YOUTH IN CARE AND MENTAL ILLNESS:

MAPPING THE DIAGNOSTIC PROCESS

YOUTH IN CARE AND MENTAL ILLNESS: MAPPING THE DIAGNOSTIC PROCESS

By

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ABSTRACT

Research shows that a considerable number of young people in care have mental health diagnoses (Building Bridges, 2008, 9). An article in the Globe in Mail (2007) reported that 47% of youth in care were on psychotropic medication [for mental health, emotional or behaviour issues] (Philp, 2007).

As a worker within the child welfare system, working with crown wards, my own caseload reflects these numbers quite accurately. Some of the youth I work with have seen psychiatrists, psychologists or family doctors, and their diagnoses have changed with each assessment - which subsequently affects or changes how the case is managed.

This research sets to show how we arrive at a diagnosis, using institutional ethnography to map the diagnostic process. Using my experience as a children's service worker, I map the types of information gathered and by whom, as they contribute to the diagnosis a child receives.

This study provides a detailed examination of the text-action interplay in the child welfare system, showing the nature and volume of information created by various actors in the system and submitted to the assessing practitioner (i.e. psychologist, psychiatrist). The study also shows how action within the system is often prompted by liability, accountability and worker knowledge.

Recommendations are made to explore our responsibility to youth in care around child welfare documenting practices, emphasizing the importance of youth contributing to the text that defines them within the child welfare world.

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The Children's Aid Society is mandated to "provide care for children assigned or committed to its care" (Child Protection Legislation section 15:3:d). When a youth comes into care, the Society takes on the role of "corporate parent" and attempts to do "what a good parent would do" (OACAS, 2009, 6) by seeking to make decisions in the best interest of that child (CPL section 37:1).

I have worked in the child welfare system now for seven years charged with exactly that task: "promoting the best interest, protection, and well being of children" (CPL section 1). For the last four years I have carried a case load of twenty one crown wards. My work with these youth has been quite rewarding and challenging at the same time. There are days where I feel I have learned much more from them than they could ever learn from me. Their resiliency astounds me, and I feel a great deal of ownership as a worker (and a member of the greater community) to ensure they have the best possible care in our system.

Research shows that a considerable number of young people in care have mental health diagnoses (Ontario Association of Children's Aid Societies, 2008, 9). A report from the National Youth in Care Network in 2007 reported that 47% of youth in care were on psychotropic medication [for mental health, emotional or behaviour issues] (Lambe, 2006).

When I reflected on my own caseload I realized these numbers though staggering, were quite accurate. Out of a caseload of twenty one, thirteen youth

on my caseload were or had been diagnosed with a mental illness throughout their time in care. What was especially interesting to me was that some of these youth had multiple assessments completed over a number of years. These youth had seen psychiatrists, psychologists or family doctors, and their diagnoses changed with each assessment - which subsequently affected or changed how the case was managed as well.

As a worker I understand the benefit of a diagnosis. In many cases it can assist with accessing services or additional funding for the care of the youth. At the same time, it can be a burden for a young person who is labeled and carries the stigma associated with a diagnosis.

In this thesis I focus on how we arrive at a diagnosis. What types of information are gathered and by whom that contribute to the diagnosis a child receives? I am especially interested in the role of the case file in the diagnostic process. For youth in care their case file is most basically their biography. As "corporate parents" we collect and create the information within that file, to document the child's life and care within the system. A label from a mental health diagnosis remains in their case file indefinitely (Lambe, 2006; Chan, 2007; Philp, 2007). In turn, the information within that file determines how the system interacts with that particular youth (be that positive or negative). My goal with this research is to map the diagnostic process of a youth in care. What specifically happens to prompt a worker to seek the involvement of a mental health professional? What aspects of the system may perpetuate or influence a diagnosis?

I approach this project by examining the current system using institutional ethnography. This type of methodology is meant to help pull apart the every day functioning of the system, which can help pinpoint problems, to show where there can be improvement (Pence, 2007). It also looks at the day to day work we do as social workers, specifically the paperwork (the text, policies, procedures, etc) and how that activates the system and our practice (Smith, 2005). The literature I will present covers a wide range of information on case processing and the importance of text to the system. Although there is a wealth of information on the feelings of youth and the use of medication, and the stresses and limitations of the mental health systems, there is little information on the actual diagnostic process. It is my hope that with this research a small light can be shed on the subject, and some recommendations can be made for further research and client service.

Understanding the role text plays in practice is imperative. We can learn by examining text how the identities of "patients" and "clients" can be created through documentation. Also what these texts do to prompt work within the system, and ultimately show how it is organized through the written record. (Smith, 2005,102)

Case processing

Smith makes it clear that examining text is more than examining forms, policies, and procedures – it involves looking at how those texts activate the worker within that system. Ellen Pence uses institutional ethnography to examine how "the work of practitioners in the police and court system are organized in ways that are not observable to activists working with the victims of abuse" (Pence, 2007, 199). Specifically she looks at how calls to 911 about domestic violence are received, processed, and organized within the system. She uses Smith's approach to show that the work of criminal justice professionals is organized to secure a conviction for the perpetrator; rather than being organized around woman's safety (Pence, 2001, 200). Pence's work shows that the system "produces institutional accounts of women's experiences that erases the violence and intimidation women face in their intimate relationships" (Pence, 2001, 200). Ultimately her work shows that administrative forms, regulations, etc. are the instruments of power in this system, continuing to silence and oppress the women who require most the advocacy and power of the system (Pence, 2001).

This thesis focuses on the processing of cases in a particular service context: children in the care of the child welfare system.

Child welfare Case Processing

All aspects of case processing and action in child welfare are guided by Child Protection Legislation. The legislation is very prescriptive and dictates how workers will interact and complete their work on each case. The legislation provides the power for child protection workers to implement their job. It also directs all decision making within the child welfare system. As workers it is our job to show that we follow this legislation to its fullest extent, and we do this through documentation; case notes, policies, procedures, and other child protective recording tools (i.e. recordings, e-forms).

When a youth comes into the care of the Children's Aid Society "they activate a complex system of agencies" and procedures (Pence, 2001, 201). The case file is the key organizational tool used by workers, management, and the ministry to create action within the system. The file is composed of a number of sections that mark areas of importance in the child's life: from contemporaneous information about what is happening with the child (case notes), to school reports, medical information, court documents, assessments (medical, educational, etc.), and keepsakes. This information is used to help plan for the

child while he/she is in the Society's care. It is often shared with caregivers like foster parents and doctors.

Generally the documents in a case file are created by professionals who work with the youth. For instance, report cards are created by teachers and the school system, psycho social assessments by psychologists, medical and dental records by physicians, case notes by child protection workers, any court documents written by workers, or received and created by court officials. There is also a section for keepsakes which can include anything from photographs, school work, to newspaper clippings (most times created by or about the youth).

A case file is most basically a youth's life story. In particular for crown wards and those who are permanently in the Society's care, often the only record of their childhood is what is found in this file. Pictures, report cards, and memories normally collected by family are collected and created by professionals, leaving the Society responsible for gathering all important information about the child as they grow, understanding that the youth may require or request this information at a later date.

The case file also provides the information needed to act on and guide a case. The information within the file is used within the system to "define, prioritize, schedule, highlight, route, mask and shape" (Pence, 2001, 201). A case file will be touched by a number of workers throughout the system, each worker does

something with the case then records those things needed to move the case to the next occasion for action (Pence, 2001, 201).

By examining text we are able to study the process that organizes worker's responses, and potentially their consciousness about the cases they work with (Pence, 2001, 202). This moves us away from the worker's personal attitudes and beliefs and requires us to look deeper at the potential underlying factors for their action (Pence, 2001, 202). Pence expands on this argument stating that "Case files rarely contain verbatim transcripts of what occurred, instead they contain documents that are organized to record 'what of institutional significance' occurred at each processing occasion" (Pence, 2001, 203). The question then becomes what is "of institutional significance" in child welfare? What is the important information that prompts movement/ action on a file? And how do we as workers recognize and record this?

Child Welfare Documentation and Case Processing

The primary instruments of implementation and action in the child welfare system are greatly intertwined. For instance, the Society's involvement with a child/youth is directly connected to the parents' (family) file and every tool that is used to assess and make decisions about the child's safety. In turn, information in the family file will be used to help make decisions about the care of the child in foster care. At the same time, the information from the child file will be used to make a

number of decisions in the family file: like when/if the child could return to the parents' care.

In child welfare, like many other systems, there has been an increase in institutionalized forms to create consistency in service delivery, and in case outcomes (Parada, 2007). Some argue that the child welfare system has introduced "[standardized assessment tools] to help reduce the uncertainty and fallibility of child protection work through bringing so called scientific order and consistency to the decision making practices of social workers" (Parada, 2007; Cradock, 2004; Schwalbe, 2004). Specifically for youth in care, tools like the plan of care are used with every child to identify strengths and needs and develop his/her plan of care, addressing a number of life dimensions: health, identity, family and social relationships, emotional and behavioural development, self care skills and education (Provincial Report, 2006). This tool uses the developmental model, is strengths-based and grounded in resilience theory (Provincial Report, 2006) with the stated intention of encouraging positive outcomes (i.e. permanency and transitioning from care).

For the purpose of this thesis I will be focusing on what type of documents, scripts, and forms, are used with children in care to gather and distribute to mental health specialists like psychologists and psychiatrists. Through examining these documents I will explore what ***processing occasions*** occur,

how they affect the youth's care, and their implications for how and if the child is diagnosed with a mental illness

Institutional Language in child welfare:

What are the terms that are institutionally organized in children's services /child welfare? As workers and "members of the institution we are trained to read and write in an institutionally recognizable way" (Pence, 2001, 203). DeMontigny discusses in "Social Working: An Ethnography of Front Line Practice" how social workers learn to write and document our work. He tells us that "social work inscriptive practices are affected primarily through documentary production… we make sense of face to face conversations with clients by inscribing particular details in the record. These details follow established protocols for documentary production, such as length of entry, focus on clients, attention to mandated concerns even child protection as a professional language and attitude towards clients" (DeMontigny, 1995, 28). He argues that our work and interactions with clients are often explained in a few sentences, "taking away all emotion to reflect the agency standpoint and agency concerns" (DeMontigny, 1995, 29).

Code words, red flags, or "mentionables"

Many of the researchers who use institutional ethnography talk about the idea of "mystical connections" (DeMontigny, 1995), "red flags","mentionables" (Hak,

1998), or "key words" that create action within the system. As professionals "we are trained to translate what we see and hear and gather from the everyday world into professional discourses about that world - which appears to be objective work – but in fact are professional discourses" (Pence, 2001, 203).

Which leads us to another point regarding "how ideas are formed or presumed in social work" and that is knowledge. How do workers know what is important to recognize, assess, and address regarding a child's behaviours? DeMontigny discusses social work discourse in his book citing that the "[c]entral piece of my education in social work, and that of my colleagues, was our exposure, through our classroom lectures, readings, and participation in field work, to tests that addressed the issues, topics, concerns, and boundaries of the profession" (DeMontigny, 1995, 65). As social work students we learn about our work by engaging in on-going experimentation or role-playing to see and think through the situations we may encounter as we imagine seasoned social workers would (DeMontigny, 1995, 65)

I acted as a teaching assistant for a university level social work class, we taught the basics of how to interact and form professional relationships with your clients. The course content was based on social work texts, and also the experience and knowledge of the professor and teaching assistants. As students practiced interviewing "clients" (actors) we critiqued and provided feedback to them to help shape how they practice when they enter the field. Through mentoring and the

"feedback" we provided them in class we taught them to recognize issues with clients and what symptoms and key phrases, should prompt action and response from them as professional social workers. We even provided feedback to students on how to emote and respond to client's feelings; what we were doing was providing the basis of how these students would project and act as social workers.

These are especially important points as we examine youth in care and mental illness. We need to look at "how ideas are presumed or formed by the assessor/social worker/child protection worker" (DeMontigny, 1995, 65). What assumptions does the worker make when she or he reads a text or explains a youth's actions?

Tony Hak argues in his article *"'There are clear Delusions'. The Production of a Factual Account"* that the assessment of symptoms depends on the process of documentary interpretation (Hak, 1998, 421). Hak showed how the assessment interview in his research functioned as a stage in the process of confirming, and partly revising a previous psychiatric report rather than as a "new" independent assessment of the patient's problems (Hak, 1998, 421). Perhaps the same could be argued in children's service work. As noted above there is a great deal of overlap between the family file and children's service file. Often there is information shared between the two, including reports from parents, and people in the community (be they professional or lay persons). These reports potentially

act as the "previous assessment" Hak discusses, then as workers we "fit" this with our own understanding of behavioural problems and construct our case (which would be represented in our own reports, assessments, etc. found in the child's case file).

Voice of Service Users:

"Any time you are without freedom of choice you are incarcerated" (Through the Eyes of the Judged as cited by National Youth in Care Network, 2006, 67)

The literature about youth in care tells us that youth are concerned and feel their voices are not being heard within the child welfare system (NYICN, 2006, 67). The Youth In Care Network released a *Primer Anthology* in 2006; the anthology "explores the results of the consultation with youth in care across Canada, examining the five major challenges, the ideal intervener qualities, and recommendations to nurture resiliency, well-being" (NYICN, 2006, 67). The Anthology specifically talks about youth and documentation stressing that "voice is crucial to the development and empowerment of young people" (NYICN, 2006, 67). They go further to note that "the most significant and important way to have a voice is to be allowed to provide input into the formation of their Plan of Care [part of their case file]" (NYICN, 2006, 67). The research continues to report that "Youth in care have repeatedly reported the damaging effects of child welfare record keeping practices, which tend to focus on negative events and perceived behaviour problems and to prevent this youth in care must participate in the design of [their case] record" (NYICN, 2006, 67).

How voice is affected by case processing

Tony Hak uses his study of psychiatric intervention to show the importance of examining the process of how assessment interviews are completed (Hak, 1998, 419). His work shows that through the process of interviewing/assessment the client's voice is lost (Hak, 1998, 421). By using institutional ethnography he is able to show quite explicitly where the client is excluded and what specifically can be done to make it better (Hak, 1998, 421).

This study focuses on how the assessment and processing of young people is 'institutionally organized' at a Children's Aid Society. How is information gathered, sorted, prioritized and defined in the case file? How does this information and how it is presented affect a processing occasion, like a referral for a mental health assessment? What role do we have as workers in the construction of a mental health diagnosis?

Methodology:

This study takes the form of "Institutional Ethnography" (Smith, 2005). "This is a method of research which investigates, ethnographically, a "section" of the social world from the standpoint of the organization of the work of those who in various ways are involved in its production" (George W.Smith, Eric Mykhalovskiy, and Douglas Weatherbee as cited in Smith, 2005,172). A method coined by Dorothy E. Smith it shows the problematic as the complex relations in which the local world is rooted (George W. Smith et al. as cited in Smith, 2005, 172). What is interesting about this approach is that it does not only look at what can be directly observed, or what interviewees or participants have observed but shows how the "bureaucratic, professional, legislative, and economic – as well as other social relations are involved in the production of local events and activities" (George W. Smith et al. as cited in Smith, 2005, 172)

Susan Turner used Dorothy Smith's framework to show how you could use Institutional Ethnography in its most literal form to present its key concepts in the form of a map (as cited in Smith, 2005, 139). Turner argues that mapping shows the great capacity texts have to produce and organize people's activities that can be extended to specific agencies, locales, etc (as cited in Smith, 2005, 139). This type of mapping is different than organizational mapping, it is the process of showing "day to day text based work" as well as the relevant governing laws,

policies, procedures that shape up the on-going activities of an institution (as cited in Smith, 2005, 139). With mapping the focus is on "'individuals' observable activities with texts in particular settings" (as cited in Smith, 2005, 140). So for instance you start with a particular "text like a report, a recording even a letter or piece of legislation but the investigative goal is to [pull] the text back into the action where it was produced, circulated, and read; where it has consequences in time and space" (as cited in Smith, 2005, 140). At this point you examine what is done with that particular text, looking at how it is read, what kind of action does the text prompt, what kind of language is used and what of this is important? (as cited in Smith, 2005, 141).

This type of approach can create a working knowledge of institutional systems and all the unique activities that take place within them (as cited in Smith, 2005, 141). One of the benefits of using this approach is that it gives you the power to move beyond political boundaries and discrepancies (Turner lecture, 2009) it is about working knowledge: where do you come from, what you know. It is about mapping what you know first and then finding the overall governing policies and procedures that may shape this (Turner lecture, 2009). It also allows you to examine the macro level of the situation showing you what overriding texts exist and organize your work, such as ministry standards, the eligibility spectrum, the child protection legislation, and so on (Turner lecture, 2009)

Design of the study:

In this study I map the diagnostic process in child welfare drawing on my own experience as a worker. Interviewing, although an important method of gathering data is not always necessary when using institutional ethnography. There are multiple researchers who have mapped their own experiences with systems. Susan Turner used mapping to explore her experience with a land development project in her neighborhood (as cited in Smith, 2005, 139). Janet Rankin wrote a chapter in the book *Managing to Nurse* where she and her aunt filled out a satisfaction survey and discussed how the form mismatched their experience (J.Rankin, M.Campbell, 2006).

In mapping, texts are a main source of data. In this study, relevant texts were mostly accessible online. The information I gathered on "process" which includes policies, procedures, and worker knowledge was provided from my own experience as a worker (which I describe below).

As Turner suggests, I started this study by positioning myself and mapped "what I know" (Turner lecture, 2009). I used my understanding of what happens when a youth comes into care, and throughout their time in care obtains a mental health diagnosis. I created maps by hand of how I do my job and what kind of general interactions I have with other staff and community members when it comes to caring for a youth in care. I used Turners mapping scheme: "text – action – text", to break down each process I was drawing (Turner lecture, 2009).

You can find copies of these maps on pages twenty five (b) and fifty four (b). I've used the basic format of:

Rectangles represent text and ovals represent action. The lines between each shape show the connection and direction in which text provokes action. People are represented by a small picture of a face and if there is a dialogue box beside it, it means that discussion is required to create the text or during the action it is connected to.

I then created a detailed narrative of my work with a youth who receives a mental health diagnosis while he is in the care of the Children's Aid Society. Matt's story was derived from the experiences of multiple youth I have had contact with directly or indirectly (i.e. youth I have learned about through the stories of my colleagues). To maintain confidentiality I have not used any one youth's story but rather brought together aspects of many youths stories. As well I have altered or not included any details that could identify any particular youth. Young people's stories in care often shared themes and experiences, and provide a base point for us to examine the diagnostic process for a youth in care.

I then took the narrative of my day-to-day work with Matt and created a commentary on it that links my work to the broader texts and guidelines that govern my practice. Occasionally I also include (in italics) my feelings as a

worker about the young man's experience and the work that I am doing with him. Both commentaries are meant to expand on the narrative to help the reader understand the "process" of moving through the system.

At this point I took this information and used it to reflect on the maps I had created. I was able to take apart the stories to create a visual representation of how each worker action was prompted in the case and what text was associated with it.

Institutional ethnography requires the analysis of both text and process (Smith, 2005). As noted, the texts I have used in my research were all accessible online or were described by myself from my recollection of practice. To ensure the confidentiality of my geographical location of practice I will not provide references to agency specific documents (i.e. job descriptions, policy manuals) and will delete all references to province specific legislation as well. Quotes will be presented exactly as they appeared in the original documents with of course the exception of identifying information (DeMontigny, 1995, 8).

There are obvious limitations to this study. For instance, because I am the only source of practice/ process data we must be careful when we make generalizations about practice from my experience. Although CAS actions are governed by the Child Protection Legislation, policies and procedures may differ from one agency to the next. In my experience, agencies respond to situations in

different ways depending on service needs, service availability, concerns about liability, geographical location, etc. At the same time, as IE suggests, institutional practices are standardized in a range of ways, and it is these common, routine aspects of the diagnostic process that I examine in this thesis.

Presentation of Findings and Analysis:

The goal of this research is to map the diagnostic process of a youth in care. As stated above, institutional ethnography focuses on the "process of work" and what specifically prompts action within a system. Using institutional ethnography the findings and analysis section presents a few of the major processing occasions that highlight how the child protection system activates the actions of the children's services worker. In turn I show what texts, forms, and policies organize how the worker completes her work with the youth.

To set up the analysis, I review here the role and job description of the children's services worker, identify her coworkers, and outline in general terms one of her key tasks: the creation of the case file. I then describe my primary data source – Matt Martin's story – and proceed to the formal findings and analysis section of the thesis.

Children's Service Worker – Job Description

When youth come under the Society's guardianship there are a number of people who interact and contribute to the child's day to day care.

These people are organized into a number of categories; first we have agency workers (i.e. foster care workers, intake workers, children's service workers, as well as their supervisors). Then we have the primary caregivers – foster parents and group home staff. Lastly we have community service providers that range from teachers, counselors, doctors, and dentists to probation officers, landlords, coaches, and employers.

It is the job of the children's service worker to liaise between all of these players and act as the "case manager." The children's service worker meets with these people on a regular basis, gathering information about the youth to help orchestrate and implement the services that are in the best interest of the youth.

As you can see in this example of a children's service worker's job description a large portion of the job requires the sharing information, planning and on going assessment of a youth in care:

"Nature of the Job"

1. To provide an ongoing assessment of the child's needs and to develop an appropriate Plan of Care based on these needs.

2. To coordinate and attend meetings to review Plans of Care and to ensure the continued implementation of strategies and services to meet the child's needs.

3. To participate in the development and implementation of alternative residential care plans for children requiring placement.

4. To work closely with foster parents and other care providers in supporting and planning for children in care.

5. To work with foster parents and other Society staff to assist in the facilitation of access between children in care and their natural families.

6. To monitor childcare practices within placements and to alert the Supervisor of any potential problems regarding the care and protection of the child.

7. To report child protection concerns involving children in care and, in the event of an investigation of abuse or neglect, to support the child through the investigative process.

8. To provide information and support to the appropriate parties during and after serious occurrence investigations. (Children's Service Job Description, City X, 2009)

The types of education and knowledge required (as they are formally defined) appear below, in a list typically found in children's service job posting:

Required Education and Qualifications:

- Bachelor of Social Work Degree / Master of Social Work or BSW equivalency

- Master's Degree in a Human Services related field, and a minimum of three (3) years relevant experience working with children and families.

- Bachelor's Degree in a Human Services related field, and a minimum of three (3) years relevant experience working with children and families.

- CYW and a minimum of three (3) years experience working with children and families.

- Previous experience in clinical services to children combined with a direct knowledge of residential systems is desirable.

- Knowledge of normal child development. (Children's Service Job Description, City X, 2009)

Required Knowledge:

- Good working knowledge of Child Protection Legislation, Ministry standards and guidelines, and Society policies and procedures.
- Good knowledge of diagnostic and treatment theories with the ability to integrate theory and practice.
- Good knowledge of childhood, emotional, behavioural and social disturbances in order to assess child's requirements and develop appropriate plans of care.
- Analytical skills to assess client's needs and to determine ongoing appropriate requirements.

- Organizational skills to prioritize tasks, be self-initiating and work independently.
- Good written communication skills to document information in a clear, concise and accurate manner.
- Good interpersonal skills to liaise with community professionals and other Society Staff.
- Good verbal communication skills to provide support and guidance to foster parents. (Children's Service Job Description, City X, 2009)

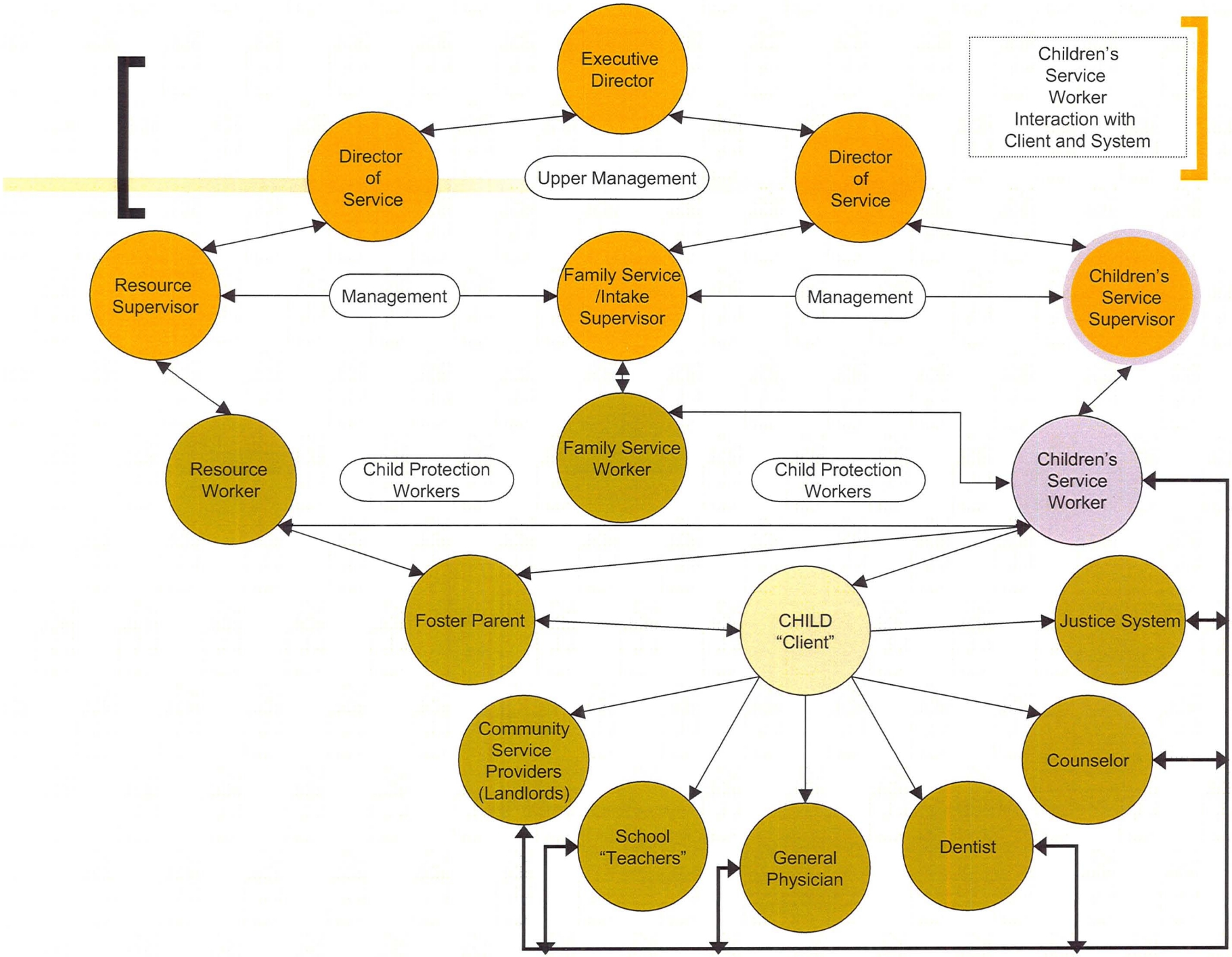
Organization of a file

Though the above job description does not provide the details of the day to day administrative aspects of the position it does allude to a set of standards all workers must understand and comply with: "Ministry of Child and Family Services Standards and guidelines, and Society Policies and Procedures" (Child Protection Legislation, 1990).

One of those standards is the documentation of the worker's interactions and "work" completed on each case file. It is expected that every interaction workers have with the key players I list above will be documented in case notes to help form a case file that can and will be used for a number of purposes while the child is in the Society's care.

The map below offers a visual representation of the relationships between the children's services worker, her coworkers and supervisors, and the client. As you can see the children's service worker acts as case manager and interacts with a number of people who are connected with the youth (all olive bubbles).

The worker gathers information from all of the people in these bubbles to add to the case file, and implement any planning for Matt. The people in the beige bubbles represent upper management and how they are connected and interact with the children's service worker, and client (see next page for map).


Children's Service Worker Interaction with Client and System
Executive Director
Director of Service
Upper Management
Director of Service
Resource Supervisor
Management
Family Service /Intake Supervisor
Management
Children's Service Supervisor
Resource Worker
Child Protection Workers
Family Service Worker
Child Protection Workers
Children's Service Worker
Foster Parent
CHILD "Client"
Justice System
Community Service Providers (Landlords)
School "Teachers"
General Physician
Dentist
Counselor

Summary of the Case: Matt Martin's story

The story I present is that of Matt Martin, a 15 year old boy who came into care after concerns with his mother's mental health, lack of supervision, and exposure to domestic violence. Matt has two siblings both younger than him. His two siblings were placed in different foster homes than Matt, and he has regular visits with them with his parents, and also on their own. The visits with his parents are supervised by the Society and are sporadic.

In just two and a half months Matt has been in three different foster homes. His foster parents and teachers have described on-going concerns with Matt following the rules, paying attention in class, using drugs, leaving school property and running from the foster home. The foster parent finds notes in Matt's room saying "I feel like I'm dead inside", "I wish I was dead", "I hate CAS". When Matt came into care he had a number of marks on his arms that looked like they could potentially be scars from self-harming.

I become concerned as a worker when Matt begins to engage in fairly high risk behaviour when he runs from school or home (i.e. hitch hiking, taking money from strangers, staying at people's homes he does not know). His running increases and at one point Matt is gone for close to one month. Finally the decision is made for Matt to move to a more structured setting. He is placed in a group home and rather than stabilizing Matt things appear to get worse.

We pick up the story, and the analysis, from here. It is important to note that I am only discussing Matt's immediate care. I am not discussing his familial visits, or what is happening with his parents and their involvement with CAS.

The following section provide examples of how a child's file is constructed focusing on the role of the children's service worker/"case manager" in the construction process.

As a reminder to the reader, the text that appears in the left hand column (**in bold**) is the "day to day" work that happens with Matt, the text on the right is the commentary about the work. The text that is *italicized* presents my feelings as a worker about the young man's experience and the work that I am doing with him.

Narrative

There are a number of meetings that take place as Matt runs more frequently from his foster home. The people who attend these meetings are: the children's service worker, the family service worker, the resource worker, and each of their supervisors. We meet on a fairly regular basis to review the status of the youth who has run (Matt), what information we have to tell us about where the youth may be, and who will follow up on these leads.

Commentary

These meetings take place to help document our on-going efforts to locate Matt. They also provide an opportunity to brainstorm ways to locate Matt and what we can do for him when he returns. Also, because of "the running" Matt is considered a "high risk" youth. This "high risk" label can be linked back to the Child Protection Legislation. When the Ministry audits the case files of Society youth they use a set of criteria to determine if youth's behaviours are considered "high risk" and require a closer level of supervision. Although I don't have the criteria the Ministry uses, I can refer back to the Child Protection Legislation which clearly outlines the criteria for admission to secure treatment. The key idea from this section is that the youth has "caused or attempted to cause serious bodily harm to himself, herself or another person" (CPL, 117:iii).

Commitment to secure treatment: Criteria

117. (1) The court may order that a child be committed to a secure treatment program only where the court is satisfied that,

(a) the child has a mental disorder;
(b) the child has, as a result of the mental disorder, within the forty-five days immediately preceding,

(i) the application under subsection 114 (1),
(ii) the child's detention or custody under the Young Offenders Act (Canada), under the Youth Criminal Justice Act (Canada) or under the Provincial Offences Act, or
(iii) the child's admission to a psychiatric facility under the Mental Health Act as an involuntary patient, caused or attempted to cause serious bodily harm to himself, herself or another person;

(c) the child has,
(i) within the twelve months immediately preceding the application, but on another occasion than that referred to in clause (b), caused, attempted to cause or by words or conduct made a substantial threat to cause serious bodily harm to himself, herself or another person, or
(ii) in committing the act or attempt referred to in clause (b), caused or attempted to cause a person's death;

(d) the secure treatment program would be effective to prevent the child from causing or attempting to cause serious bodily harm to himself, herself or another person;

(e) treatment appropriate for the child's mental disorder is available at the place of secure treatment to which the application relates; and

(f) no less restrictive method of providing treatment appropriate for the child's mental disorder is appropriate in the circumstances.
R.S.O. 1990, c. C.11, s. 117 (1); 2006, c. 19, Sched. D, s. 2 (35).

Narrative cont...

During one of these meetings (July 10th, 2009) the supervisors begin to question if regular foster care is appropriate for this youth. The worker's and supervisors discuss how the needs of Matt are much higher than what we normally ask of foster parents.

When it is my turn to speak I express concern that Matt is engaging in high risk behavior when he runs. Specifically I review the fact that he will often hitch hike, steal, use drugs, stay with people he does not know and take money from a strangers (making sure to note the incident where he showed his genitals to a stranger for money).

Commentary cont...

The ministry would be very aware of Matt's running and if they had concerns with how we were managing the situation they could request a review of the file. As an agency we need to show that we have done everything in Our power to keep Matt safe.

The meeting is documented in the form of a supervision note. In this supervision note a supervisor will write down the details of what was discussed in the meeting and who will follow up on the noted concerns. There is a time line placed on each task that is assigned, and the supervisor and each of the workers will sign and date this form. It is an agreement that we understand what work needs to be completed, and an acknowledgement that we will complete this task by the noted date. In the event that a worker does not complete the task by the assigned date disciplinary action could be implemented.

I know when I have a chance to speak in a meeting – it's important. I am tired as a worker of chasing Matt, and worried about what it will mean if we find him a new placement that can't handle his needs. At the same time, I'm worried about Matt. I haven't had a chance to really connect with him as a worker and he doesn't seem to take care of himself. I'm not sure how to engage him and I'm hoping that a good placement will help him settle and stabilize.

Narrative cont..

I review the information I have received from his foster parents and teachers. His foster parents say that Matt does not follow the rules of the home, steals from his foster parents and siblings, and is often yelling, swearing and throwing things in the home. They also have found notes in his room saying "I wish I was dead", "I hate CAS", "I hate my life". His teachers say that Matt does not do well in the classroom, constantly disrupting the class, leaving school property, and has been found smoking and doing drugs on school property.

Commentary cont...

All of this information can be found in Matt's file specifically in case notes from my conversations and meetings with the foster parents and school. Case notes act as a legal record of what I as a worker saw, heard, did, or even ideas or opinions formed during that client interaction.

As workers we are taught to "case note" everything of importance that takes place while we are at the client's home. The information considered 'of importance' has to do with whether or not the child is safe in the current situation. Much of our work is guided by a tool used in the intake process: "The Safety Assessment". Although the safety assessment is used to determine the safety of a child in the initial stages of a child protection investigation, the key ideas permeate our on-going practice with clients. This may happen subconsciously but we are taught as workers to regularly use case notes to document how the situation is safe or unsafe, outlining information about the following (summarized from the Safety Assessment):

- the conditions of the home
- parents' mental and physical health
- any physical injuries that are unexplainable on the children
- concerns around/suspected sexual abuse
- are the parents protecting the children appropriately with rules, boundaries and expectations with regards to being in the community
- is there food in the house on a regular basis
- are the parents taking care of medical and emotional needs of the children
- are there any issues with drugs/alcohol, or domestic violence

If I documented any concerns around the above mentioned issues then this would constitute a "safety concern". All aspects of the safety assessment are related to the child protection legislation and what is legally

Narrative cont..

Commentary cont...

considered child abuse (be that physical abuse, sexual abuse, or neglect).

"Child Protection Legislation": Child in need of protection

(2) A child is in need of protection where,

(a) the child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,

(i) failure to adequately care for, provide for, supervise or protect the child, or

(ii) pattern of neglect in caring for, providing for, supervising or protecting the child;

(b) there is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,

(i) failure to adequately care for, provide for, supervise or protect the child, or

(ii) pattern of neglect in caring for, providing for, supervising or protecting the child;

(c) the child has been sexually molested or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause (c) is repealed by the Statutes of the Province X, 2008, chapter 21, section 2 and the following substituted:

(c) the child has been sexually molested or sexually exploited, including by child pornography, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child;

See: 2008, c. 21, ss. 2, 6.

(d) there is a risk that the child is likely to be sexually molested or sexually exploited as described in clause (c);

(e) the child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment;

Narrative cont...

Commentary cont...

(f) the child has suffered emotional harm, demonstrated by serious,

(i) anxiety,

(ii) depression,

(iii) withdrawal,

(iv) self-destructive or aggressive behaviour, or

(v) delayed development,

and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child;
(Child Protection Legislation, Province X, 1990)

I was taught to how to "case note" in my fourth year social work placement. I attended a staff training day where a number of new workers gathered to begin to understand the record keeping procedures in the agency. The trainers provided us with a narrative of a typical child protection case, and then asked us to "case note" this scenario. An instructor came around to each person and read their account of the situation, to critique what we wrote and tell us what information is important in our documenting.

We were taught it is important to document factual information that is objective and does not carry judgement. It is not appropriate to write that the home was extremely messy and unsafe. It is appropriate to write that the home seemed congested, with many boxes piled high along the hallways; there was food garbage on the floor, and animal feces in many spots on the carpet. The animal feces had what appears to be mould growing on it (white fluffy substance with dark blue portions). The children's beds had no sheets, and there were no clear walkways on the upper level of the home.

All of the above highlight what would be considered "safety concerns". For instance if there was a fire, the fact that there was no clear entrance or exit because of the boxes in the hallways could mean

Narrative cont...

The family worker talks about Matt's parents making a number of complaints about the fact that the Society has not been able to keep Matt stable in one place. She says the parents are upset that he's already had three moves in a matter of months, never mind the fact that he's running all the time. The parents present as worried, but the family worker believes that they know where Matt is. The parents just aren't disclosing this to CAS.

Commentary cont...

that the parents and children would not be able to leave the home safely. The food, garbage, and feces on the floor are also "safety concerns". There would be concerns around disease, the potential for the children to ingest or choke on something on the floor.

We learned that sticking to 'the facts' is also important when describing "interactions" with clients. So for instance, it is important that you document what you say to the client. When you meet with them to address the issues brought up in the referral (initial call to intake leading to the case opening) you need to write down (at the very least) an outline of what you said to them. At this point you would document how the client responds to you describing what words they use, and what attitudes they verbalize about your concerns (i.e. The client said loudly "you are nosey and have no idea what you are talking about - the children are fine"/or perhaps they said "I've been struggling with this for a really long time and I've tried everything - I just don't know what to do").

Case notes are the bulk of the information in family and children's service files. They are completed by child protection workers who have contact with the family. They are used to track all interactions between the Society and client. As a worker you understand that this information could be called into court at any time. It is agency policy that case notes are completed in a timely manner. This means that they need to be written (by hand or on computer) within 24 hours of your interaction with the client.

There are two key ideas that emerge from this next portion of text: stability and the Society's plan for children in its care.

Stability:

Stability and permanency is a key theme for youth in care. Literature around child resiliency tells us that stability in child placements leads to success

Narrative cont...

Commentary cont...

(i.e. being able to engage in community activities without difficulty, connecting with peers in a positive way, attaching and feeling cared for in a foster home) (OACAS, 2008). The idea of keeping a youth in one consistent placement, without numerous changes in caregivers as well as community activities is considered "best practice". Matt has already had a number of placements in a short amount of time.

It is easy to see that this would affect his behaviours and his ability to connect with the people around him. Youth have noted before how difficult it is to attach and make friends with people who they feel will likely reject them when they start to act out (for any number of reasons) (NYICN, 2006).

As well, as an agency we would be concerned that Matt's parents are making complaints about Matt's instability in care. We are in court regarding Matt's parent's inability to take care of him and his siblings. Yet, we as a Society have not been able to stabilize Matt in our care. This could affect our case, and could do one of two things: the judge could decide that Matt was better off with his parents and return him to their care, or he could acknowledge that Matt is a challenging youth that requires professional care.

The Society's Plan for Matt:

When a youth comes into care the documentation shows that there are concerns related to the safety of a child, and that there are no other possible ways to resolve the situation (i.e. by having the youth stay with extended family or friends while the parents address the Society's concerns). At this point there are a number of things that happen: from court involvement, to very specific work between the family worker and the family. The family worker will likely attend the family home within a few days of the apprehension and outline the Society's concerns explaining to the family what the Society would like to see happen so that the...

Narrative cont...

Commentary cont...

...children can be returned to their care.
The Society will have also submitted this plan to the court to show that we will work with the family to address these concerns (see below for Child Protection regulations about advising the court CAS' plan). The family worker then sets time limits for these goals with the family. The Society will provide updates to the court regarding the family's progress.

The children's service worker will provide similar updates to the court regarding the children's status while they are in care. This happens in the form of an affidavit and provides factual information about the child's placement. The format of an affidavit may vary from agency to agency, however I was taught to outline the following information in my new worker legal training:

- What types of activities the child is participating in (i.e. are they going to school, are there any issues with schooling)
- Any counselling the child may be involved in
- How does the youth interact with their peers and family?
- How is the child doing with family visits (i.e. do visits effect behaviours? And if visits do effect the child's behaviours are they positive or negative?)

For instance an affidavit for Matt would outline how he really enjoys visits with his parents. However, when his parents do not attend visits Matt becomes physically aggressive vocalizing anger and frustration, at times running from his foster home to try and find his parents. I would point out that Matt appears sad and disappointed showing these feelings through physically aggressive and at times impulsive behaviours. I would talk about how Matt wants desperately to be home with his parents, and feels let down when his parents don't follow through with what the Society is asking them to do. I would need to provide factual examples of this information from conversations with Matt, or information in the

At meetings we discuss the fact that every time Matt runs, we (staff at the Society involved in Matt's case) believe he runs to his parent's home.

The family worker brings us up to date on reports from neighbours and people in the community that they have seen Matt with his parents or leaving his parents home on a regular basis. Police often attend the Martin residence and feel that the parents are not being honest with them about Matt's whereabouts.

The family worker says that on one occasion Matt's mother told her that Matt always checked in with her when he ran. When the family worker tried to engage Lynda Martin (Mom) in a conversation about trying to keep Matt safe and in one place, Lynda said that Matt can take care of himself and he is safe. Yet days

form of an incident report, or even notes we may find written by Matt.

Ultimately if our documentation shows the parents 'meeting the plan', then it makes the case to the court that the family has addressed the concerns leading to the apprehension. If our documentation points out ways that the parents have not met the plan, it makes the case that the parents do not have the ability to parent their children.

Child Protection Legislation: Society's plan for child

56. The court shall, before making an order under section 57, 57.1, 65 or 65.2, obtain and consider a plan for the child's care prepared in writing by the society and including,...

(d) where the society proposes to remove or has removed the child from a person's care,

(i) an explanation of why the child cannot be adequately protected while in the person's care, and a description of any past efforts to do so, and

(ii) a statement of what efforts, if any, are planned to maintain the child's contact with the person;

Often when a child comes into care the biological parents are not aware of where the child is placed. This is for two reasons. Some foster parents are not comfortable with biological parents knowing where they live. There is also the concern that biological parents may potentially attempt to remove the child from the foster home. At times parents may make threats to locate the child, and remove them from care themselves. This type of situation is seen to put the foster parents and their family at risk of harm, but the youth in their care as well. Most agency's err on the side of caution and keep this information confidential.

In the case of Matt, the information Matt's mom has provided to workers appears inconsistent and confusing. I can recall situations that I've dealt with in the past

later Lynda began calling the family worker saying she is worried about Matt.

The family worker is unsure how to "read" this situation and believes Lynda knows where Matt is but is really unsure about what to do.

The resource worker (the primary contact for the foster family) reiterates that the needs of this youth are far greater than what are regular foster parents are able to provide. We come to a decision that Matt is too "high risk" for regular foster care; when he returns he will require a more secure setting.

My supervisor tells me to speak to the resource department and start the process of finding an appropriate placement. She tells me to fill out a new child profile, and finish the form required to have the placement approved

where biological parents have interfered with the child's placement (i.e. by helping them run from foster care, providing them with money and food, etc. when the child has run). In one case in particular our Legal department sent a letter to the mother advising her that she is breaking the law and if she continues to interfere with the child's placement we will contact the police and attempt to bring legal charges against her.

There is an on-going shortage of foster parents in the Child Welfare system. Finding a foster home that can manage the needs of challenging youth can be difficult, and Society staff are often concerned not to disrupt or burn out the homes available. When staff are looking to place a youth who has had some difficulty settling, we want to make sure it's a good fit for them. At the same time we want to make sure that we aren't overloading the foster parent so the placement will break down and we will again have to move the youth to another foster home. The goal is always to have as few moves as possible.

A "regular" foster family usually consists of one or two parents, some have their own biological children, and up to four foster children. These homes are trained to deal with many of the issues that youth in care deal with (i.e. anxiety, depression, acting out physically, sexually). However, there is a limit to what regular foster parents can provide. In this situation we may look for what is called an "outside paid resource" (OPR). An OPR is a group home that is run by trained staff (social service workers, child and youth workers). The ratio of staff to youth is usually fairly high, and they are trained specifically to deal with behaviour issues and provide counselling to youth who have experienced trauma. OPR's often have a great amount of structure and routine, and the structure of the home generally reflects some sort of evidenced based therapeutic approach/behaviour management model.

by the director of service.

My supervisor has to speak verbally with the director of service to advise them that Matt will need an "outside paid resource" and outline the reasons why he cannot be maintained in regular foster care. At the same time I fill out the required form for this to be approved and forward it to my supervisor who will also take it to the director of service. This form will include a description of the current behaviors, and why his needs are too much for regular care. The resource worker "reserves" a bed (coincidently it is also the only bed available in the immediate area) and is placed on "hold" until Matt is located. We pay a fee to keep the bed open to us but we feel it's necessary until we find the youth...

This takes time. It's frustrating because the child profile is a fairly time consuming document and basically reiterates all the information you just verbally relayed in the meeting. Every other child on my caseload will have to wait while I complete this information.

The discussion of "money" and what money is spent on each youth is an on-going discussion and concern within the system. As workers you become very aware that there is a need to justify any funds spent on the youth. The ministry audits our spending on a regular basis and if we have not followed the minister's guidelines and cannot justify our spending we are at risk of losing funding or potential punishment for misuse of funds. A youth who resides in an OPR costs the Society upwards $300,000 a year, some charging close to $100-$450 a day. Most agencies have regular meetings (i.e. quarterly) to advise workers of where we (as an agency) stand financially. In these meetings you learn about what things the ministry is examining on a regular basis (i.e what type of spending: on foster care, mileage, daily expenses of workers).

Earlier I presented a diagram titled Children's Service Worker Interaction with Client and System. The purpose of mapping in I.E is not to show the hierarchy of worker organization. This map shows instead the multitude of people involved in one child's life while she or he is in the child welfare system. At the same time the map shows the relationships through which information is obtained and shared and the number and range of institutional representatives who are involved with this.

It is interesting to note that upper management often make significant decisions on the case file (i.e. when and where to move a child, money spent on services, how to proceed with a legal case) from information gathered and presented by the children's service worker. As is also apparent from the diagram, the "client"/child in care rarely meets or speaks with anyone at this level of the agency, a point to which I return in the discussion.

Analysis Section Two:

Case Summary:

Matt was located on July 25th, 2009 by police and arrested for shoplifting. He was released from police custody and given conditions to reside where CAS deems fit (as well as a number of other common conditions for youth). Matt was moved to the group home where we secured a placement and he continued to struggle in CAS care.

Initially there were difficulties with him attending the on-site school, and then a few important events/facts occurred:

1. Matt locked himself in his bedroom with another resident and took apart a bed and used the bed slats as baseball bats to scare staff away from the room. Police were called and Matt received a warning about his behaviour.
2. Matt began making inappropriate gestures towards female residents (i.e. grabbing parts of their bodies, making comments about wanting to do sexual things to them, and telling them to do sexual things to him). Some of the residents became scared and said they didn't feel safe in Matt's presence.
3. Matt continued to run from the group home on a regular basis, often running to his parent's home, returning to the group home with drugs and using drugs more regularly.
4. On a regular room check the group home staff found notes written by Matt stating that he wanted to die, and feels dead inside. He was taken to the emergency department for a psychiatric assessment. The psychiatrist on-call felt that Matt was not suicidal, but troubled, and referred him to a child psychiatrist.

Narrative:

September 5th, 2009
I get a call from a children's psychiatrist office to schedule an appointment with Matt and myself. The appointment is scheduled for September 9th, 2009.

September 9th, 2009
I pick up Matt from the group home and remind him that he has an appointment with a psychiatrist.

He asks me why he's going to a psychiatrist. I say to him – do you remember when you went to the hospital the other week? Well – that doctor wanted you to be seen by someone who specifically works with youth. This will give you a chance to talk to someone who is not CAS, or from the group home – and maybe we can get a better understanding of what we can do to help you.

Matt says he doesn't need help – and this

Commentary:

I try to be as open and honest as possible about the appointment. I know it's hard for kids to talk to new people about what is going on in their lives. In particular for kids in care they are regularly meeting new professionals in their lives. I find that I personally feel anxious for kids as they have to move through the system. I feel at times we only make it tougher for them. For instance, I know that it is very unlikely that Matt will talk to the psychiatrist today. I also know that it is unlikely that he will obtain any sort of consistent service from this referral. It's hard to encourage a youth to talk to someone when you know it's only going to lead to them having to tell their story again to someone else. It feels like we're going through the motions.

After we attend the appointment, I will make a make a case note that documents the visit. If Matt were to decide not to attend the appointment I would simply document that he would not attend. We have to show the ministry we tried to follow up with the psychiatric referral, but we cannot force a child to attend or participate.

is probably a waste of time. I tell him to give it a shot if he doesn't like the doctor He doesn't have to talk to her – just see if maybe it will be a good thing. Matt reluctantly agrees to go.

We arrive at the psychiatrist's office and are greeted by a receptionist. We check in and wait for about an hour before we are seen. Matt is frustrated and fidgets a great deal in the waiting room. He paces, flips through magazines, and begins to pull posters off the wall. He tells me that this is taking too long and that he does not want to be here. I give him money to get items from the vending machines to give him something to do.

The psychiatrist meets first with me. She requests information on Matt's status as a ward, his family and social history, time in care so far, and any information I think is important.

I have this feeling that I have to speak quickly. There is never a lot of time and doctors are always behind schedule.

I tell her about how Matt came into care about the traumatic apprehension and subsequent running from multiple foster homes to his parents home. I briefly outline how he has had trouble concentrating in school and often will not attend at all. I talk about different issues we've had while he's been in care, drug use, yelling, swearing, generally having trouble following direction and listening to the rules. When she asks about Matt's family I tell the doctor about mom's history of domestic violence, and also concerns with mom's mental health. I tell her that we don't have a specific diagnosis from Mom – but that police mentioned concerns that she was suicidal, and that we have historical information in the family file saying that she was depressed and was on medication at one point as well. I give detailed

Most of the information workers share with a psychiatrist is guided by the psychiatrist and her or his questions.

Through experience in the field you start to get an understanding of what questions psychiatrists ask and what information they want. Also, you learn that you need to present this information in a clear and concise manner.

As I begin to talk about Matt's family and social history I know I need to outline the fact that there is a family history of mental illness, that Matt has witnessed domestic violence, and the he has had periods of his life where he moved frequently and experienced large gaps in his education. I say these things because I have come to know that:

1. Having mental illness in your family leaves you with a greater risk of contracting it as well.
2. Witnessing domestic violence may be traumatic and may lead to experiencing post traumatic stress disorder, depression, or anxiety.
3. Frequent moves and changes in caregivers may contribute to something like an attachment disorder.

This report will be placed in Matt's file indefinitely. It will be filed under "assessments/reports" to allow for quick access if needed in the future. This report will be read by any worker who has access to the file, and could potentially be used in court. It is likely in Matt's situation a copy of this assessment would be placed in the most recent affidavit to update the court on the status of the children. It would inform the court that Matt is a child who has higher needs than other children. At the same time this information could be used to show the court that the parents were not addressing his unique needs.

information around specific incidents Matt may have witnessed of domestic violence (i.e. when mom's boyfriend once pulled mom outside by her hair and slammed her head into the sidewalk). I say we have records that mom and kids had moved a number of times in a short period of time (2 years – 4 places). I tell her that some of this information is reported by community persons – like teachers, police, etc.

This psychiatrist tells me that she will meet with Matt for a bit and talk with him – but unfortunately she won't be able to follow up with him. She says she will provide an assessment, and make a referral for further services.

The psychiatrist then meets with Matt for about 25-30mins and comes out to tell us that we will receive her report in about 3-4 weeks.

October 2nd, 2009
The psychiatrist's report arrives, listing Matt's diagnoses – Generalized Anxiety Disorder, ADD, ODD, and Dysthmia. She does not recommend medication at this time.

I remember being incredibly frustrated that the Psychiatrist gave no recommendations around Matt's care. Her one suggestion was that Matt should be in counseling to address these specific diagnoses.

The Psychiatrist provides a referral to a specific counseling agency run by a hospital. I receive a letter from this agency stating that they received the psychiatrist's referral and that there is a six month wait for services at this time. Contact them if there are any significant changes in the youth's life.

October 9th, 2009
The staff from the group home calls me and request a meeting with myself and the probation officer to review the results of the psychiatrist's report. At this time, the group home staff expresses concerns that there are mental health issues at play and the psychiatrist's report

does not give adequate information around treatment. They would like a fuller assessment, with components to address education as well – and ask that the youth have a psychological assessment.

October 11th, 2009
I take this information back to my supervisor to review, and she agrees that another assessment would be helpful for treatment as well as helping to guide how we manage Matt's placement and treatment needs. I tell her that the group home has a specific psychologist they like to use. I then begin the process of obtaining approval for the psychologist. I obtain the name and contact information for the psychologist – and call them requesting a copy of the CV and quote for service. The psychologist will fax this information to me and then I will present this

I take this information to my supervisor because the group home has raised a concern about Matt's mental health and they believe he requires a detailed treatment plan. Although the group home didn't say it implicitly I'm worried that Matt's placement will break down and it's important we do everything we can do stabilize him. I agree with the group home that we need more information to help build an adequate plan for Matt to stabilize. I know that we cannot wait for service through the psychiatrist's referral, and we need to pay for service that could begin immediately. However, I don't believe that it would be in Matt's best interest for us to start him on counselling right now without a thorough plan. So I want to wait for the recommendations from the psychologist before we plan any further. I would rather not introduce more people into Matt's life if we don't have to

information along side the concerns leading to our request for a psychological assessment to a supervisory committee at the agency. This committee makes all major decisions around money used at the agency.

October 13th, 2009 The supervisory committee approves Matt's assessment. At this point I contact the psychologist on the phone and initiate the process of gaining the assessment.

For accounting purposes I need to provide a copy of the psychologist's CV and a quote for the expected cost. The cost has to be approved by the supervisory committee, and they also need to approve the service provider (psychologist). This paper work is not kept in the child's file, it is used solely for accounting purposes. Workers generally do not have the power to approve significant financial expenses on a file. There is a process and formula for approving any money spent on a case. Generally anything under $500 can be approved by your direct supervisor and anything above that amount needs to be approved by a director of service.

Narrative cont...

October 14th, 2009
The psychologist faxes me a number of forms that they want to have filled out by myself, the group home, and also the teacher who has been working with Matt. These forms generally ask questions about the day to day functioning of Matt. I take these forms and give them to the appropriate people. Some of these forms are ticky box forms. The form I fill out has both tick boxes and space for a narrative.

I fill out the form like so:

Patient History Information

Please complete this form to the best of your knowledge. Please write N/A for questions that are not applicable to you.

DEMOGRAPHIC INFORMATION:

Today's Date: Oct/14/2009 (mm/dd/yyyy)

Patient name: Mathew (First) Michael (Middle) Martin (Last)

Date of Birth: Jan/15th/1996 (mm/dd/yyyy) **Age:** 15 **Grade:** 9

Address: 156 Holton Avenue

City: Little Britain **Province:** AB **PC:**_____

Home Phone: _____ **Alternate Phone:** _____

Name of person completing this form: Sarah Milmine
Relationship to patient:
☐ Mother ☐ Father ☐ Grandparent ☒ Other: Child Protection Worker

BIRTH HISTORY:

Was the baby on time? ☒ Yes ☐ No
If no, was he/she ☐ early or ☐ late? By how many weeks? _____

Weight of child at birth: 6lbs 2oz

Age of mother at birth: 18 **Age of father at birth:** 23

Check all that apply:
☒ Spontaneous labor ☐ Vaginal delivery
☐ Induced labor ☐ C-section (planned? ☐ yes ☐ no)
☐ Breech presentation ☐ VBAC (vaginal birth after c-section)

Please add any comments regarding the items noted above: Matt's mother describes a healthy delivery and no complications with his birth.

POST-DELIVERY PERIOD:

How many days did the baby stay in the hospital after birth? 2

Check Yes / No for the items below which may have occurred during the days following the child's birth:

Yes	No		Yes	No	
☐	☒	Difficulty breathing	☐	☒	Infection
☐	☒	Need for ventilation	☒	☐	Jaundice
☐	☒	Blood transfusion	☐	☒	Poor feeding
☐	☒	Bleeding in head	☐	☒	Vomiting / Reflux
☐	☒	Water on the brain	☐	☒	Floppy muscle tone
☐	☒	Turned blue	☐	☒	Neonatal ICU (NICU)
☐	☒	Fever	☐	☐	Other

Please explain all "yes" answers: Matt's mother states that he was slightly jaundiced and was held for observation, but he was discharged a few days later with no concerns.

FAMILY HISTORY:

Marital status of parents:

☐ married ☒ never married ☐ separated ☐ divorced ☐ widowed

Who lives in the house with your child?

Name:	Age:	Male / Female	Relationship to child:
Matt currently lives in foster care....		☐ M ☐ F	
Lynda Martin	33	☐ M ☒ F	Biological Mother
Steve Frid	37	☒ M ☐ F	C.L partner
Lucy Martin	14	☐ M ☒ F	Sister
Dillon Martin	12	☒ M ☐ F	Brother
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

Please check all that apply for the last 12 months:

☒ family moved	☐ parent changed job	☐ parents separated or divorced
☒ conflict in family	☐ death in family	☒ family financial problems
☒ changed school	☐ new baby at home	☐ family accident or illness
☐ repeat a grade	☐ history of abuse	☐ other: _____

Please add any comments regarding the items noted above: Matt was recently brought into the Society's care (March 2009). Society records show that Matt's family has moved three times over the last year and a half. Matt has had to change schools twice during this time, and then changed schools again when he came into care. When Matt came into care the Society had concerns around domestic violence in the home. It has been reported by numerous community sources that Matt and his siblings witnessed significant violence between his mother and her boyfriend. Matt's mother also expressed concerns about finances and was actively using the food bank in the community, and on Government Assistance.

For CAS Referrals:

Reason Child Was Removed from parents home:

Concerns regarding supervision, exposure to domestic violence, and mother's ability to parent (possible mental health).

ADDITIONAL INFORMATION:

Please add any additional information you think is relevant or that you would like the doctor to know :

There have been on-going concerns about Matt while he has been in care. He is currently on probation and reports to his probation officer on a regular basis. We are especially concerned with Matt's running. Matt has been running from foster care on a fairly regular basis and while he is gone he participates in fairly high risk behaviour (from hitchhiking, drug use, at one point showing his genitals to a stranger for money). When he is in the group home, he does not follow the rules and has been physically aggressive with staff or residents. There were also reports from the group home that Matt was touching residents of the opposite sex in their private areas (breasts or buttocks). Some residents felt unsafe around Matt, and we have hired a one to one worker to help supervise Matt around other residents (and hopefully help stabilize him in the home). Attached please find all incident reports from the group home describing these incidents. If you would like further information please do not hesitate to call.

There are portions of the form that have been deleted; for instance a section on medication, developmental milestones, father's social history, and some information on educational needs.

Narrative:

I fill out these forms by looking at the family file, and affidavits filled out by the family worker. At one point I call Matt's mother and ask her questions about her pregnancy with Matt and his early development. I make sure to highlight the same information I felt important for the psychiatrist: about domestic violence, concerns about transiency, lack of supervision, mom's mental health, and gaps in education.

I gather as much information as I can about problems and concerns we have had while Matt has been in care. Specifically I want to include information where he has put himself and others at risk. This information is important because it shows his lack of care and concern for himself and those around him, signs I know are concerning if they continue over a period of time, particularly if they increase in frequency. If we see a pattern in Matt's behaviour it may be related to a specific traumatic incident from his past, or it could be related to his comments about wanting to hurt himself and his apathy towards life. To expand on these concerns I will include information in the package about his reactions to staff speaking to him about these problems (because he does not listen or care about punishment). As you can see above I also noted I would send relevant incident reports, which would include:

1. **Report by the group home worker about the bed slat situation**
2. **Report by the group home worker Inappropriate interactions with peers of the opposite sex**
3. **Serious Occurrence completed by myself about the incident where he showed his genitals to a stranger for money**
4. **Reports by foster parent, and group home worker about the notes found in his room about wanting to die on two occasions**
5. **My observations about the marks on his arms that were present when he came into care**
6. **Any report from foster homes/group homes about Matt running from foster care**
7. **Any report from the group home about drug use**

It is important to note his experimentation and use of multiple drugs. This information is imperative because some psychotic episodes are induced by drug use. I learned about this, from working with other youth on my caseload. I would also include any copies of his charges and conditions from his criminal charges.

There is not a lot of time spent talking about Matt's strengths. But there is a small section of the form that talks about Matt's likes and dislikes:

HOME LIFE:

What are your child's favourite activities? Matt likes to play video games, hang out with his friends, and ride his bike. Matt also loves to draw.

What are your child's <u>least</u> favourite activities? Matt does not like school.

How often must you discipline your child? Group home staff have to re-direct or discipline Matt multiple times in a day

What forms of discipline are used? Behaviour modification: i.e. rewards for good behaviour, and restrictions on things he likes if he does not follow the rules.

What have you found to be the most effective form of discipline? Matt responds very well to positive reinforcement and rewards for good behaviour (i.e. extra time watching TV, money, candy, extra time with friends)

Describe your child's typical mood: Generally Matt presents as quiet, and low. You rarely see Matt smile.

Narrative Continued... *Commentary:*

October 22, 2009
I forward all the completed forms to the psychologist and her office contacts the group home to set up the first of three meetings. Matt is not happy about these meetings and doesn't understand why they are necessary. I talk to him and try to explain that we are doing this because we are concerned about him and the fact that he doesn't feel the best about himself. I tell Matt we want him to feel good where he is living and have a chance to settle. Matt tells me that he just wants to go home and he doesn't need a counselor or anyone to tell him that.

I'm not present for the meetings between the psychologist and Matt. However the psychologist calls me a number of times to ask questions about Matt and clarify information. For instance she wants to know about prenatal history and if we have any information suggesting that mom used drugs or alcohol during her pregnancy.

Also, she wanted clarification of the information she received about Matt's time in foster care – for instance she wanted to know about the running – how long and where did the youth go? Can we confirm any information about drug use? I tell her I'll get back to her.

In checking the details of Matt's story the psychologist may be trying to see if he is exaggerating or lying about incidents or the timeline of events. This is a fairly common practice, in which the assessor wants to ensure they have accurate information. It is perhaps another way to assess behaviours or gain an understanding of the youth's view of events. The questions she asks about prenatal history and drugs/alcohol are probably related to potential concerns about Fetal Alcohol Syndrome. I learned about FAS in a two day training seminar early on in my child welfare career. The instructor taught us about how to obtain a proper diagnosis of FAS, and what types of information (i.e. prenatal history) are important in the diagnostic process. FAS is a common issue with youth in care. The symptoms of FAS are very similar to a number of other diagnoses our kids normally receive. Along with physical facial characteristics (i.e. shape and position of eyes, lips and nose) some of the behavioural symptoms are learning difficulties, constant need for redirection, short attention span, impulse control, nervousness, and anxiety. Even if the child displays these symptoms, very few doctors will diagnose FAS without confirmation from the parents, or people who directly observed the mother drinking while she was pregnant.

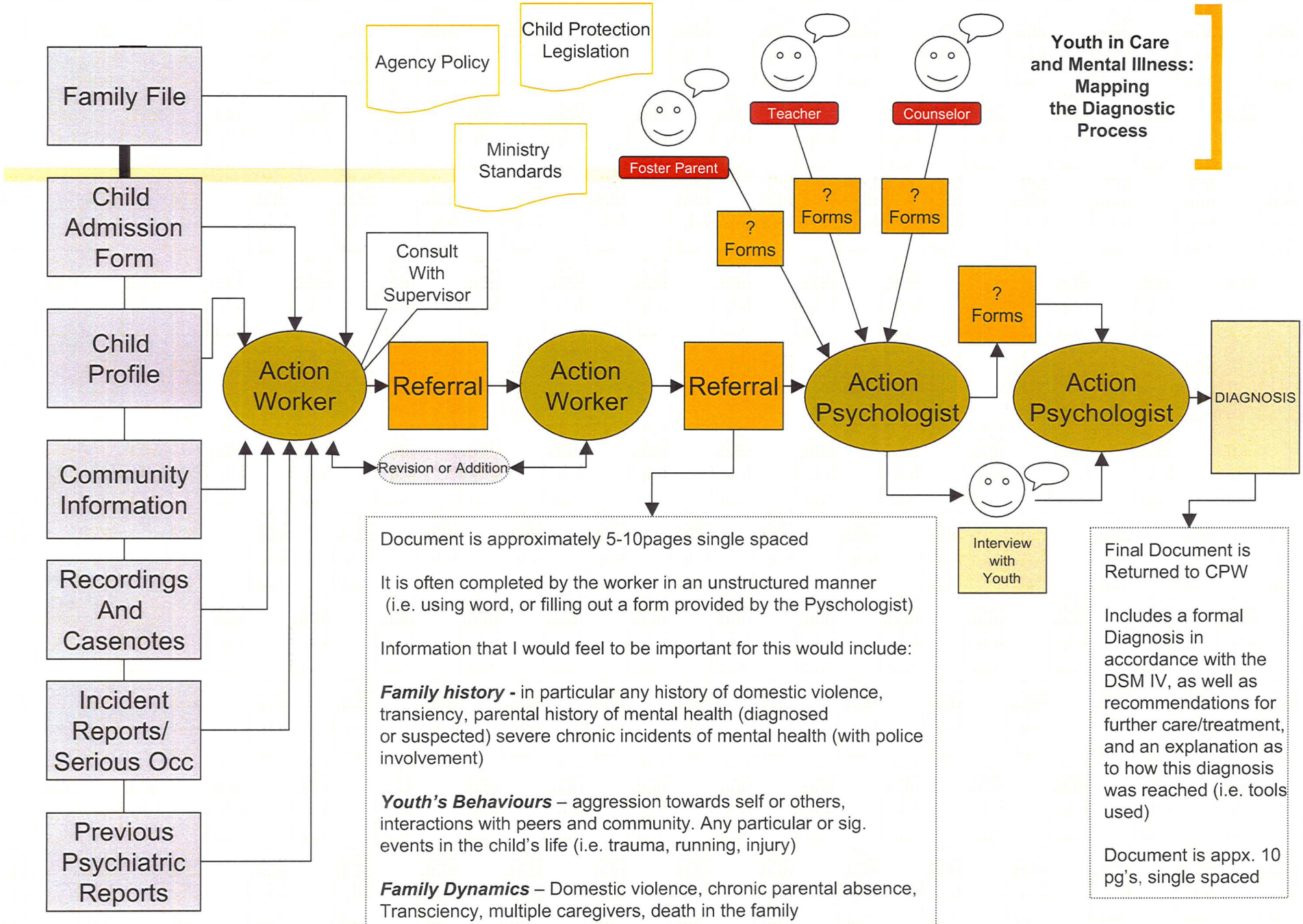
December 3, 2009 The Society receives a report from the psychologist. This report is approximately ten pages in length single spaced, and has sub headings with a narrative and results to each of the tests she conducted. At the end of these results she uses the DSMIV to list each of Matt's diagnoses on the appropriate axis. Matt is diagnosed with Reactive Attachment Disorder, Social Phobia, ADD, and anxiety. After this there is a section called "recommendations" and at this point the psychologist makes a number of treatment goals for Matt's placement as well as recommended extensive counseling . So for instance one goal for Matt is "an age and gender specific therapy to address sexually aggressive behavior and appropriate boundaries in peer relationships."

These results can be important for a youth in care. If there is a diagnosis with specific treatment goals, as a worker I can use this to access further services for the youth. It would be the responsibility of the Society to follow through with these treatment goals and ensure the youth is receiving these services in a timely manner. Yet, it is uncommon to review the results with the youth, and I don't recall reviewing the final assessment with Matt.

Map of the diagnostic process (with focus on the role of the CSW)

Below is a visual representation of the diagnostic process as I describe it in the preceding section, from October 13th, 2009 when the supervisory committee approves the funding for the referral to the psychologist.

To review briefly: the Children Service worker draws together a number of files and forms to create a referral to a psychologist these are all noted on the left hand side of the map. These documents are used to piece together the information required for the psychologist's referral document. This document once completed is reviewed and approved by my supervisor before I return it to the psychologist and if there are any revisions I complete them as necessary. This information is forwarded to the psychologist along with information completed by the school, foster parent, and potentially a counsellor (if the youth is involved with one).


Youth in Care and Mental Illness: Mapping the Diagnostic Process
Family File
Child Admission Form
Child Profile
Community Information
Recordings And Casenotes
Incident Reports/ Serious Occ
Previous Psychiatric Reports
Agency Policy
Child Protection Legislation
Ministry Standards
Consult With Supervisor
Foster Parent
Teacher
Counselor
? Forms
? Forms
? Forms
? Forms
Action Worker
Referral
Action Worker
Referral
Action Psychologist
Action Psychologist
DIAGNOSIS
Revision or Addition
Interview with Youth
Document is approximately 5-10pages single spaced
It is often completed by the worker in an unstructured manner (i.e. using word, or filling out a form provided by the Pyschologist)
Information that I would feel to be important for this would include:
Family history - in particular any history of domestic violence, transiency, parental history of mental health (diagnosed or suspected) severe chronic incidents of mental health (with police involvement)
Youth's Behaviours – aggression towards self or others, interactions with peers and community. Any particular or sig. events in the child's life (i.e. trauma, running, injury)
Family Dynamics – Domestic violence, chronic parental absence, Transciency, multiple caregivers, death in the family
Final Document is Returned to CPW
Includes a formal Diagnosis in accordance with the DSM IV, as well as recommendations for further care/treatment, and an explanation as to how this diagnosis was reached (i.e. tools used)
Document is appx. 10 pg's, single spaced

Discussion and Conclusion:

This research set out to investigate youth in care and mental illness. What I've done is map the diagnostic process using institutional ethnography to explore the text-action interplay in the child welfare system. The findings have provided us with a detailed examination of the diagnostic process especially as the Children's Service Worker is involved in this process.

Some of the key ideas surrounding the diagnostic process are: liability, accountability, voice, and worker knowledge.

Accountability and Liability:

It was a fairly common theme that activities and aspects of the worker's job were completed to satisfy the requirements of the system, rather than the needs of the youth; for example, when I pick Matt up from the group home to take him to the psychiatrist (pg.25). My commentary about this interaction outlines my frustration with the system

> *"I feel at times we only make it tougher for them. For instance, I know that it is very unlikely that Matt will talk to the psychiatrist today. I also know that it is unlikely that he will obtain any sort of consistent service from this referral"(pg.41).*

If I had arrived at the group home felt Matt was not going to engage with the psychiatrist I could have cancelled the appointment right then and there. But this is where accountability and liability are intertwined. As a worker I need to show

that I have followed the psychiatrist's recommendations to follow up with the child psychiatrist to assess Matt's mental health. In the event that something were to happen with Matt, for instance he hurt someone or hurt himself, and had not attended a recommended appointment, this could have consequences for the Society – it might be taken as evidence in perhaps a file review/audit that the Society was not caring for Matt appropriately. It could also result in disciplinary action for me personally as a worker. It would potentially show that I was negligent in my duties to manage the care of this child, which would likely result in a review of all of my files, relief of my duties, and I could potentially be fired.

An example of an internal processing occasion can show us the increased demands and accountability for Child Welfare around finances.

On page forty seven I describe the process of gaining financial approval for the psychological assessment; "*The psychologist will fax [the referral] to me and then I will present this information along side the concerns leading to our request for a psychological assessment to a supervisory committee at the agency. This committee makes all major decisions around money used at the agency.*" Children's Aid Society's have been under increased scrutiny for their management of funds. What has happened because of this is an increase in all administrative paperwork and practices around finances. Although, this type of accountability to the community is important, it is time consuming. It would take at least one morning away from my regular work to complete the paperwork required, and attend the meeting to present this information. Imagine a worker

who has at least three or four youth on their case load who are similar to Matt. The workload is unmanageable; and because of that youth who aren't as troubled as Matt don't see their workers as often.

I would also like to draw your attention to the simple task of case noting. Throughout all of my interactions with Matt and the child welfare system there is case noting. Whether this be through my own notes, or the notes of other workers who have contact with me about Matt, or even my supervisor who completes a "supervision note" every time we speak. We (as workers) document these interactions to remember what we've done, to show that we are doing our job, and that we have done all that we can to help. These notes also carry a lot of responsibility. They are reviewed by supervisors, auditors, even the ministry representatives on occasion. I feel like there is an underlying suspicion that workers aren't doing their job correctly. Albeit, I believe it is more than fair to say the Society has made mistakes in the past and at the same time the Society has a great deal of power and a level of accountability is important. I wonder how this level of scrutiny affects worker confidence in their ability to assess and manage the situation. If workers are more concerned and consumed with completing paperwork what type of service are they providing to clients?

Worker Knowledge

An interesting observation is the fact that the actual diagnostic process is guided by the worker's assessment and knowledge; whereas, most other aspects of

child welfare practice are very prescriptive, and guided by child protection legislation and child welfare recording (i.e. e-forms).

As the worker I gathered what I felt was important, mentionable and necessary for the psychologist to make her assessment. As we reflect on the actual process we can see that I place importance on certain aspects of Matt's life (i.e. mother's mental health, transiency, aggression in the group home, sexual behaviours). In my commentary on the case, the knowledge I draw on as a worker becomes apparent. I know, for instance, that:

1. Having mental illness in your family leaves you with a greater risk of contracting it as well.
2. Witnessing domestic violence may be traumatic and may lead to experiencing post traumatic stress disorder, depression, or anxiety.
3. Frequent moves and changes in caregivers may contribute to something like an attachment disorder.

Where does this knowledge come from? There are courses, and classes workers take as they complete their orientation, to help further their development as a worker. Some of these classes outline the "high risk" and concerning behaviours workers should be aware of, or able to identify.

I think it could easily be argued that workers assess clients using psychiatric criteria. I have knowledge of the DSMIV and although I understand I could never provide a client with a mental health diagnosis, over time I believe I have learned to realize what types of issues are concerning and may need further assessment.

There are a number of instances throughout the narrative where you can see how the concerns of medicine/psychiatry have entered into my own mind and way of seeing. For instance something simple like the phone call from the psychologist. She was calling to clarify information about Matt's history. As you can see in my commentary I'm aware that her questions about Matt's prenatal history have to do with her thinking about or assessing the possibility of FAS: *"The questions she asks about prenatal history and drugs/alcohol are probably related to potential concerns about Fetal Alcohol Syndrome."* (pg.32). There is also what I consider "mentionable" about Matt's mother. It seems fairly obvious when you reflect on Matt's story that any mother with a difficult teenager, who has been in an abusive relationship, would experience a period of depression. For me, however this becomes an important point to relay as it shows a history of mental illness in Matt's family, a genetic explanation. Although I personally may understand that Matt's mother has a number of very challenging issues in her life that of course would affect her emotionally. My first reaction is to identify her depression as a genetic link for Matt rather than organizing it as situational. It would appear that there is an interplay of discourses, where as workers we describe and categorize things in a similar manner to mental health experts. This shows us that worker knowledge is not merely knowledge, but a certain kind of knowledge.

Youth's Voice

As I completed this research I was reminded how much power I have as a worker in the life of a youth in care. Children's Service Workers are often the advocate and voice for the youth you work for in the system. Yet at the same time we represent the System and all of its interests (i.e. financial, with responsibility and accountability to larger governing bodies). Text plays a large role in how the case is managed and how youth moves through the system. In fact I'm sure as you read excerpts of Matt's story he was lost in the paperwork and procedures of this job. You can imagine how hard it would be to see who Matt is and understand who he is as a person through all the mandated paperwork that is presented in a case file. This text is created by Society workers, other professionals and other systems representatives.

As is quite visible in the diagram of the diagnostic process, young people in care have no contact with this paper work. The diagram on page fifty five shows us the youth does not enter the diagnostic process until the interview with the psychologist/psychiatrist. The youth does not see the forms sent by the psychologist to the worker, or review or respond to the workers information sent back to the psychologist. Even as you review the narrative the youth has little information about the process, having little say in who they spoke with, and why they were speaking with them. The literature tells us that youth's involvement in their plan of care and treatment is imperative (Lambe, 2006). "Youth in and from care must participate in the design of their record" (NYICN, 2006).

There are also a few points to be made about service delivery. In a system that has such significant impact on youth's lives (be that positive or negative) we need to take great care in how we document each child's life – understanding how it can affect their subsequent care. There has been more emphasis placed on describing and elaborating on who the youth is as a person in our case notes and recordings (NYICN, 2006). However, this requires more attention then elaborating on the youth's personality. There needs to be an understanding that youth are "co-actors" not sources of data in this system (Pence, 2001).

Lastly, we are missing what happens when the youth enters into the psychiatrist/ psychologist's office. Through my research it appears a great deal of information comes from the system rather than the youth. I can imagine as a professional it would be difficult to ignore reports from other "experts" in the helping profession about a client. More research needs to be completed to explore this aspect of the process.

Recommendations for Research and Service

This study has outlined how information is gathered and presented to psychologists/psychiatrists when they are providing a mental health assessment for youth in care. We have followed the process of a youth in care through the child welfare system, however more research is required to examine what happens at the next stage of this process: in the psychiatrist/psychologist's office. What do they do with the information that is gathered by child welfare professionals? What do they see as important? What are their "red flags", "code words" or "mentionables"?

This study could also benefit from the voices of youth and other workers. Having others map their experience with the system to challenge or corroborate my telling of this story would provide great depth to this study.

What seems quite apparent through this research, is the need for youth to play a role in the text - that defines who they are - within the child welfare system. Perhaps, there is a need to explore co-authoring case notes or finding other creative way for youth to engage in their permanent record. Maybe youth could review their files along side the ministry auditors, to provide feedback, in their own words about their experience in care. It may also be beneficial to implement a process in which youth are notified when the Society is seeking to obtain a mental health assessment. Full disclosure is imperative to help build trust, and

accountability between youth and the system. This process should include the youth's ability to review not only the referral document (completed by the children's service worker) but the assessment (completed by the psychologist). The youth should have the ability to respond to either of these documents in a way that is accessible to their age and ability. It is my understanding that there are some forms used by psychologists that require self-reporting (usually for youth over the age of 11 or 12). Though I don't have a great understanding of this specific tool, utilizing these types of approaches could greatly impact the process.

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