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INTERDEPARTMENTAL PROTOCOL AGREEMENT

FOR

CHILDREN/ADOLESCENTS

WITH

SEVERE TO PROFOUND EMOTIONAL/BEHAVIOURAL DISORDERS

June 8, 1995

A partnership of:
Manitoba Healthy Living · Manitoba Aboriginal and Northern Affairs · Manitoba Culture, Heritage and Tourism · Manitoba Education, Citizenship and Youth · Manitoba Family Services and Housing · Manitoba Health · Manitoba Justice · Manitoba Labour and Immigration / Status of Women

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information package

Interdepartmental Protocol Agreement

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Manitoba Education and Training
Manitoba Family Services
Manitoba Health
Manitoba Justice

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INTERDEPARTMENTAL PROTOCOL AGREEMENT FOR CHILDREN/ADOLESCENTS WITH SEVERE TO PROFOUND EMOTIONAL/ BEHAVIORAL DISORDERS

1.0 Development of the Protocol

The Interdepartmental Protocol Agreement between the Ministers of Education and Training, Family Services, Health and Justice for the coordination of services for children/adolescents with severe to profound emotional/behavioral disorders was released March, 1995 (Appendix A). This protocol mandates a shared interdepartmental/ multisystem case management approach to delivering services to such high risk children/adolescents and their caregivers. This approach is also designed to ensure available resources in context of fiscal realities are utilized in an effective and highly focussed manner.

The protocol was developed collaboratively by the Child and Family Support, Child and Adolescent Mental Health Services, Community and Youth Correctional Services and Student Services branches of the respective government Departments. Between the period of September 1990 to September 1993, an interdepartmental pilot project was established to evaluate the effectiveness of providing coordinated multisystem services for children ages 5-11 with profound emotional behavioral disorders. (Appendix B). Cases served

during the Pilot Project trial period, as well as cases randomly selected by the four Departments from ongoing caseloads were reviewed to identify those factors which facilitate as well as impede positive service outcomes. Cases which used a multisystem approach to implement an integrated intervention plan based on a comprehensive needs assessment were more likely to have positive service outcomes. In these cases there was a common understanding and commitment by all agencies/departments involved on the needs of the child and family. Those needs were seen in the context of the whole child. There was a case management process that identified the lead agency/department; who was responsible for each of the service components, an ongoing monitoring/evaluation process, and knowledge and flexibility by personnel involved in working within a multisystems approach. In these cases a member of the interagency team was designated as case manager to facilitate team meetings and to ensure that intervention plans were coordinated and maintained their effectiveness. A more comprehensive list of factors which affect service outcomes is attached in Appendix C.

The Interdepartmental Coordination of Services Committee prepared a draft protocol to incorporate the findings of the case reviews. The protocol was presented to an interagency focus group with representation from direct service personnel from the child welfare, youth corrections, education and mental health systems. Their recommendations were incorporated and a final draft of the protocol was forwarded to the Children and Youth Secretariat, presented to the Human Services Committee of Cabinet and subsequently released for implementation.

2.0 Target Population

The Interdepartmental protocol applies to children/adolescents with emotional/behavioral disorders who present the following profile:

- the child/adolescent is a danger to self and/or to others and his/her actions are marked by impulsive, aggressive and violent behavior
- the behavior is chronic - the disorder is persistent over a lengthy period of time
- the behavior is pervasive and consistent - the disorder negatively affects all the child's/adolescent's living environments including home, school and community
- the child/adolescent requires or is already receiving a combination of statutory and non-statutory services from the Child and Family, Education, Mental Health and/or Justice systems as defined within the Child and Family Service Act, Young Offenders Act and the Mental Health Act.

Children/adolescents who have developed emotional/behavioral disorders at levels of severity consistent with the criteria outlined in the profile, are a relatively small but highly visible group. The "Health of Manitoba's Children" (Postl, 1995) reports rates of 18 - 30% for children with mental health problems requiring intervention, and 3% with severe psychiatric disorders. Offord (1988) found similar prevalence rates of 18.1% for emotionally disturbed children (aged 4 to 16 years) in Ontario. Children/Adolescents may develop such severe disorders in response to a combination of interrelated and traumatizing stressors such as high risk social, genetic, and environmental factors including neurological/neurochemical deficits, mental disorders and overwhelming life events generally associated with extreme family dysfunction, alcoholism, substance abuse, family violence and persistent emotional, physical and/or sexual abuse.

Children/adolescents who for a variety of reasons have learned that their world is a hostile; dangerous and uncaring place develop coping styles to meet their safety and survival needs. It is through their life experience they learn to perceive the world as safe or unsafe, to develop or avoid social relationships and to trust or mistrust significant others in their lives. The fundamental problem for children/adolescents who have experienced persistently non-nurturing and traumatizing relationships in their family and social systems, is that they typically generalize from their experiences and treat others in a manner to which they themselves have become accustomed. Carl Hammerschlag (1994) observes:

> "By early childhood we've learned something about the people who are important to us and whether or not we can depend on them. We learn to behave in ways that our parents and teachers want us to because we are afraid that if we don't, they will withdraw their love. Children conform their behavior to parental expectations because of the threat of the withdrawal of love. On the other hand, if children don't believe anybody really loves them, then it becomes very difficult to get them to conform their behavior to anybody's expectations, because you can't take away something from them that they already believe they don't have and can't get".

It is in this context that children/adolescents with profound emotional/behavioral disorders are "victims" in that they are affected by a combination of traumatic social, environ-mental, as well as genetic factors. Often, as a result of their experiences, they also become "offenders" because their self-destructive and aggressive coping styles indiscriminately affect their social relationships in all their living/learning environments, home, school, and community. That in essence is also a fundamental reason why one dimensional approaches to the treatment of children/youth with severe to profound emotional/behavioral disorders tend to be limited in effectiveness.

3.0 Rationale for establishing a System of Care

There is widespread professional agreement that many children and youth with severe to profound emotional/behavioral disorders as well as their families and/or substitute caregivers require multiple services involving several agencies as well as the education system. Typically such children/adolescents do receive a combination of child welfare, special education, mental health or juvenile corrections services. A critical weakness in the delivery of such services is that they are often fragmented as each service system focusses on a particular aspect of the child's/youth's problems. In fact, such services sometimes work in contradiction to each other.

Nelson and Pearson (1991) report that historically the preponderance of approaches to the treatment of children/youth with emotional/behavioral disorders are based on a micro-level perspective...."in that the child is seen as the source of the problem, and interventions are directed toward correcting problems inherent in the child". However, one dimensional approaches tend to have limited success in ameliorating significant adjustment problems; particularly for younger children who can have only limited influence on changing their life circumstances. On the other hand, an ecological model assesses service needs in context of a child's/youth's family and other social systems in order to develop a more comprehensive intervention plan. Such plans involve caregivers (parents, foster parents, group home and residential treatment staff), educators (teachers, teaching assistants, special education personnel) and clinical personnel in providing consistent intervention plans for managing self-destructive and aggressive behavior as well as

meeting nurturance needs. The following case example illustrates an ecological approach:

> A 14 year old female, expelled from her school program because of her oppositional behavior and aggressive acting out, received anger management training. Because she was not responding to this intervention in any demonstrable way, a multiagency conference was convened to discuss her situation. When a multisystem team shared information and reviewed the case, the team learned that this girl's mother not only became sexually involved with her daughter's boy friends, but herself was an exceedingly volatile and punitive care giver. All the efforts at teaching anger management consequently were of extremely limited value because she naturally felt fully justified in her anger about her relationship with her mother, who also presented like her daughter's adolescent friend. The intervention plan consequently was changed to address not only her current living situation but also to provide counselling support and special programming in her school environment. Anger management training subsequently became one of several components in a more comprehensive and coordinated context.

The concept of developing a "system of care" on a case by case basis involving a multi-system team including caregivers in developing child centered intervention plans has been under consideration by professionals for many years. Stroul and Friedman (1994) review many initiatives which provide such focused and coordinated service. In Brandon, Manitoba, the Multi Agency Preventative Programming for high risk youth project is also an example of collaborative interagency planning. The protocol is intended to assist professionals in child welfare, education, mental health and youth correction services in developing such coordinated systems of care.

4.0 Principles of a System of Care

Stroul and Friedman (1994) define a system of care as..."a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents". This definition is consistent with the objectives of the Interdepartmental Protocol Agreement which promotes collaborative planning for such children/adolescents by developing comprehensive intervention plans which address both the behavioral concerns and developmental needs of such children/ adolescents. This requires the involvement of the education and social service systems to ensure that appropriate structure is provided to deal with behavioral concerns in a consistent manner in all the child's/adolescent's living/learning environments and that developmental needs are addressed.

At an interagency systems level, a system of care approach could lead to developing formal interagency mechanisms through which multisystem planning is supported. On a case by case basis it means delivering services which are complementary in supporting a comprehensive intervention plan based on common treatment goals. This approach necessitates that both assessment information and resultant intervention plans are integrated. Nelson and Pearson (1991) conclude that unlike a "continuum of services" perspective which delivers services which are progressively more specialized and restrictive, a system of care..."focuses on broadening and strengthening the community base as the essential arena for treatment and rehabilitation. Stroul and Friedman (1994) identify three core values and ten principles on which effective systems of care are based. These are reported in Table I, page 8.

5.0 Implementing the Multisystem Case Management Approach

"The Protocol formalizes a shared interdepartmental/multisystem case management approach to enhance good practice and to maximize the effective use of available resources to address the service needs..." of children/adolescents with very severe to profound emotional/behavioral disorders. (Protocol, p. 1). It outlines a sequential process for the implementation of an integrated "system of care" which provides timely and goal oriented intervention/treatment programming on a case by case basis for this high risk population.

The multisystem process is initiated at the local level between Child and Family, Mental Health, Community and Youth Corrections and school division personnel for those children/adolescents described in the profile, Section 2.0, Target Population. Since these children/adolescent already have involvement with multiple service providers, the first step for the service system which identifies the need for a multisystem approach is to convene a meeting of all caregivers directly involved with the child/adolescent. This may include agency personnel, education personnel, consultants and clinicians, parents/guardians, alternative care givers (foster parents, group home and day care personnel) and the child/adolescent where appropriate.

The purpose of the initial meeting is to share pertinent case information including identifying data on the child/adolescent and family, a description of the presenting

problems in the child's/adolescent's home, school and community environments and the rationale for initiating a multisystem process. With regard to such information sharing, issues of confidentiality may arise. This is discussed on page 4 of the protocol. Service providers must balance the need to respect the child's and family's privacy with the need to share information for purposes of developing an appropriate intervention plan. In general terms, however, decisions about information sharing must be based on the best interests of the child particularly in those high risk cases where the greater harm would be not to provide necessary services in a collaborative and integrated manner.

The initial multisystem service meeting is the beginning phase in the needs assessment and intervention planning process. The multisystem team needs to identify a casemanager(s) to ensure that a coordinated case plan is developed and implemented, future meetings are organized, contact is maintained between service systems and care services involved and a process is established to monitor progress. It does not automatically follow that the service system which initiates the multisystem process assumes case management responsibility. It is the multisystem team which needs to identify which service system is most appropriate to take the lead.

During the assessment phase the focus is on sharing information required to develop an appreciation for the child's/adolescent's emotional/behavioral history. In some cases assessment information shared by the multisystem team may already be comprehensive enough to form the basis for developing a multisystem intervention plan. In other cases

however, additional assessment data, for example from a psychiatrist, psychologist or neurologist, may be required.

The next phase in the multisystem process is to develop and implement an intervention plan based on assessment information, with strategies to address behavioral concerns and developmental needs in the child's/adolescent's living/learning environments. This requires that direct care givers (parents, foster parents, group home personnel, teachers, teacher assistants and day care personnel) receive professional support and consultation to implement the "system of care" developed by the multisystem team. This also requires that the multisystem team ensure all the resources which may be utilized in a specific case (eg. respite care workers, teaching assistants which provide 1 on 1 support in school, or play therapist) deal with the child/adolescent in a manner consistent with treatment objectives developed. To illustrate with a case example from the Interdepartmental Pilot Project:

> A 5 year old girl with a history of sexual abuse involving multiple offenders became violent when both peers and adults came within physical proximity. She was a permanent ward, and had several placements before her placement in a special rate foster home. The school was not aware of her history and was having significant problems managing her behavior. The Child and Family Service worker was contacted and a meeting was arranged involving all her caregivers, the resource teacher, classroom teacher, psychologist, private therapist, Child and Family Service worker and foster parent. Information about her background was shared and her explosive behavior, particularly when it involved close contact with others was understood in

terms of her fear and anxiety about such interactions as well as her need to feel safe in her environment. The multisystem team developed strategies which initially minimized her involvement in social situations and allowed her to gradually develop relationships with a teaching assistant, play therapist and foster mother. The Child and Family Service worker, psychologist, play therapist and resource teacher consulted with the direct care givers to support them in implementing strategies to manage the self-destructive and violent behavior. The play therapist provided opportunities for behavioral rehearsal and she was gradually introduced to increasingly more complex social situations. After about 18 months, she was able to tolerate a classroom environment and her explosive behavior gradually declined.

The intervention plan developed by the multisystem team had a positive impact on modifying the girl's the behavior, first, because the girl's safety needs were respected and second, because the case management process facilitated a consistent and integrated approach at school and in the foster home which was supported by therapists involved. This was a vast improvement over each system struggling independently with widely varying approaches to managing the girl's behavior. Moreover, resources were utilized in a consistent manner to achieve defined objectives and the foster mother and paraprofessional personnel involved felt supported by being part of an intervention plan in which the various components complemented each other.

The multisystem approach developed in Manitoba has the advantage of coordinating and integrating services to children and families in those cases where multiple service

providers are or need to be involved. It promotes collaborative planning, continuity of care and facilitates a more effective and efficient use of limited resources.

6.0 Provincial Coordination of Services Committee

The Provincial Coordination of Services Committee involving the directors of the Child and Family Support, Community and Youth Corrections, Child and Adolescent Mental Health, and Student Services branches is mandated to facilitate the implementation of the Interdepartmental Protocol agreement.

The Committee is prepared to collaborate with relevant education and social service personnel in planning regionalized training opportunities to support the implementation of the protocol. Consultant support will be provided from within the Departments of Education and Training, Family Services, Health and Justice in those exceptional cases where service providers at the local level are experiencing significant difficulties in developing appropriate intervention plans.

The Committee may be reached by contacting the Secretary, Provincial Coordination of Services Committee, Room 206, 1181 Portage Avenue, Winnipeg MB R3G 0T3.

References:

1. Child and Youth Secretariat, A Handbook for Integrated Case Management, 1993. Government, British Columbia.

2. Nelson, Michael C. and Pearson Cherryll A., 1991. Integrating Services for Children and Youth with emotional and behavioral disorders. Council for Exceptional Children; 1920 Association Drive, Reston, Virginia.

3. Offord, D., 1988. Ontario Child Health Study: Children at Risk, Ministry of Community and Social Services, Ontario.

4. Postl, B., 1995. The Health of Manitoba's Children. Report of the Child Health Strategy Committee, Manitoba Health.

5. Stroul, Beth A. and Friedman, Robert M. (1986). A system of care for children & youth with severe emotional disturbances. (Revised Edition) Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

APPENDIX A

INTERDEPARTMENTAL PROTOCOL AGREEMENT BETWEEN THE MINISTERS OF EDUCATION AND TRAINING, FAMILY SERVICES, HEALTH AND JUSTICE FOR THE COORDINATION OF SERVICES FOR CHILDREN/ADOLESCENTS WITH SEVERE TO PROFOUND EMOTIONAL/BEHAVIORAL DISORDERS

The Ministers of Education and Training, Family Services, Health and Justice have mandated the interdepartmental service protocol for increased service coordination at the local level for children/adolescents with very severe to profound emotional/ behavioral disorders. Each of the departments has specific responsibilities for facilitating the delivery of a continuum of services in context of specific mandates. This protocol formalizes a shared interdepartmental/multisystem case management approach to enhance good practice and to maximize the effective use of available resources to address the service needs for this high risk population.

A. PROFILE OF CHILDREN/ADOLESCENTS WITH SEVERE TO PROFOUND EMOTIONAL/BEHAVIORAL DISORDERS

This protocol applies to children/adolescents with the following profile:

- the child/adolescent is a danger to self and/or to others and his/her actions are marked by impulsive, aggressive and violent behavior.
- the behavior is chronic - the disorder is persistent over a lengthy period of time.
- the behavior is pervasive and consistent - the disorder negatively affects all the child's/adolescent's living environments including home, school and community.
- the child/adolescent requires or is already receiving a combination of statutory and non-statutory services from the Child and Family, Education, Mental Health and/or Justice systems as defined within the Child and Family Service Act, Young Offenders Act and the Mental Health Act.

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B. MULTISYSTEM APPROACH TO CASE MANAGEMENT

Children/adolescents with severe to profound emotional and behavioral problems almost always require services from more than one service system. The factors which precipitate and maintain the emotional/ behavioral disorder are often highly complex. The fact that each of the problems manifested may be addressed by different service systems with specific mandates, sometimes working in contradiction to each other, causes confusion for the child/adolescent, the parents/guardians as well as collateral agencies themselves. In this context, it is difficult to provide timely, goal oriented intervention/treatment programming. There is a need therefore, for increased cooperative planning and intervention at multisystem service levels. The purpose of this protocol is to promote a formal case management approach.

The following process is designed to facilitate service coordination on a case by case basis at the local level through a multisystem intervention planning and implementation process. It is essential that interdepartmental and multisystem information sharing occurs at all levels to develop appropriate intervention plans.

1. Initiating the multisystem process

- All children/adolescents referred to in this process must demonstrate service needs consistent with the profile of emotional/behavioral disorder (Section A).

- The multisystem process is initiated at the local level between the Departments of Education and Training, Family Services, Health, Justice, Child and Family Service agency and/or the school division/district.

- Initial case information sharing includes basic identifying data on the child/adolescent and family, a description of the presenting problems and reasons for initiating the multisystem process.

- The school division/district or local agency representative initiating the process takes the lead in convening the initial multisystem planning meeting.

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2. Initial multisystem meeting

The service system representative initiating a referral assumes responsibility for the following:

- inviting all care givers directly involved with the child/adolescent. This may include agency personnel, education personnel, consultants and clinicians, parents/ guardians, alternative care givers (foster parents, group home and day care personnel) and the child/adolescent where appropriate.

- chairing the meeting and ensuring that meeting participants share relevant information.

- ensuring minutes are taken and distributed.

- ensuring a case manager is identified.

3. Ongoing case management process

The case manager is responsible for coordinating intervention planning and implementation. All parties involved in this multi-service process must consult with the multisystem team before making significant changes to the intervention plan.

The case manager facilitates the following:

- sharing information required to develop an appreciation for the child's/adolescent's adjustment in developmental terms in order to identify service needs, appropriate treatment strategies and the comprehensive individual intervention plan. In so doing, the case manager shall take reasonable steps to ensure that any legal restrictions to the sharing of information are honoured, and that, wherever reasonably possible, the consent of the child's custodial parent or legal guardian (or where appropriate, the consent of the child himself or herself) to a proposed sharing of sensitive personal information is obtained.

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- identifying service system personnel to implement the individual intervention plan in a consistent manner in each of the child's/adolescent's living environments.

- evaluating and monitoring of the individual intervention plan within defined timelines to ensure program effectiveness.

- consulting with the multisystem team to ensure that direct care givers (parents, foster parents and group home personnel, teachers, teacher assistants and day care personnel) receive professional support and consultation to implement intervention strategies.

C. ACCESSING SPECIAL FUNDING SUPPORT AND RESOURCES

When the multisystem team identifies the need for special funding and/or programming support (e.g., low-incidence support from the Department of Education and Training, inclusion in an intensive probation supervision program, special rate foster home care or intensive community mental health services), the designated team representative can apply to the appropriate department according to established procedures.

D. PROVINCIAL COORDINATION OF SERVICES COMMITTEE

A Provincial Coordination of Services Committee, with representation from the Departments of Education and Training, Family Services, Health and Justice, is mandated to support a multisystem case management approach to the provision of services for children/adolescents with severe emotional/behavioral disorders.

Submissions to the Provincial Coordination of Services Committee may be made by contacting committee representatives at the provincial offices of the Student Services, Child and Adolescent Mental Health, Child and Family Support, Community and Youth Corrections Branches of respective departments.

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The Committee offers the following support to the multisystem case management process:

1. Leadership in planning regionalized training opportunities, to familiarize relevant education and service system personnel and direct caregivers with developing a comprehensive interagency case management approach to planning and delivering coordinated services for children/adolescents with emotional behavioral disorders.

2. Mediation of the case management process when service partners are not able to resolve issues involving their administrative structures.

3. Identification of appropriate consultant support on request from within the Departments of Education and Training, Family Services, Health and Justice in those exceptional cases where local service providers are experiencing service planning difficulties.

The Committee may be reached by contacting the Secretary, Provincial Coordination of Services Committee, Room 206, 1181 Portage Avenue, Winnipeg MB R3G 0T3, telephone 945-7908.

REFERRAL PROCESS TO THE INTERDEPARTMENTAL CRISIS RESOURCE COMMITTEE FOR CHILDREN BETWEEN AGES 5-11 WITH THE MOST EXTREME BEHAVIORAL ADJUSTMENT DISORDERS

The Interdepartmental Crisis Resource Committee, with representation from the Child Care and Development, Child and Family Support and Child and Adolescent Mental Health Services Branches, will accept priorized referrals, effective September 1, 1990, of selected cases where efforts at the local level to provide comprehensive community-based 24-hour education/treatment programming for children, ages 5-11, with extreme behavioral adjustment problems have been exhausted.

Personnel from local school divisions, Child and Family Service agencies and regional mental health services presently collaborate to develop community-based educa-tion/treatment programming for children with severe behavior adjustment disorders. However, there are some cases where, because of the severity of the behavior, the complexities of the case and/or local factors, such collaborative planing at the local level reaches an impasse and coordinated multidisciplinary programming is not delivered. In such selected cases, the involvement of the Interdepartmental Crisis Resource Committee can assist and support the local school, child caring agency, and mental health personnel in fulfilling their direct service responsibilities.

Referrals to the Interdepartmental committee will be submitted jointly by the Special Education Coordinator of a school division/district and Executive Director of a Child and Family Service agency in those select cases where an impasse at the local level in the education/treatment delivery process occurs. It is expected that the child is either receiving or has been referred for Mental Health Services.

(1) The Interdepartmental Crisis Resource Committee, with representatives from the Department of Education and Training, Family Services, and Health, will accept priorized referrals, effective September 1, 1990.

(2) The immediate target population to be served in the Metro Winnipeg area[1] by the Interdepartmental Crisis Resource Committee is limited at any one time to up to ten children in crisis, ages 5 - 11, who exhibit the most severe acting out and violent behaviors which endanger themselves and/or others. These children are priorized by a Metro School Division and Family Service Agency as urgently requiring a comprehensive, 24-hour community based education/treatment program, including a mental health service component.

(3) In those instances where the school division, (with involvement of school clinicians) and the Child and Family Service Agency are not successful in developing a 24 hour community-based education/treatment plan at the local level, a joint case specific submission signed by the Special Education
Coordinator and Executive Director of the Child and Family Service Agency may be submitted in writing to A. Gazan, Interdepartmental Crisis Resource Committee, 206-1181 Portage Avenue, Winnipeg, Manitoba, R3G 0T3.

(4) The submission will be conferenced by a representative of the Interdepartmental Crisis Resource Committee at a network meeting with the school division, (including the school clinicans), and Child and Family Service personnel and the child's direct caregivers (parents/guardians) in order to prepare the individual education/treatment plan to be implemented.

(5) Each education/treatment plan will be reviewed by the Inter-departmental Crisis Resource Committee which may provide access to those resources from the Departments of Education and Training, Family Services and Health identified as essential for providing a 24-hour education/treatment program.

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[1]In rural/northern areas, the regional coordinator of the Child Care and Development Branch is available to assist divisions/districts in facilitating case specific interdepartmental/interagency education/treatment plans at the local level.

The effectiveness of the individual education/treatment plan will be evaluated periodically in accordance with case specific outcome criteria to be determined in the planning process.

Ron Fenwick, Child and Family Services, Department of Family Services
Dr. Ken Webster, Mental Health Division, Manitoba Health
N. Cenerini, Child Care and Development, Department of Education and Training

August 24, 1990

FACTORS IMPEDING POSITIVE SERVICE OUTCOME

In reviewing the case examples provided by the four departments, there were several common factors identified in cases that did not work.

1. **There was a lack of clarity regarding who calls the system together and takes the case management direction.**

2. **Systems tended to be activated by a crisis, but did not do sufficient long term planning. The symptoms were addressed but not the cause.**

3. **Families and agencies alike made contact with many programs before finding the most appropriate program for the needs of the child/adolescent and family.**

4. **The system responded to the "label" of the child/adolescent, not to the whole child/adolescent.**

5. **Mandates and their interpretation limited working in partnership with the result that each agency had only a partial picture of the child/ adolescent.**

6. **The cases were very complex with multiple problems and multiple helpers; single path solutions and lack of flexibility were common.**

7. **There was multiple agency involvement with no one designated to take leadership responsibility.**

8. **The involved agencies could not find agreement on the identification of the child/adolescent's problems**

9. **Interventions with the child/adolescent and family were fragmented.**

10. **Urgency was defined differently by different departments and agencies.**

11. **There was no dynamic functional needs assessment for the child/adolescent; there was no attempt to develop an appropriate 24 hour plan for the child/adolescent.**

12. **Different policies on confidentiality, and the interpretation of same, limited information sharing with other departments and the understanding, therefore, of the whole child in his/her context.**

FACTORS FACILITATING POSITIVE SERVICE OUTCOME

In reviewing the case examples provided by the four departments, there were several common factors identified in cases that worked.

1. **There was an integrated plan to address the needs of the whole child. All systems agreed to the overall plan and the priorities. For some children/ adolescents, a 24 hour 12 month plan was developed.**

2. **There was ongoing involvement by the family/ guardians throughout the process.**

3. **There was a case management process that was clear and accepted by all involved.**

4. **There was knowledge by all involved of the multi-systems approach to assessment and intervention**

5. **There was flexibility in meeting the needs of the child/adolescent and family.**

6. **There was a commonly agreed to comprehensive needs assessment, treatment plan and monitoring/evaluation process.**

7. **There was common language across the systems that were involved.**

8. **There was early identification and involvement with the child/ adolescent and family.**

9. **There was an identified leader or facilitator.**