her social workers told her, "Oh well Lee Ann, I don't do accounting." Then Lee Ann said, "Well then who does? Let me speak to accounting directly." Lee Ann was told, "Well no, we deal with accounting." Lee Ann spends so much energy trying to navigate the system, she describes it as sometimes more difficult and more frustrating than parenting a child with EBD.

Parent advocacy. The participants were asked about their thoughts on the idea of having a parent advocate to assist families who have a child or adolescent with EBD. The parent advocate's role is to listen to the parents of children with EBD and provide assistance in understanding the system and accessing much needed supports.

All of the participants in both cases felt that a parent advocate would be an extremely valuable resource to parents of children with EBD. The parent advocate was seen as someone who would be non-threatening to parents of children with EBD and who might help improve communication between parents and support providers. Page, the social worker in the first case, described her thoughts on the benefits of having a parent advocate. She said:

> I think that a lot of parents in my role as a front line social
>
> worker – they are quite intimidated by authority and family
>
> services is a system of authority whether we like it or not, even

though we try to come in as supportive, people do see us as

authority and it's a threat to them. So having someone else

to explain things helps. For example there was a case that

I was on and the parent was very reluctant around me and

resistant to services. So having someone else almost as a

buffer would be helpful for the parent. They would be able to

benefit from services without feeling like she was being manipulated

or forced into doing anything.

Cheryl, the social worker in the second case, said that she was aware of a service

provider who offered a parent advocate for families and in her experience the assistance

of the parent advocate had been very valuable. Cheryl also thought that the provision of

a parent advocate might be particularly helpful if a child or adolescent was involved

with the justice system. Cheryl said, "… A lot of times birth parents don't hear what the

worker is saying because they are too caught up in directing a lot of their anger at us and

that person [the parent advocate] can step in and say, "You know what she's saying is

the truth," especially around court and laws and legalities…"

In the second case, the foster parent said her social worker was supposed to be her

advocate. However, she did not feel as though anyone was advocating for her and her

foster child. Lee Ann said she liked the idea of a parent advocate, but as far as she was

concerned she wasn't receiving any advocacy. She frequently used the term, "We've

been left high and dry," and described herself as fighting for every bit of support she

was getting. She said,

Dr. Scott [a mental health professional supporting Tina] gave

me a letter basically terminating all our visits with him because Cheryl and the other social worker forgot to show up. He just says, "Where are the others?" And I said, "I don't know. We were all here the last time you made an appointment", and then one of the social workers phones my cell and says, "Tell him I'm not coming I've got another crisis". Well could you not send somebody who is supposed to represent the agency? And he just said, "You know what Lee Ann, I wish you the best of luck, but this is bullshit and I'm not in the middle of this," and he said, "When they can acts together, give me a call". I sat there saying, "Please don't quit."

Lee Ann shared that she knew other foster parents who also felt unsupported when caring for children with EBD. She said, "Tina's brother's foster mom said to me that she's contemplating giving both kids back and throwing in the towel…She said a lack of support, calling and calling and calling and calling and saying, "We're in crisis. We've got no social worker."

In both cases, most of the participants felt that services and support for children with EBD and their families, whether biological or foster, could be improved. There appeared to be an overriding feeling of a lack of control on the part of support providers. First, they felt that they had no control over the child's or adolescent's behaviour from day to day and second, they felt that they had little or no control in determining the services and supports that they or their child would be eligible to receive. This lack of

empowerment left some of the participants feeling disenfranchised and disillusioned with

the system of care process.

Chapter 5

Conclusions

In this study, I examined two cases involving one child and one adolescent with

EBD. In case one, I interviewed the child's parent, social worker, and school based

social worker and asked them about their experiences and perspectives on the system of

care. In case two, I interviewed a foster parent, social worker and resource teacher

/counselor and also obtained their experiences and perspectives about the system of care.

In this chapter, I briefly summarize the major findings from this study, describe the

limitations of the study, and explore implications for improving the system of care in

Manitoba, as well as the need for future research.

Summary of Findings

This summary identifies the major findings from this research and provides

support from the literature which supports these findings.

Resources. In both cases the issue of inadequate and insufficient resources for

children and adolescents with EBD permeated much of the discussion. Most of the

participants shared stories about their personal struggles to access support. The analogy

of a board game comes to mind when listening to the stories that the participants told. In

some cases the participants were successful at "playing the system of care game" and

received support and in some cases they were not. One of the primary obstacles to

accessing support involved the use of labels and categorical funding. Specifically,

variations in how emotional and behavioural disorders were defined and variations in

criteria to determine eligibility to receive services were described by most participants in

both cases as interfering with access to much needed support. This finding is consistent

with the research that indicates that the variability in definitions of EBD, and eligibility used by service providers can interfere with the receipt of services and obstruct the implementation of a system of care (Anderson, 2000; Friedman, Kutash, & Duchnowski, 1996; Kutash & Duchnowski, 1997).

Disagreements about who should pay for services was also described by most participants as interfering with the timely receipt of services for children and adolescents with EBD. In the case of Tina, the educational system and the child welfare system were in conflict over who should provide a cognitive assessment and who should provide support at noon hour. The longer that support providers debated about whom would fund these supports the greater the strain on the relationship between service providers and the longer Tina was denied appropriate supports. This finding is consistent with the research by the Indiana Division of Mental Health (1999) which found the existence of separate funding streams across service providers makes it extremely difficult to coordinate services and also may lead to gaps in the provision of services. The emotional and behavioural needs of children and adolescents may be secondary to the service needs of the organization from which the child or adolescent may qualify to receive support (Lourie & Isaacs, 1988).

Recognizing the difficulties created by separate funding systems, Margaret, the school based social worker in case one, and Cheryl, the social worker in case two, suggested support providers use strategies like "cost sharing" in order to better meet the needs of children and adolescents with EBD. This recommendation is consistent with the research that says the existence of flexible funds is essential to the effectiveness of systems of care (Bruns, Burchard & Yoe, 1995; Shulman & Athey, 1993; Whitbeck &

Robinson, 1991). In the absence of flexible funding to support children and adolescents with EBD, agencies may become protective of their own resources and a spirit of competition may result.

Relationships. In both cases all of the participants said they felt it was important to develop positive relationships with the other members of the multidisciplinary team. The participants' responses about the value of relationships is consistent with the work of Santarcangelo, Bruns, and Yoe (1998) who found that feelings of involvement and feeling listened to are a particularly potent predictor of service satisfaction. Margaret, the school based social worker in the first case, explained that when there was a positive relationship between the members of the team more "proactive planning" occurred. This observation is consistent with the research of Kendziora et al. (2001) who found that when individuals supporting children and adolescents with EBD felt the lines of communication were open, they described themselves as more willing to disclose information, share resources and advocate for the child.

Most participants in both cases also shared that the personalities of the members of the multidisciplinary team had occasion to clash, which had a direct impact on collaborative planning for the child and family. Lippitt & Von Til (1981) have explored the impact of personality traits on collaboration and have found that when personality traits clash it can lead to a spirit of competition instead of cooperation. Research has also shown that some individuals may feel the need to defend their professional integrity by resisting recommendations that are proposed by other disciplines whose philosophy and goals they perceive as differing from their own (Skiba, Poslgrove, & Nasstrom, 1996). When problems arise in individualized care planning, it can be because professionals

have difficulty agreeing with each other and supporting a consistent approach, rather than because the child's and families needs are complex. It has been suggested that when less than half of a support team is composed of professionals and brainstorming and consensus decision making are used, the frequency of these problems is reduced (Kendzioria et al., 2001). In terms of playing the system of care "game" if a child and family roll the dice and happen to get a team that "gets along" the outcomes may be better for the child and family.

Roles. In both the first and the second cases, the professional staff were restricted by what they perceived their role should be in supporting the child and family in need. When discussing the care of a child EBD who may be suspended from school, Page said,

It's not the school's responsibility because the child is

suspended. It's not child and family services responsibility

because the parents are the guardians, but the parent has to be

at work and if its extreme, the parents miss a lot of work and

can't take more days off.

In the second case, Connie, the resource teacher/counselor, said that she had tried to provide supervision for Tina over the lunch hour as a way of preserving a relationship with the foster mother, who was becoming overwhelmed by Tina's needs. When Connie and the school started to provide this support which is outside of their prescribed role they were questioned by their superiors. They were asked, "Where the hell is the foster mother [at lunch hour]?" When team members, "connect with people in convention-bound roles," creativity may limited and individualized planning may be restricted (Ibid.). "In theory multidisciplinary teams come together to develop coordinated plans

for children . However, in reality teams assemble with an agenda or preconceived idea about what their involvement with a particular child will be (Bartlett & Freeze, 2005). However, if services are perceived as being ineffective because a child is not making progress, Wolfensberger and Glenn's (1975) notion of Model Coherency should be used to assess the appropriateness of the support being provided. Through program analysis Wolfensberger and Glen (1975) suggest asking "are the right people working with the right clients, who are properly grouped, doing the right thing, using the right methods and consistently so?" (p. 35). These questions need to be raised and perhaps new, alternative ways of supporting individuals with EBD need to be explored.

In addition, a lack of shared understanding of roles and responsibilities between partnering service providers led to conflict in both cases. Cheryl, the social worker in the second case, talked about how she felt there was a lack of understanding between child welfare and the educational system that was creating barriers to collaboration. As a way to overcome these barriers, Cheryl suggested that partnering service providers should learn about each other's systems. She talked about the fact since she had children attending school, she had increased opportunities to interact with the educational system and her knowledge base had improved. Anderson (2002) supports cross-system training as a way to overcome some of the barriers to collaboration in a system of care by allowing individuals to gain empathy and understanding of other disciplines' work challenges. Koskie and Freeze (2001) also found that sharing information, knowledge and skills across disciplinary boundaries through transdisciplinary teaming helped to overcome some of the challenges inherent in collaboration.

In both cases, some social work functions had been contracted out to other service providers and were therefore being shared. Most participants in both cases, mentioned that when services were contracted out, another layer of bureaucracy had been added which further complicated the provision of services. Page, the social worker in case one, also mentioned that when social work functions were contracted out the roles of the social worker could sometimes become "blurred." Margaret, the school based social worker, shared that when she called Josh's social worker about an issue she was told to call the other social worker because she had more direct contact with the family. Lee Ann, the foster mother, talked about how her two social workers did not know what each other's roles were and neither did she and that it made her feel uncomfortable. Cheryl, the social worker in case two, also characterized her relationship with the other social worker as "rocky." Cheryl wanted to be involved in supporting Tina and she felt that the other social worker was shutting her out. Cheryl's experience is consistent with the research of Anderson (2002) who found that a lack of clarity over roles and responsibilities in a system of care can lead to what Anderson (2002) describes as "turfism." When turfism occurs individuals may subvert or avoid collaboration.

Hierarchy. Some participants talked about how a hierarchy existed when several disciplines and parents came together to address a child's needs. Based on the participants' comments the parents saw themselves as having the least authority. Margaret, the school based social worker, who is also a foster parent said, "...I'm just the MOM ..." when asked about her input at multidisciplinary meetings. Lee Ann, the foster parent, also saw herself as lacking authority, she said, "I can't sign a permission slip because I'm just the foster parent." Lee Ann continued, "I'm not entitled to copies of

anything because I'm the foster parent," when referring to Tina's funding application and other assessments. The parents' experience is consistent with the findings of Skrtic (1995) who found that the notion that the professionals know best permeates the professional bureaucratic model. In addition, the parent in first case, had been excluded from multidisciplinary meetings about her child. According to Anderson and Matthews (2001), if the family is not present, the meeting should not take place. The exclusion of a child's family from a multidisciplinary planning meting contradicts the values of a system of care (Stroul & Friedman, 1986; 1994).

The school personnel also referred to a hierarchy and saw themselves as having little authority. The school personnel described themselves as having most of the responsibility for developing plans for children and adolescents with EBD, but little decision making authority about the receipt of services. Connie, the resource teacher/counselor said, "… the school is at the bottom," when referring to multidisciplinary teaming. The group that was identified as having the most perceived authority was the medical profession. While the medical profession was described as having a high level of status and authority they were described as only peripherally involved in supporting children with EBD. Connie, the resource teacher/counselor, mentioned that she had not had a meeting with all of the medical professionals present. She said, "We haven't had a million dollar meeting yet." According to Epstein et al. (1993) it is important to have a commitment from all individuals, public and private agencies, and family members if a system of care is to be effective.

Collaboration. All participants in both cases, shared that collaboration was essential to the success of a system of care. Most participants relayed examples of how

they had worked together with other service providers and families in important and effective ways. When the participants talked about examples of successful collaboration they stressed the value of informal communication. Lee Ann, the foster parent in case two, shared that she felt comfortable "… just phoning the school principal or resource/counselor anytime." Margaret, the school based social worker, talked about the value of having frequent informal meetings with the family and other service providers to talk about successes.

Information sharing. Several barriers to collaboration were also identified in both cases by most participants. The participants referenced issues like poor communication and inadequate information sharing as barriers to collaboration. This finding is consistent with the research of Anderson (2000) who also found poor internal and external communication can be a barrier to the development of a system of care. Connie, the resource teacher/counselor in the second case, provided an example of how difficult it was to obtain much needed information about Tina. She described "…having to be a detective," when it came to trying to obtain reports about assessments and or services Tina had received from other agencies. Page, the social worker in the first case, talked about having to rely on the child's or parent's explanation of mental health difficulties because reports were difficult to understand and despite repeated attempts, she had been unsuccessful in speaking to the doctor involved. According to Anderson (2002) in a system of care the jargon used in each discipline should be defined by the partnering service providers and a new language that is common to all participants should be used. Cheryl, the social worker in the second case, also shared that rules about confidentiality had made her reluctant to share information about children in care, which may interfere

with collaborative planning. This finding is consistent with the work of Brewer (1983) who also found a lack of a formal mechanism to house and share information about children who receive services from multiple agencies can lead to service providers being denied access to essential information.

Accountability to separate authorities. Another significant factor that most of the participants in both cases described as interfering with collaboration was the fact that the individuals involved were accountable to entirely separate authorities. Based on the responses most of the participants in both cases felt that there was little incentive to collaborate. Most of the conflicts that occurred between agencies and parents involved agencies trying to have services provided by someone else. Lee Ann, the foster parent, frequently talked about her conflicts with a child welfare agency over payment for support and had come to the conclusion that no one ever got back to her because they know that ultimately "… I'll pay for it … it's almost a screw you system." These kind of barriers to collaboration usually occur when resources are scarce and there are limitations in time, staff, technology, money, or experience with collaboration (Hodges et al., 1999).

Case management. In both the first and second case, most participants described themselves as case managers. While the title of case manager was used across systems there was not a consistent definition or model of case management described by service providers. According to Burns et al. (1996) case management is an "ill-specified and variously implemented paradigm" (p. 476). Different forms of case management were described by the participants. In case one, Page referred to "layers of case management." Cheryl the social worker in case two referred to "co-case management." Case management has been described as an essential component in ensuring children and

adolescents with EBD receive a full range of services in a coordinated and integrated way. It is further described as central to a system of care (Stroul & Friedman, 1986; 1994). In spite of the need to integrate services, the role of the case managers in both case one and case two appeared to be limited to the coordination of services in their particular service system. This finding is consistent with the research of Burns et al. (1996) who found that in absence of reduced case loads and specific training in case management, service providers are unlikely to take on case management functions like the service coordination, outreach, advocacy and cross agency liaison work. Furthermore, research also has shown that when existing support providers were formally given the title of case manager it did not necessarily increase the amount of time they spent performing case management functions (Ibid.).

Outcomes for children and adolescents. In both the first and second case, most of the participants expressed concern that there were frequent changes in support personnel. In both cases, the social worker assigned to the child and family had changed within the last year. In case two, the social worker had changed three times in the last year. Lee Ann, the foster parent in case two, talked about Tina's attachment disorder and then said, "People have to stop coming in and out of her life." In the case of Tina, Lee Ann the foster mother also talked about how several support workers had quit after spending a very short time with her. These experiences are consistent with other research on the system of care that has found:

> ...teams experience stress related to difficulties with recruiting and retaining
>
> quality people in support positions, such as offering respite, mentoring, and
>
> providing one-on-one assistance in school situations. Providers reported an

inadequate applicant pool owing to the small number and lack of preparation and experience of the applicants. As a result, providers, parents, and school professionals found that support staff were unprepared, given the complexities of the issues and situations, to work competently and creatively with the child or the family (Kendziora et al., 2001, p. 140).

In both cases, the children also had transferred to new schools within the last year. The parent in the first case, and the foster parent in the second case, reported that when Josh or Tina had a behavioural outburst at school, the school usually responded by sending them home from school. Both the parent and the foster parent reported that this response had led to a strained relationship between themselves and the school personnel. They also felt that there should be other options available as opposed to just sending the child or adolescent home. The parent and foster parent wondered if there were more supports available for children and adolescents with EBD so that their children wouldn't have to be sent home from school. These findings are consistent with the work of Knitzer (1993) who found that the availability of effective crisis intervention and mental health support services, pre-referral strategies and on going staff development made schools less likely to resort to exclusionary practices.

Even in their current schools, the idea of placing both Josh and Tina in segregated programs for children with EBD had been discussed. In the case of Josh, the school had applied to have him placed outside of his community school in a segregated program but due to limited space he was refused entry. Compared with students with other disabilities, students with EBD are far more likely to be placed in segregated settings (United States Department of Education, 1994). According to Walker (2004) what is

needed is a "… true cascade or continuum of appropriate and effective services promoting behavioural and emotional health, which extends from all students in a school to a select few who have been targeted for intensive intervention" (p. 905). Eber, Osuch and Redditt (1996) also found that when mental health and other individualized supports were made available for children and adolescents with EBD in the school setting, teachers were less hesitant to include them in regular education classrooms.

Impact on families. In both the first and the second case, the parent and foster reported feeling confused and frustrated with the bureaucracy involved in accessing support. This finding is consistent with the research that indicates that parents of children with EBD are often overwhelmed with the task of having to navigate their way through multiple agencies, support workers, and eligibility requirements (American Psychological Association, 1994). Alisa, the parent in the first case, reported finding it difficult to meet the day to day challenges of parenting her child and was not actively seeking out additional services for her son. Many parents of children with EBD are overwhelmed by the day to day challenges of parenting their child and daily living, and may not have the time or energy to become involved in advocating for additional support (Clausen et al., 1998). Furthermore, Alisa, also shared that her lack of access to transportation and child care prevented her from taking her son to appointments with a mental health professional. When evaluating the Child and Adolescent Service System Program [CASSP] which provided a system of care in California it was also found that parents of children with EBD had been restricted in their ability to participate in planning and treatment for their child because of a lack of access to transportation and child care (Ibid.).

When asked about their thoughts about having a parent advocate to assist them in negotiating the system of services, both the parent and the foster parent felt this kind of support would be beneficial. Lee Ann, the foster parent in case two, had worked in the child welfare system, in spite of her experience in this field she still reported needing someone to advocate for her and her foster child. Page, the social worker in case one, reported that Alisa, the parent, was on a wait list to receive a parent advocate. Page felt that a parent advocate might help Alisa to overcome her own feelings of inadequacy and lack of self-esteem. According to Evans, Armstrong and Kuppinger (1996) when parent advocates have been provided to parents of children with EBD parents report feeling more empowered and more likely to access support. The role of a parent advocate may include:

> ...translating for parents who are uncomfortable with system
>
> jargon; advocating for working within the system; educating
>
> professionals with whom they worked; providing information
>
> to parents; listening to parents; and helping parents to build the
>
> confidence and skills they need to advocate for their children (p. 59).

Cross Case Analysis

In comparative case studies two or more cases are studied and then the cases are compared and contrasted (Bogdan & Knopp Biklen, 2003). In this study similar themes emerged in both case one and case two. In spite of these similarities, there were also distinct differences between the cases that warrant further discussion. For a comparison of the themes that emerged in each case (see Table 2).

Table 2

Cross Case Analysis

Case 1	Case 2

Support for Parents

Family/community support	Formal support

Barriers to the receipt of funding

Segregated student placement	Inexperienced resource teacher

Barriers to the receipt of mental health services

Parent overwhelmed	Conflict over payment

The kind of support that the parent and foster parent were relying upon differed. The biological parent in case one was relying more on informal family and community supports, rather than formal supports provided by the system. Overall, the parent in case one reported feeling satisfied with the familial and community based support she was receiving. In case two, the foster parent was relying exclusively on formal supports from child welfare, the educational system and mental health, and reported feeling disappointed with the amount and type of support she was receiving.

Another difference between the two cases involved the reasons that neither school division was receiving Level III support under the category Severe to Profound Emotional Behavioural Disorder for the child and adolescent in question. In the first case, it appears as though Level III funding was not applied for because the school was planning to send the child to a segregated program for children with EBD. In this "cluster program" the student teacher ratio would have been significantly lower and funding for several students would have been pooled. In the second case, Level III funding was applied for but it was denied. It appears as though the inexperience of the resource teacher/counselor, and a lack of information sharing, may have contributed to the funding being denied.

Furthermore, there were also differences between the two cases in terms of the barriers to accessing mental health support. In the first case, the mother's lack of transportation and personal challenges had prevented her from taking her son to see a mental health professional. In the second case, there were also barriers to the receipt of mental health services but the inadequacy of the support appeared to be the result of conflict among service providers over who would pay for much needed services.

<u>Natural and formal supports</u>. In case one, Alisa, the biological parent, shared her experiences with "the system." She described that support providers had changed, and that she and her son had been placed on numerous waiting lists to receive support. Alisa also described that she had been forced to move her son from one school to another school because of his behaviour. Even though the services that were provided by "the system" had not met her expectations, she was quite optimistic and described herself as having, "A lot of good support." The support that Alisa described as most beneficial was not provided by an agency but rather by her family. Alisa [a child of the foster care system] had developed a close relationship with her foster brother and his wife. When formal supports were breaking down for her and her child, she opted to move into the same government housing project as her brother, his wife and their children. Alisa's relatives were only a few doors away and she shared that their support had been invaluable.

Alisa also talked about the support that was provided directly in her housing complex. She regularly attended parenting sessions and took her children on community outings. She explained that childcare was provided at many of these sessions and so it had been easy for her to attend. The supports that Alisa talked about did not involve an application process or concerns over transportation. The research of Kendziora et al. (2001) has also stressed the value of natural supports for children with EBD and their families. They found, "Natural supports were a significant source of culturally relevant emotional support and caring friendship for children, youth and families. Providers, parents and children dedicated time and energy to building informal supports because they were self-sustaining and often more meaningful (p.138).

The experiences of Lee Ann, the foster parent in the second case, differed from that of Alisa. She described her extended family as not "understanding" Tina's needs and instead of participating in family gatherings and bringing Tina around friends, she felt as though she needed to stay away. Foster parenting a child with EBD was her choice and she didn't feel right about subjecting her extended family to Tina's behavioural difficulties. She described that her extended family was planning a trip to a cottage and because of Tina's behaviour she had decided that she and her immediate family could not attend. Lee Ann's experience is similar to the situation described by Kendziora et al. (2001), many families of children with EBD "have been previously rejected by extended family members or have become isolated because of their difficulties. For many families their natural supports had disappeared from their lives" (p. 138). Lee Ann also lived in a middle class neighborhood where community supports for a child like Tina were not readily available. A lack of natural supports had made Lee Ann entirely dependent on formal supports provided by child welfare, mental health and the educational system. Given the shortage of adequate supports for children and adolescents with EBD (Burns & Goldman, 1999), Lee Ann did not feel as though she and Tina were receiving adequate support to meet their needs. Even once supports were in place, Lee Ann described issues like staff burn out, staff turn over, inadequate funding and bureaucracy as interfering with Tina's support and treatment. Similarly (Kendziora et al., 2001) found that there were challenges to finding and retaining front-line personnel to support children and adolescents with EBD. In addition, inadequate respite care, a lack of summer programming and limited in-home behavioural supports were cited by families of children with EBD as creating significant stress (Kendziora et al., 2001). One of the most

significant stresses for Lee Ann was having Tina's mental health treatment suddenly

terminated, not because she no longer needed the treatment, but because of bureaucratic

issues. However, Lee Ann's experience is consistent with the research has also found

that many children and adolescents with EBD are not receiving the treatment they require

(Rossenblatt & Attkisson, 1992; Leaf et al., 1996).

Barriers to the receipt of funding. In both the first and second case, neither child

was receiving full time support at school. In both cases all of the participants described

the child in question as requiring full time support at school. However, in each case the

reasons for not receiving full time support or LIII funding under the category Severe to

Profound Emotional Behavioural disorder differed and warrant further discussion. In the

first case, Margaret, the school based social worker, talked about how the school had

been planning to send Josh to a "cluster program." It is not uncommon for schools to

send students with EBD to more segregated settings. According to McInerney, Kane and

Pelavin (1992) most schools have little internal capacity or resources to address the

mental health issues of children and adolescents with EBD. The segregated program

identified for Josh consisted of eight students with severe to profound emotional and

behavioural disorders, one teacher and approximately two to three teaching assistants. If

Josh had been admitted to the segregated behavioural program he would not have

required a full time teaching assistant of his own. In the segregated program, supports

are pooled and the students do not have one-to-one support. According to Margaret, the

school temporarily "covered Josh" by using their level I support system. This coverage

served as an in-term support while the school waited for Josh to be admitted into another

program. In traditional models of service delivery the immediate needs of the service

provider may outweigh the long-term needs of the "client" (Shulman & Athey, 1993).

The process of applying for level III funding is a great deal of work for school personnel.

When involved in a system of care the need for complex coordination may hinder

collaborative efforts. According to Anderson et al. (2002) "Normal workloads may

already be overwhelming, and staff may not have the skills, experience, desire or time to

coordinate activities among and across agencies and systems" (p. 520). Ultimately, due

to limited space Josh was not admitted into the specialized program and therefore would

only receive Level II or part time coverage for the next school year. Even if Josh had

been admitted into the segregated program, a lack of full time support is problematic

because if Josh were to move to another school division that did not offer a segregated

program or wasn't willing to sacrifice their level I support, Josh would again be without

necessary supports.

In the second case, Tina was also not receiving adequate support. In her case, the

school had made several unsuccessful applications to the province for support. Most

recently, the school had applied for level III support under the category Severe to

Profound Emotional Behavioural disorder but had been denied. As a result, the school

was drawing on their level I support system to support Tina for a full day at school. In

this case it appeared as though the reason that Tina was not receiving adequate support

was entirely different than the case of Josh. In Tina's case, the school based resource

teacher/counselor was eager to develop a 24-hour plan, an individualized education plan

and a behaviour intervention plan to address Tina's needs, as well as a comprehensive

application for funding to make a case to the province. However, by her own admission,

Connie said that she did not have a special education certificate, this was her second year

as a resource teacher, and only the second time that she had ever been involved in applying for funding for a special needs student. Connie went on to say that Tina's application had been denied because she was not able to "...wield her pen..." in a way that she was able to make a case for Tina. When asked about the funding application being denied Connie went on to say, "...it really comes down to me." Anderson et al. (2002) described a lack of employee training as a system level barrier to the successful implementation of a system of care.

Barriers to the receipt of mental health support. There were several barriers to the receipt of mental health services identified in both case one and case two. However, there appeared to be distinct differences between the two cases that warrant further exploration. Alisa, the parent in case one, is an Aboriginal woman with limited education and limited income. She acknowledged her son's need for treatment and described how she had been unable to take him to appointments. She explained that it was easier for her if support providers came to her home, and that while she knew her son needed treatment she was not able to explore it at this time. Josh's experience is consistent with the research of Offord (1987) and Sturm et al. (2003) who found that individuals who are most in need of mental health services may not receive mental health support. Offord (1987) also found that children whose mothers are educated, have access to transportation and live a relatively short distance from the treatment facility are more likely to receive services. Research has also shown that there are also disparities in access to services across socioeconomic and ethnic groups (Sturm et al., 2003). According to Alisa, Josh had been prescribed stimulant medication in the past, but she reported that he was not presently taking any medication. Research has also shown large differences in the use of

stimulant medication, with the highest use being in areas with higher income and fewer

minorities (Sturm et al., 2003).

In second case, Lee Ann, the foster parent, had a high school education and had

12 years of experience working in the field of child welfare. She further described

herself by saying, "I'm white but I'm Métis." She had taken several courses and attended

many training sessions to learn how to effectively meet the needs of children and

adolescents with EBD. She was married and her husband was a professional. She lived

in a middle class neighborhood in a new home, and owned her own vehicle. Lee Ann's

willingness to access mental health support is consistent with the findings of Offord

(1997) and Sturm et al., (2003). Lee Ann described that she took Tina to all of her

medical appointments and made sure that she took all of her medication, which included

stimulant medication, antipsychotic medication and medication to help her sleep. Tina

had been on long waiting lists to receive mental health support, but Lee Ann had come to

expect long waiting lists, and while they were problematic, she could accept that there

was a shortage of mental health professionals. Lee Ann's biggest frustration involved

dealing with the conflict over who was going to pay for Tina's treatment. The act of

"cost-shifting" or trying to have services funded out of another service provider's budget

(Anderson et al., 2002) was described as the largest hindrance to the receipt of mental

health services.

Cautions and Interpretations

In this study I have tried to tell the stories of the individuals involved in

supporting one child and one adolescent with EBD. However, the data collected involve

the participants' perceptions of reality and as such were filtered by their own biases and

predispositions. The study also was small in scale and involved only one jurisdiction. As a result, the results should not be generalized beyond the scope of this study.

Although this study used a small and selective sample from one jurisdiction, efforts were made to ensure that the participants' stories were told as accurately as possible. First, my advisor read my field notes to help to ensure that I accurately interpreted the stories being told. Second, member checking was used to help to ensure that the transcripts reflected the participants' intended messages. Third, the research was conducted outside of the researcher's place of employment to help to reduce the potential for bias. This research does not intend to imply that all participants in system of care would have similar perceptions and should not be generalized to other situations.

Implications

Future research should involve examining how other jurisdictions have developed provisions for the implementation of a system of care. "In the absence of a shared framework and specific provisions for implementation, the adoption of the system of care has created uncertainty with the partnering and invited much cross-disciplinary stress" (Bartlett & Freeze, 2005, p.48). A plan to guide the implementation of the system of care in Manitoba needs to be developed to clarify the roles and responsibilities of the partnering service providers and make the realization of a system care possible.

In addition, more progressive service delivery models like the wraparound approach should be explored as a way of meeting the needs of children and adolescents with EBD and their families. A system of care involves the utilization of existing community supports and services to support an individual with EBD and their family. The way the wraparound model differs from a system of care is that it is a family driven

process for planning and individualizing services for the child and family. It also

requires the existence of a flexible pool of money that is shared by multiple child-serving

agencies and not tied to categorical services (Kendziora et al., 2001).

Moreover, there needs to be some shared accountability among service providers

involved in supporting children and adolescents with EBD. Presently in the province of

Manitoba, "the educational system is the only partnering agency whose funding is

dependent on the development of a system of care plan" (Bartlett & Freeze, 2005).

Service delivery models that incorporate a truly collaborative approach to service

provision for children and adolescents who have multi-service needs should also be

explored.

Clarification of the roles and responsibilities of case managers across systems

should also be researched. The benefits of employing clinical case managers who are

independent of existing service providers and can focus their energy of advocating for the

child and family might be beneficial. Burns et. al. (1996) found that clinical case

managers who were independent of existing service providers were better able to broker

for services for children and adolescents with EBD.

Further research should also involve examination of whether or not the existing

system of care model is meeting the needs of children and adolescents and their families

from cross cultural groups and or parents with limited education and low socioeconomic

status. In addition, future research should also explore how the provision of a parent

advocate for a parent of a child with EBD might help to overcome some of the challenges

that parents from cross cultural groups and or with limited education and low

socioeconomic status face.

Children and adolescents with EBD may be involved with many agencies and barriers to accessing information may exist. "Separate systems of record keeping are currently used, which can lead to a lack of information sharing and even to the concealment of information" (Bartlett & Freeze, 2005). Future research might involve examination of the utilization of a centralized database for housing information for individuals involved with multiple service providers.

Approaches like transdisciplinary teaming which guide collaboration also may be useful in overcoming the conflicts that inevitably arise when several disciplines are expected to work together in the best interests of the child or adolescent with EBD. Transdisciplinary teaming is a process by which multidisciplinary teams can share information, knowledge and skills across disciplinary boundaries and learn about the roles and responsibilities of other team members by taking on each others roles (Koskie & Freeze, 2000), and should be explored as a way of improving collaboration in a system of care.

Exploration of the value of natural supports in assisting children and adolescents with EBD and their families in coping with and overcoming challenges should be examined. In addition, strategies for building natural supports for children and adolescents with EBD and their families, who have become isolated because of their behavioural needs also warrant further study.

Future study might also involve an examination of the number of applications made for level III support under the category Severe to Profound Emotional Behavioural Disorder to determine why the application was denied. This research might also involve a survey of schools to determine whether or not school personnel were reluctant to make

applications for level III support because of the workload involved, the requirement of multidisciplinary involvement, and the fear that the application would likely be denied. Another question to be asked of schools would be how many were using other support systems like level I support, because they needed to provide support to a child with EBD who was a danger to themselves or others.

Finally, there appear to be significant barriers to the receipt of services for children and adolescents with EBD and their families. According to the participants in this study, there were several factors that were interfering with the realization of a true system of care. In order to overcome these barriers, all support providers must recognize the need to improve support for children and adolescents with EBD and their families. Furthermore, support providers must show a willingness to overcome disciplinary boundaries and collaborate to make this goal possible.

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Appendix A: Human Ethics Protocol Submission Form

1. Summary of Project:

In an effort to better meet the needs of children with severe emotional and behavioural disorders, the province of Manitoba has adopted the system of care model and mandated the coordination of services across the disciplines of mental health, family services, justice and education, through the development of the "Interdepartmental Protocol Agreement for Children and Adolescents with Severe to Profound Emotional and Behavioural Disorders" (Manitoba Education and Training, Manitoba Family Services, Manitoba Health & Manitoba Justice, 1995). According to the province of Manitoba, the system of care model is a consensual process for coordinating multi-system services and developing shared service goals for children and youth with severe to profound emotional and behavioural disorders. It is a method that involves all caregivers in sharing information, resources and expertise (Government of Manitoba, 2000).

The purpose of my study is to obtain the perspective of a resource teacher, guidance counselor, principal, social worker, and parents/ guardians about the efficacy of the system of care. My research question is, "Is the system of care in Manitoba achieving its stated objectives?" Using a case study approach, I will interview the aforementioned individuals about their experiences and opinions of the system of care approach, as it relates to one particular child with whom they are currently involved. The child with whom they are involved will currently be receiving support through a "system of care." The child will also be receiving Level III funding support from the province of Manitoba under the category of profoundly emotionally behaviourally disordered. The individuals who are interviewed will be asked to reflect on this child's case when responding to

questions about the system of care. The goal of the study is not to obtain personal

information about the child, but rather to obtain information about the participants'

opinions and experiences with the systems that support the child.

2. Research Instruments: See attached

3. Study Subjects:

    After receiving approval for my study from the Director from Child and Family

Services, I will ask the Director of Child and Family Services to suggest two to three

cases that fit the criteria of my study. Once the cases have been identified, I will ask

Child and Family Services to approach the families of the children involved to obtain

permission to use the child's case as the basis for the study. I will also obtain consent

from the parent(s) to interview them and their child's social worker. Once this consent is

obtained, I will contact the school division and obtain consent to interview the school

personnel involved with the child. I will interview 3 school personnel who work directly

with the child being supported by a system of care. The 3 school personnel that I

interview will be the resource teacher, guidance counselor and principal.

4. Informed Consent:

    Consent in writing will be obtained from each of the participants in the study.

Consent from the child's parents/guardian, which may be Winnipeg Child and Family

Services will also be obtained to use their child's case as an example.

5. Deception:

    There will be no deception used.

6. Feedback/Debriefing:

The subjects involved in the study will be given the opportunity to discuss the study with me. If requested, they will also receive a summary report of my findings.

7. Risks and Benefits:

None

8. Anonymity and Confidentiality:

The names of the participants in the study will not be used in any documentation. Their place of employment or any other identifying information will also not be used. Two or three cases will be identified, but only one case will be used in the study.

9.Compensation:

The participants will not be compensated for their participation in this study.

Appendix B: Ethics Approval for Initial Study

UNIVERSITY OF MANITOBA

RESEARCH SERVICES & PROGRAMS
Office of the Vice-President (Research)

244 Engineering Bldg.
Winnipeg, MB R3T 5V6
Telephone: (204) 474-8418
Fax: (204) 261-0325
www.umanitoba.ca/research

APPROVAL CERTIFICATE

25 February 2004

TO: **Nadine Bartlett**   (Advisor Z. Lutfiyya)
           Principal Investigator

FROM: **Stan Straw, Chair**
           Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2004:014**
           "The System of Care"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board,** which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note that, if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

Appendix C: Application to Research Records

APPLICATION TO RESEARCH RECORDS

THE CHILD AND FAMILY SERVICES ACT

TO:

1. I/we, *NADINE BARTLETT* and *———N/A———*, applicants, hereby apply to access the records listed below in order to conduct bonefide research for the purpose of *MASTER DEGREE*

<u>Title</u> <u>References</u>

CASE STUDY INTERVIEWS OF A RESOURCE TEACHER, GUIDANCE COUNSELLOR, PRINCIPAL, SOCIAL WORKER, AND PARENTS/ GUARDIANS OF A CHILD RECEIVING SERVICES FROM A SYSTEM OF CARE, INCLUDING LEVEL III EBD FUNDING.

2. I/we undertake not to disclose or publish the contents of any record or part thereof which could reasonably be expected to identify the subject of the record or any other person who is identified in the record.

3. I/we understand that access will be granted to the records listed above for the stated purpose of the project only and for the duration of the project or up to one year from the date of the approval of this application, whichever date comes first.

May 11/2004
_____
Date

_____
Applicant

_____
Date

_____
Applicant

APPROVAL OF APPLICATION

I, Joy Cramer, Director of Child and Family Services, do hereby approve the application by _____ and *———N/A———* to access the files listed in this application and in accordance with the terms and conditions set forth in this application.

May 17/04.
_____
Date Approved

_____
Director of Child and Family Services

Appendix D: Amendment Approval for Current Research

UNIVERSITY
OF MANITOBA

| RESEARCH SERVICES &
PROGRAMS
Office of the Vice-President (Research)

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AMENDMENT APPROVAL

06 October 2004

TO: **Nadine Bartlett**
Principal Investigator

FROM: **Stan Straw, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2003:014**
"The System of Care"

This will acknowledge your e-memo dated September 22, 2004 requesting amendment to the above-noted protocol.

Approval is given for this amendment. Any further changes to the protocol must be reported to the Human Ethics Secretariat in advance of implementation.

Appendix E: Consent Letter for the Program Manager of Child and Family Services

Nadine Bartlett

January 12, 2004

Research Project Title: The System of Care

Researcher: Nadine Bartlett

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take time to read this carefully and to understand any accompanying information.

Dear **Program Manager for Winnipeg Child and Family Services,**

I am a graduate Student in Inclusive Special Education at the University of Manitoba. One of the requirements of my program is to complete a research study. I have chosen to complete a study about the "system of care" in Manitoba. The purpose of my study is to obtain the perspectives of school personnel, social work and parents about the "system of care" in an effort to determine whether or not the "system of care" is achieving its stated objectives. In order to obtain the perspectives of these individuals I will interview them for approximately 1 hour. The individuals that I interview must currently be supporting the same child, who is involved in a system of care. During the 1-hour interview the participants will be asked to reflect on this child's case when responding to questions. The goal of my study is not to obtain personal information about the child who is involved in a system of care, but rather to obtain information about the opinions and experiences of the service providers involved in the system of care.

I am writing to you to ask you to identify 2-3 potential cases for my study. In order to be involved in the study the child/adolescent should be receiving support through a system of care approach and also be receiving Level III funding in the educational system under the category Profoundly Emotionally Behaviourally Disordered. The children/adolescents should be enrolled in the same school division.

I am also asking that you obtain the permission of the parent/guardian and social worker of the child involved to have their names released to me so that I may obtain their consent to participate in the study. Once I have the names of the parents/guardians I will contact them and obtain their permission to interview them and their child's social worker, resource teacher, guidance counselor and school principal.

Once the parent/guardian agrees to participate in my study and consents to having their child's social worker, resource teacher, counselor and principal interviewed, I will contact the school division involved in order to obtain consent from school personnel to participate in the study.

I want to assure you that although I will be publishing my study, I will not be using any names in any of my documentation. All of the information that I collect will be strictly confidential. Your participation in an interview is voluntary and you have the right to withdraw at any time.

If you require information about this study, please do not hesitate to contact my advisor Zana Lutfiyya from the University of Manitoba at 474 – 9000.

If you would like information about the results of my study when it is completed, I will be happy to discuss it with you or give you a written report. I thank you in advance for your consent to participate in this study. Please sign this letter and return it to me at your earliest convenience.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The Education/Nursing REB has approved this research. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and references.

Signature of Participant   Date

Signature of Researcher   Date

I _____ would like a copy of the summary of the results of the study. Please mail a copy of the results to _____.

Appendix F: Consent Letter for the Parent/Guardian

Nadine Bartlett

February 8, 2004

Research Project Title: The System of Care

Researcher: Nadine Bartlett

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your consent will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take time to read this carefully and to understand any accompanying information.

Dear parent/guardian,

I am a graduate Student in Inclusive Special Education at the University of Manitoba. One of the requirements of my program is to complete a research study. I have chosen to complete a study about the "system of care" in Manitoba. The purpose of my study is to obtain the perspectives of school personnel, social work and parents about the "system of care" in an effort to determine whether or not the "system of care" is achieving its stated objectives.

I am writing to you to ask you to **participate in this research study.** If you agree, you will be asked to participate in a one- hour interview. The purpose of the interview is to obtain your opinions and perspectives about the system of care and how it has supported your child.

I am also asking for your **consent to interview your child's social worker, resource teacher, guidance counselor and classroom teacher** involved in the system of care. The purpose of these interviews is not to obtain personal information about your child, but rather to obtain opinions and perspectives about the system of care. I will ask the aforementioned individuals and yourself to reflect on your child's situation when responding to questions about whether or not the system of care is achieving its stated objectives.

I will be tape recording the interviews that I conduct. The tape recording of the interview will be transcribed. After I transcribe the interview, I will review the transcription in order to help me interpret what has been said. I will be sharing the transcription and my interpretation of the transcription with my course instructor and or thesis advisor. Throughout this process your identity will be concealed. If there is some

confusion about what is being expressed, I may contact the participants a second time to ensure my interpretation is correct. The tapes and transcripts will be stored in a locked, secure location. After I complete my interpretation of the transcripts I will destroy the tape of the interview and the transcripts.
I want to assure you that although I will be publishing my study, I will not be using any names in any of my documentation.

Your decision to participate in this study and allow me to interview your child's social worker, resource teacher, guidance counselor and classroom teacher is voluntary.

If you require further information about this study, please do not hesitate to contact my advisor Zana Lutfiyya from the University of Manitoba at 474 – 9000.

If you would like information about the results of my study when it is completed, I will be happy to discuss it with you or give you a written report.

Signing this letter indicates that you are agreeing to participate in a one-hour interview. It also means that you are giving your consent for me to interview the aforementioned individuals who support your child.

Please sign this letter and return it to me at your earliest convenience. Thank you.

The Education/Nursing REB has approved this research. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and references.

Signature of Parent/Guardian   Date

Signature of Researcher   Date

I _____ would like a copy of the summary of the results of the study. Please mail a copy of the results to _____.

Appendix G: Consent Letter for the Social Worker

Nadine Bartlett

February 4, 2004

Research Project Title: The System of Care

Researcher: Nadine Bartlett

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take time to read this carefully and to understand any accompanying information.

Dear social worker,

I am a graduate Student in Inclusive Special Education at the University of Manitoba. One of the requirements of my program is to complete a research study. I have chosen to complete a study about the "system of care" in Manitoba. The purpose of my study is to obtain the perspectives of school personnel, social work and parents about the "system of care" in an effort to determine whether or not the "system of care" is achieving its stated objectives.

I am writing to you to ask you to be a participant in the study. If you agree, you will be asked to participate in an interview. The interview will take about one hour to complete. I will be tape recording the interview. The tape recording of the interview will be transcribed. After I transcribe the interview, I will review the transcription in order to help me interpret what has been said. I will be sharing the transcript and my interpretation of the transcript with my course instructor and or thesis advisor. If there is some confusion about what is being expressed, I may contact you a second time to ensure my interpretation is correct. The tapes and the transcript of the tape will be stored in a locked, secure location. After I complete my interpretation of the transcribed interview I will destroy the tape of the interview and the transcripts.

In this study you will be asked to reflect on your experiences with the system of care as it relates to a particular child. The purpose of this study is not to obtain personal information about a child involved in the system of care, but rather to obtain the perspectives of service providers about the efficacy of the system of care.

The parents/guardians of the child, with whom you are involved, that is being supported by a system of care, have consented to having their child's case used in this study. They

have also provided consent for you to discuss your experiences with the system of care as it relates to their child, should you decide to do so. (Please see the signed attached parental consent forms).

I want to assure you that although I will be publishing my study, I will not be using any names in any of my documentation. All of the information that I collect will be strictly confidential. Your participation in an interview is voluntary and you have the right to withdraw at any time.

If you require information about this study, please do not hesitate to contact my advisor Zana Lutfiyya from the University of Manitoba at 474 – 9000.

If you would like information about the results of my study when it is completed, I will be happy to discuss it with you or give you a written report. I thank you in advance for your consent to participate in this study. Please sign this letter and return it to me at your earliest convenience.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The Education/Nursing REB has approved this research. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and references.

Signature of Participant   Date

Signature of Researcher   Date

I _____ would like a copy of the summary of the results of the study. Please mail a copy of the results to _____.

Appendix I: Consent Letter to the Program Manager of Child and Family Services

Appendix H: Consent Letter for the Superintendent of the School Division

Nadine Bartlett

May 20, 2004

Research Project Title: The System of Care

Researcher: Nadine Bartlett

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take time to read this carefully and to understand any accompanying information.

Dear **Superintendent,**

I am a graduate Student in Inclusive Special Education at the University of Manitoba. One of the requirements of my program is to complete a research study. I have chosen to complete a study about the "system of care" in Manitoba. The purpose of my study is to obtain the perspectives of school personnel, social work and parents about the "system of care" in an effort to determine whether or not the "system of care" is achieving its stated objectives.

In order to obtain the perspectives of these individuals I will interview them for approximately 1 hour. The individuals that I interview must currently be supporting the same child, who is involved in a system of care. During the 1-hour interview the participants will be asked to reflect on this child's case when responding to questions. The goal of my study is not to obtain personal information about the child who is involved in a system of care, but rather to obtain information about the opinions and experiences of the service providers involved in the system of care.

I have already obtained consent to participate in this study from the parents/guardians of the following students _____, _____. The parents/guardians also have provided consent for me to interview their child's resource teacher, counselor and principal. Please see attached parental consent forms.

I am requesting that you contact the resource teacher, guidance counselor and principal involved with these students in order to obtain their permission to have their names released to me. Once I have their names, I will contact them in order to ask them to participate in a 1-hour interview.

I want to assure you that although I will be publishing my study, I will not be using any names in any of my documentation. All of the information that I collect will be strictly confidential. Your participation in an interview is voluntary and you have the right to withdraw at any time.

If you require information about this study, please do not hesitate to contact my advisor Zana Lutfiyya from the University of Manitoba at 474 – 9000.

If you would like information about the results of my study when it is completed, I will be happy to discuss it with you or give you a written report. I thank you in advance for your consent to participate in this study. Please sign this letter and return it to me at your earliest convenience.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The Education/Nursing REB has approved this research. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and references.

Signature of Participant   Date

Signature of Researcher   Date

I _____ would like a copy of the summary of the results of the study. Please mail a copy of the results to _____.

Appendix I: Consent Letter for School Personnel

Nadine Bartlett

February 4, 2004

Research Project Title: The System of Care

Researcher: Nadine Bartlett

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take time to read this carefully and to understand any accompanying information.

Dear **School Personnel,**

I am a graduate Student in Inclusive Special Education at the University of Manitoba. One of the requirements of my program is to complete a research study. I have chosen to complete a study about the "system of care" in Manitoba. The purpose of my study is to obtain the perspectives of school personnel, social work and parents about the "system of care" in an effort to determine whether or not the "system of care" is achieving its stated objectives.

I am writing to you to ask you to be a participant in the study. If you agree, you will be asked to participate in an interview. The interview will take about one hour to complete. I will be tape recording the interview. The tape recording of the interview will be transcribed. After I transcribe the interview, I will review the transcription in order to help me interpret what has been said. I will be sharing the transcript and my interpretation of the transcript with my course instructor and or thesis advisor. If there is some confusion about what is being expressed, I may contact you a second time to ensure my interpretation is correct. The tapes and the transcript of the tape will be stored in a locked, secure location. After I complete my interpretation of the transcribed interview I will destroy the tape of the interview and the transcripts.

In this study you will be asked to reflect on your experiences with the system of care as it relates to a particular child. The purpose of this study is not to obtain personal information about a child involved in the system of care, but rather to obtain the perspectives of service providers about the efficacy of the system of care.

The parents/guardians of the child, with whom you are involved, that is being supported by a system of care, have consented to having their child's case used in this study. They

have also provided consent for you to discuss your experiences with the system of care as it relates to their child, should you decide to do so. (Please see the signed attached parental consent forms).

I want to assure you that although I will be publishing my study, I will not be using any names in any of my documentation. All of the information that I collect will be strictly confidential. Your participation in an interview is voluntary and you have the right to withdraw at any time.

If you require information about this study, please do not hesitate to contact my advisor Zana Lutfiyya from the University of Manitoba at 474 – 9000.

If you would like information about the results of my study when it is completed, I will be happy to discuss it with you or give you a written report. I thank you in advance for your consent to participate in this study. Please sign this letter and return it to me at your earliest convenience.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The Education/Nursing REB has approved this research. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and references.

Signature of Participant   Date

Signature of Researcher   Date

I _____ would like a copy of the summary of the results of the study. Please mail a copy of the results to _____.

Appendix J: Interview Schedule for Parent/Foster Parent

R: In an effort to better meet the needs of children with severe emotional and behavioural disorders, the Province of Manitoba has adopted the system of care model that mandates the coordination of services across the disciplines of mental health, family services, justice and education. I am going to be asking you about your experiences with the system of care in Manitoba, but first I would like to learn about you and your background.

1. Tell me about yourself?

2. Have you received any training in parenting children with emotional and behavioural difficulties?

R: I would now like you to respond to the remainder of the questions as they pertain to your child (foster child).

3. Describe your role in the development of your child's system of care plan.

4. Describe how agencies have come together to support your child?

6. Can you tell me about the process of obtaining a 1-1 T.A. for your child at school?

7. Can you tell me about the process of obtaining community and home supports for your child?

8. Describe the case management process for your child?

9. Describe the process that is used to share information about your child across agencies?

10. Can you tell me about how shared service goals were identified and developed for your child?

11. What factors have helped or hindered the receipt of services for your child?

12. If you could change anything about the system of care process, what would it be?

Appendix K: Interview Schedule for Social Worker

R: In an effort to better meet the needs of children with severe emotional and behavioural disorders, the Province of Manitoba has adopted the system of care model that mandates the coordination of services across the disciplines of mental health, family services, justice and education. I am going to be asking you about your experiences with the system of care in Manitoba, but first I would like to learn about you and your background.

1. What is your current position?

2. Tell me about your background in social work?

3. What has been your experience and or involvement in working children with emotional and behavioural difficulties?

R: I would now like you to respond to the remainder of the questions as they pertain to the child with whom you are currently involved, who is being supported by a system of care.

4. Describe how interdisciplinary teaming has occurred for the child with whom you are involved?

5. Can you tell me about the process of obtaining a 1-1 T.A. for this child at school?

6. Can you tell me about the process of obtaining community and home supports for this child?

7. Describe the case management process for this child?

8. Describe the process that is used to share information about this child across agencies?

9. Can you tell me about how shared service goals were identified and developed for this child?

10. What factors have helped or hindered the receipt of services for this child?

11. If you could change anything about the system of care process, what would it be?

Appendix L: Interview Schedule for School Personnel

R: In an effort to better meet the needs of children with severe emotional and behavioural disorders, the Province of Manitoba has adopted the system of care model that mandates the coordination of services across the disciplines of mental health, family services, justice and education. I am going to be asking you about your experiences with the system of care in Manitoba, but first I would like to learn about you and your background.

1. What is your current position?

2. Tell me about your background in education?

3. What has been your experience and or involvement in working children with emotional and behavioural difficulties?

R: I would now like you to respond to the remainder of the questions as they pertain to the child with whom you are currently involved, who is being supported by a system of care.

4. Describe how interdisciplinary teaming has occurred for the child with whom you are involved?

5. Can you tell me about the process of obtaining a 1-1 T.A. for this child at school?

6. Can you tell me about the process of obtaining community and home supports for this child?

7. Describe the case management process for this child?

8. Describe the process that is used to share information about this child across agencies?

9. Can you tell me about how shared service goals were identified and developed for this child?

10. What factors have helped or hindered the receipt of services for this child?

11. If you could change anything about the system of care process, what would it be?

Appendix M: Follow-up Probes for Parent in Case 1

Thank you for agreeing to participate in a second interview.

1.Did you have the opportunity to read over the transcript from the initial interview? If so, is there anything you would like to add, remove or clarify?

2. In the last interview you talked a lot about how your family had helped you to cope with your son's behaviour. Tell me more about that?

3. In the first interview you also briefly mentioned the value of community resources for you and your family. Please expand on the kind of community supports that you have found most helpful?

4. Do you feel that relationships between service providers, the child and the family are important or not?

5.How do you feel about labels and the use of criteria to determine eligibility to receive services? Are they helpful or not?

6. Do you feel that there are adequate resources for children and adolescents with EBD or not?

7. Some other provinces don't use a categorical approach to funding students. Instead they call their funding "need based". So the students don't have to fit into a certain criteria to receive funding. What do you think about that kind of mode? Would it be helpful or not?

8. What are your thoughts about having a case manager who is independent of the partnering service providers to advocate for your child?

9. What are your thoughts about having a parent advocate to help you to understand and access various support systems. A parent advocate is also a parent of a child with EBD who has had experience with various systems and who would assist you in advocating for you and your child.

10. Do you think that the educational system is given an inappropriate share of the responsibility in addressing children and adolescents with EBD? Or not?

Appendix N: Follow-up Probes for School Based Social Worker in Case 1

Thank you for agreeing to participate in a second interview.

1.Did you have the opportunity to read over the transcript from the initial interview? If so, is there anything you would like to add, remove or clarify?

2. In the last interview you talked about how some children and adolescents were precluded from receiving services if they were permanent wards in the foster care system. Can you tell me more about that?

3.You mentioned that as a foster parent you learned about a lot of gaps in services can you tell me about those gaps?

4. 4. Do you feel that relationships between service providers, the child and the family are important or not?

5. How do you feel about labels and the use of criteria to determine eligibility to receive services? Are they helpful or not?

6. Do you feel that there are adequate resources for children and adolescents with EBD or not?

7. Some other provinces don't use a categorical approach to funding students. Instead they call their funding "need based". So the students don't have to fit into a certain criteria to receive funding. What do you think about that kind of mode? Would it be helpful or not?

8. What are your thoughts about having a case manager who is independent of the partnering service providers to advocate for a child with EBD?

9.What are your thoughts about having a parent advocate to help a parent understand and access various support systems. A parent advocate is also a parent of a child with EBD who has had experience with various systems and who would assist a parent in advocating for themselves and their child.

10.Do you think that the educational system is given an inappropriate amount of responsibility in addressing the needs of children and adolescents with EBD? Or not?

Appendix O: Follow-up Probes for Social Worker in Case 1

Thank you for agreeing to participate in a second interview.

1. Did you have the opportunity to read over the transcript from the initial interview? If so, is there anything you would like to add, remove or clarify?

2. In the first interview you suggested having consultation teams to provide ideas for difficult cases involving children and adolescents with EBD. Can you expand on that idea?

3. In the first interview you also talked about the contracting out of services. Can you expand on that?

4. Do you feel that relationships between service providers, the child and the family are important or not?

5. How do you feel about labels and the use of criteria to determine eligibility to receive services? Are they helpful or not?

6. Do you feel that there are adequate resources for children and adolescents with EBD or not?

7. Some other provinces don't use a categorical approach to funding students. Instead they call their funding "need based". So the students don't have to fit into a certain criteria to receive funding. What do you think about that kind of mode? Would it be helpful or not?

8. What are your thoughts about having a case manager who is independent of the partnering service providers to advocate for a child?

9. What are your thoughts about having a parent advocate to help parents to understand and access various support systems. A parent advocate is a parent of a child with EBD who has had experience with various systems and who would assist parents in advocating for themselves and their child.

10. Do you think that the educational system is given an inappropriate amount of responsibility in addressing the needs of children and adolescents with EBD? Or not?

Appendix P: Follow-up Probes for Foster Parent in Case 2

Thank you for agreeing to participate in a second interview.

1. Did you have the opportunity to read over the transcript from the initial interview? If so, is there anything you would like to add, remove or clarify?

2. In the first interview you mentioned that Tina's therapy was changing because of some reorganization in the child welfare agency. Can you tell me more about that?

3. Why do you think there is such a discrepancy between fostering a child who is a permanent ward and a child who is not a permanent ward?

5. You mentioned your need for "back-up" supports do you have any ideas about how these kinds of supports could be made available?

4. Do you feel that relationships between service providers, the child and the family are important or not?

5. How do you feel about labels and the use of criteria to determine eligibility to receive services? Are they helpful or not?

6. Do you feel that there are adequate resources for children and adolescents with EBD or not?

7. Some other provinces don't use a categorical approach to funding students. Instead they call their funding "need based". So the students don't have to fit into a certain criteria to receive funding. What do you think about that kind of mode? Would it be helpful or not?

8. What are your thoughts about having a case manager who is independent of the partnering service providers to advocate for a child?

9. What are your thoughts about having a parent advocate to help parents to understand and access various support systems. A parent advocate is a parent of a child with EBD who has had experience with various systems and who would assist parents in advocating for themselves and their child.

10. Do you think that the educational system is given an inappropriate amount of responsibility in addressing the needs of children and adolescents with EBD? Or not?

Appendix Q: Follow-up Probes for Social Worker in Case 2

Thank you for agreeing to participate in a second interview.

1. Did you have the opportunity to read over the transcript from the initial interview? If so, is there anything you would like to add, remove or clarify?

2. In the last interview you mentioned the fact that each child welfare unit had its own separate budget. Can you expand on that?

3. In the last interview you talked about the contracting out of services. Can you expand on that?

4. Do you feel that relationships between service providers, the child and the family are important or not?

5. How do you feel about labels and the use of criteria to determine eligibility to receive services? Are they helpful or not?

6. Do you feel that there are adequate resources for children and adolescents with EBD or not?

7. Some other provinces don't use a categorical approach to funding students. Instead they call their funding "need based". So the students don't have to fit into a certain criteria to receive funding. What do you think about that kind of mode? Would it be helpful or not?

8. What are your thoughts about having a case manager who is independent of the partnering service providers to advocate for a child?

9. What are your thoughts about having a parent advocate to help parents to understand and access various support systems. A parent advocate is a parent of a child with EBD who has had experience with various systems and who would assist parents in advocating for themselves and their child.

10. Do you think that the educational system is given an inappropriate amount of responsibility in addressing the needs of children and adolescents with EBD? Or not?