My Placement at the Complex Developmental Behavioural Conditions Department at Sunnyhill Health Centre

by

Sam Lerner

BA, University of Guelph-Humber 2008
BSW, University of Northern British Columbia 2017

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Abstract

My practicum at the Sunnyhill Complex Developmental and Behavioural Conditions Department has taught me about the role of Social Work within an interdisciplinary team in a medical setting, and the value of aligning with the needs and strengths of families and caregivers. This practicum has also informed me on the function of a diagnosis in determining community supports. My preparatory research included youth with developmental disabilities, the assessment process, the need for more significant structural support, the life-needs model, the portage model, how to support families and caregivers, social work within an interdisciplinary team, mindfulness and outcome evaluations. My learning experience has implications for my future practice working within interdisciplinary teams. In my future work, I aspire to promote social justice and ethical practice by using my skills and expertise of external and community resources to overcome barriers in culturally sensitivity ways that honours the client's unique strengths, needs, and their self-determination. My experience and learning enriched my professional capacity and my appreciation of the value of Social Work in supporting families and individuals.

Acknowledgements

I want to offer my sincerest gratitude to Emily Chan for inviting me into her workspace and to the entire Sunnyhill Complex Developmental Behaviours Conditions team. I would also like to thank my committee members, Dr. Indrani Margolin and Professor Dawn Hemingway, for all their guidance, patience, and unique contributions to my learning journey. Finally, I would like to honour my family who have demonstrated resilience, love and acceptance.

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Introduction

My practicum was a tremendous learning opportunity on many levels. Since that time, I have gained greater awareness of the role diagnostics plays in the provision of useful services, specifically to youth with a developmental disability diagnosis and their families. I have a deepened appreciation for the value and dynamics of an interdisciplinary team and how social work can contribute and support the team. Healthcare social work exists within an interdisciplinary approach and, therefore, must be considered within this context. Social work practice requires an understanding and sensitivity to the team dynamic, knowledge of a social context, a proficiency in developing rapport with clients, and the ability to communicate within the team. Communication includes assessment and documentation of relevant information for the interdisciplinary team.

My literature review has evolved throughout my time at Sunny Hill. My areas of study became more apparent as my understanding of the program developed. My revised literature review includes youth with developmental disabilities, the assessment process, the need for more significant structural support, the life-needs model, the portage model, how to support families and caregivers, social work within an interdisciplinary team, mindfulness and outcome evaluations. While some of my research was out of the scope of daily practice at Sunnyhill it did deepen my learning experience and my interactions with people.

According to Ward (2000), the role of social work within the interdisciplinary team is to identify critical aspects of the client’s situation that are outside of the scope of other assessments. The information provided by the social worker is necessary to the formulation of effective and person-centred services. Ward (2000), Mullaly (2006), Ventegodt, Morad, Vardi and Merrick (2004) and Walrath, Mandell, Holden and Santiago (2004) all identify the possibility for better outcomes when there is a contextual understanding of the service user within broader systemic factors.

My time at Sunnyhill in the Complex Developmental Behavioral Conditions program has been a period of great self-reflection and learning. To consider and synthesize my learning, I have sectioned my learning and reflections into affirmations of practice. I have presented these affirmations as anecdotal events of learning that took place during my placement while others are a composite of several moments and events that illustrate my processing ideas, concepts, and learning. I have incorporated journaling as part of my self-care practice and learning goals for this practicum. Discovering the value of naming my learning through journal reflection has provided me with a deeper understanding of my position, biases, and barriers. The act of naming lends to this affirmation practice of my education and is reflected in this document. Most importantly, I have learned that individuals' unique needs and strengths must be considered to provide meaningful, person centred support.

Chapter One: Placement Location

Sunny Hill Health Centre is an outpatient facility that provides children and their families throughout British Columbia with community-based diagnostic services as well as development and rehabilitation services. Children and youth accessing service, have multiple diagnoses with complex medical, physical, and developmental needs. The Complex Developmental Behavioural Conditions department is well-positioned to address the unique and often complex needs of their services users from within the community.

My placement occurred at the Complex Developmental Behavioural Conditions Program (CDBC) at Sunny Hill Health Centre. This program primarily provides diagnostic assessments as well as education, resources, consultation and information relating to a diagnosis. The teams consist of a pediatrician, a developmental pediatrician, case manager, psychologist, physiotherapist, speech and occupational therapists and a social worker. The social worker provides support and education regarding the diagnosis to families, establishes supports within the community, and fills the gaps in understanding of other professional assessments, including systemic, and socio-economic factors, and health determinants including screening for prenatal exposures. It is important for professionals to consider the diverse socio-economic backgrounds and perspectives of their clients in their formulation of assessment and service provisions. Families will have varied knowledge, parenting styles, community affiliations, and notions of childhood and development. The role of the social worker is to establish a shared space and common ground for rapport building, trust, and information sharing to take place effectively. For many families, the CDBC program is the first opportunity for a formal diagnosis. Diagnostic findings made by the CDBC team determine additional supports, including funding. For some, a formal diagnosis is welcomed;

for others, it is a source of negative emotions, stigma, and resistance. The social worker and team prepare to be with the service user and their family in all of these spaces.

Chapter Two: Personal Location

I suggest that gratitude and experience of trauma are essential elements that contribute to our narrative of personal location. I believe the inclusion of these elements yields a more in-depth analysis of power, greater empathy for others, a deeper understanding of trauma, and finally, supports a relational way of knowing.

Personal location is an essential part of critical practice that serves many purposes within social work. The concept of social location is comprised of intersectional identity, our privilege, and our ascribed relational power, specifically in contrast to the people we serve. Personal location, self-awareness, and critical reflection are necessary to social worker self-care, meaning-making, and worldview. Personal location and awareness support our work with clients, but also provide a fertile space for the cultivation of our practice wisdom, and a more inclusive worldview (Pease, 2006). Critical reflection helps practitioners contextualize the social and political experience of the service user (Mullaly, 2006: Pease, 2006). Critical reflection also allows the social workers to reflect on their power and privilege and how that power manifests within their relationships with service users and colleagues (Pease, 2006; Mullaly, 2006). Personal location exists both internally and externally; specifically, concerning perceived power, privilege, and the service users' experience of oppression. My education has reinforced my understanding of Bishop's (1994) conception of oppression as a construction that is socially learned in childhood. Internalized oppression manifests differently depending on a person's socioeconomic status, and their individual experience. Children, overall, are the most oppressed and marginalized group, regardless of other intersectional factors such as gender, socioeconomic status, capacity, and cultural background that may compound feelings of powerlessness (Bishop, 1994). In this way, we are all products of what Mullaly (2006) described as intragroup oppression. Mullaly (2006) argued that internalized oppressive and hierarchical thinking are learned through experiences of oppression. Pease (2006) and Bishop (1994) both identified exploring personal narratives of oppression as important steps to becoming an ally and engaging in a dialogue about the oppressive experience of others.

Pease (2006) implored social workers to recognize their class, gender, ethnicity, age, level of ability, and religious location to explore how these attributes shape their world view. Service users' perceptions and assumptions about my personal location can potentially trigger, harm, or act as a barrier to care. This critical awareness also includes the settings in which services are provided (Kirmayer, Brass & Tait, 2000). Medical environments are alienating for many and have historically been considered a culturally unsafe space (Kirmayer et al., 2000). It is important for service providers to be critically aware of the possibility of the client experiencing alienation in a medical setting. Social workers have an opportunity to be sensitive to this discomfort and recognize the service users' perceptions as valid and an opportunity for further dialogue (Burke, Schmidt, Wagner, Hoffman, & Hanlon, 2017). This critical self-awareness not only challenges notions of professionalism but creates an authentic space for dialogue and trust-building. The service provider and their agencies can help establish a dialogue towards cultural safety instead of perpetuating the more fixed idea of cultural competence in an already, clinical, and potentially alienating setting.

I embarked on this placement as a 39-year-old cisgender male. From a young age, I have struggled with the restrictiveness of traditional gender norms and have been resistive to attributes that typify masculine identity. However, I am not excluded from the trappings of white male privilege, as described by Pease (2006). Upon further reflection, I acknowledge how these attributes entrenched in my identity can be overlooked. I have experienced personal unease existing in restrictive and exclusive groups and have discovered that I can only thrive within an inclusive environment. It is more valuable for me to use inclusive categorical and descriptive language to be inclusive than uphold a notion of truth. I choose to process information through a filter of inclusion. This guides my internal landscape, as well as my consideration and understanding of others. Embracing all aspects of myself has enabled me to challenge my entrenched, more traditional values.

I am married with two young children. I was born as a third-generation Canadian. My grandparents immigrated from Eastern Europe to escape persecution and were able to establish themselves with limited support, including leaving family and loved ones behind. Only recently have I begun to reflect on the trauma of their experiences and the subsequent generational trauma for my parents and myself. Trauma for each generation has presented differently, and with each passing generation, more significant healing has occurred. I acknowledge the level of power and privilege my family has been able to achieve relative to other cultural groups in Canada who continue to experience systemic marginalization, and whose trauma remains unresolved and compounded by poverty; most specifically, the experience of Indigenous Canadians. Women and children also experience more oppression. Social conceptions of these groups are passed on through generations over time.

I was raised with a Jewish identity. My experience as a social worker working with seniors and their families in a long-term care setting for six years has challenged the exclusivity and dogma of my faith-based group upbringing. Specifically, this applies to the experience of suffering. In this way, my work experience has challenged and shaped my current worldview. I am thankful for the opportunity.

Consideration of the role of caregiving has been a longstanding theme in my life. I feel fortunate to be cared for by such remarkable people, specifically my grandmother and mother. Witnessing my mother care for her parents in their later years and how my grandmother was able to care for my palliating grandfather, even with her comorbidities, has given me a deep appreciation for the meaning of care. These experiences inspired my choice to work with seniors and their families and support caregivers in a professional capacity. My undergraduate thesis focused on caregiver burnout, and my previous thesis topic for my Masters was on the vicarious traumatization of caregivers and social workers. Three years ago, I decided to be a stay-home father for my young daughter and explore my role as a caregiver and father.

My reverence for childhood has evolved through education, my work with seniors, my youth, and my experiences as a parent. Working with seniors allowed me to consider lifespan development and how the experiences in childhood permeate adult life (Santrock, MacKenzie-Rivers, Malcomson, Leung & Pangman, 2014). Exploring my childhood experiences, having children of my own, and my studies of child welfare within my social work education has further broadened my exploration of childhood and impassioned me to the experience of children as a marginalized, oppressed and powerless social group. All adults graduate from this social group, but the lessons learned about hierarchical power and oppression can influence interactions as an adult (Bishop, 1994). I firmly believe children must be considered and honoured as people first. There are opportunities to meet children where they are and not overlook their limitations as merely *kids being kids*. Children communicate their needs differently than adults. It is the responsibility of adult carers to learn their language, meet their needs, and honour and respect their autonomy. My social work education and work experience have made me a more committed father and caregiver which has impassioned me to be a more empathetic social worker.

Chapter Three: Literature Review

Persons with disabilities include those who have long term physical, mental, intellectual or sensory impairment which in interactions with various barriers may hinder their full and active participation in society on an equal basis to others (Article 1, Convention on the Rights of Persons with Disabilities as cited by UNICEF, 2007)

Definitions and Prevalence

The World Health Organization's document on children disability rights defines and distinguishes impairment from disability (UNICEF, 2007). Impairment is a physical, mental, or sensory function limitation (UNICEF, 2007). Disability is the barrier, a person with impairments experience, that limit participation in their communities and activities of daily living (UNICEF, 2007). Halfon, Houtrow, Larson, and Newacheck (2012) identified that the needs of impaired youth and their level of social participation must be understood through a developmental lens. The rights-based approach, described by UNICEF (2007), is an essential progression from more traditional biomedical definitions of disability and integrates well into a needs-based, client-centred and family-centred approach. Additionally, a rights-based approach is aligned with structural social work, which values autonomy, self-determination justice, and equity.

Fourteen percent of children in Canada experience a mental health problem or impairment that will cause distresses or limit their ability to participate in their communities fully and social settings (Waddell, McEwan, Shepherd, Offord & Hua, 2005; Singh, Lancioni, Winton, Sing, Curtis, Wahler & McAleavey, 2007). Research based on the United States suggested even higher prevalence, particularly in urban settings (Benn, Akiva & Arel, 2012). According to the World Health Organization, ten percent of youth experience some form of impairment. Additionally, more than half of children with a mental health diagnosis suffer from comorbidities. Halfon et al. (2012) identified increasing socioeconomic disparities as a contributing factor for the increase in physical and cognitive disabilities in children.

Children living in poverty or with pre-existing health conditions are at higher risk of disability (Halfon et al., 2012). While childhood impairments exist at all socioeconomic levels, poverty can create more barriers to social participation and magnify the experience of disability (Halfon et al., 2012). Additionally, children with complex health needs are at higher risk of having unmet care needs (Halfon et al., 2012). The primary goal of service for children with health care needs is to overcome environmental and systemic barriers to participation in society.

This increase of youth physical and mental impairment has consequences on the family system, society and the economy (Cameron, 1997; Halfon et al., 2012; Murphy, Christian, Caplin & Young, P. C., 2007). Caregivers of children with disabilities have higher rates of stress than the general parenting population (Cameron, 1997). Unmanaged mental health and developmental issues can compound over a person's lifespan and cause further problems in adulthood, including unemployment (Waddell et al., 2005; Halfon et al., 2012).

Despite the prevalence of child mental and physical impairment, only twenty five percent of these children receive treatment as the need exceeds treatment capacity within Canada (Waddell, et al., 2005). Most mental health issues first surface before the age of twenty five and, if left untreated, will affect a person throughout their life (Malla et al., 2018). Mental health issues impact social and economic well-being in Canada (Malla et al., 2018). Wadell et al., (2005) argued that children's mental health must be an issue of public policy to reduce the long-term suffering of individuals and their families.

The Canada Health Accord also recognizes the need for mental health and addiction services, specifically for youth (Malla, Shah, Iyer, Boksa, Joober, Andersson, Lal & Fuhrer, 2018). The Canada Health Accord stipulated that all provinces and territories must strive for health care equity both in terms of quality of services and accessibility (Malla et al., 2018). Canada's expansive and dispersed populations pose challenges to equal and accessible services (Malla et al., 2018). Additionally, barriers to health care services will exist for people and communities who have been historically alienated by the health care system (Kirmayer et al., 2000). Specifically, Indigenous peoples who mistrust the health care system and view it as culturally unsafe (Kirmayer et al., 2000). Wait times and delayed services pose a barrier to service during critical periods of development (Malla et al., 2018). Mental health services must become more family and client-centred and must support the youths' transition to adulthood, including accessing services geared to adults (Malla et al., 2018).

At a policy level, children's mental health strategies are most effective when there is a balance between services provided universally, such as preventative programs, mental health education, and targeted programs for populations that are higher risk (Halfon et al., 2012; Waddell et al., 2005). These policy approaches can be considered through the matrix of expense, number of people reached, and the level of stigma and pathology they generate. Some are critical for the efficiency of universal services that are costly and provide unnecessary services to children who are not at risk (Halfon et al., 2012; Waddell et al., 2005). Targeted provisions are valid for children living in poverty or with pre-existing health conditions as they are at higher risk of mental health issues (Waddell et al., 2005). However, targeted services should not further stigmatize children. Despite increased risks for more impoverished and marginalized people, mental health concerns exist at all levels of social strata. Thus, mental health promotion and awareness should be considered as universally beneficial (Waddell et al., 2005). There is a higher risk of stigmatization when mental heath promotion is not presented as universally beneficial. As Waddell et al., (2005) suggested, a balance among service approaches is needed and can only be determined based on the needs of the population. The services provided through Sunny Health Centre and the CBDC program are considered targeted service provisions, however, this program is rare which considers the child's needs within the context of their environmental system and their unique needs in Canada (King et al., 2002).

Poverty

The experience of family poverty is compounded by a child's complex care needs. Families and caregivers may experience financial burdens, decreased ability to work, and health and social consequences as they struggle to meet the care needs of their children without the necessary support and funding from their health care providers and community (Halfon et al., 2012; Murphy et al.,2007).

Park, Turnbull, and Rutherford Turnbull (2002) argued that financial resources are most critical for families of children with disabilities and that poverty is the most significant barrier to quality of life. Poverty complicates all of the other needs described in other research and further marginalizes the individual and their family as well as posing a barrier to social participation (Park et al, 2002). Policy reform is necessary to address the compounded impact of poverty on the quality of life of children with disabilities and their families (Park et al., 2002; Ward, 2000). The systemic problem of poverty has practice implications for social workers and health care practitioners (Ward, 2000). Park et al. (2002) acknowledged that poverty cannot be solved through a single agency or professional but instead requires more significant partnerships between health care services and agencies, community-based services, and schools. Practitioners and educators must also become advocates for policy reform, and explore meaningful partnerships with community stakeholders (Park et al., 2002).

Substance Exposure

Drug exposure during gestation poses as a significant risk factor for life long developmental disabilities (Marcellus, 2002). There is limited information on the long-term outcomes for infants exposed to drugs in terms of intensity and the nature of exposure (Marcellus, 2002). Drug-exposed infants require a wide range of collaborated services (Marcellus, 2002). There is limited information distinguishing impact from drug exposure and the effect of other risk factors such as demographics and the environment (Marcellus, 2002). Moreover, varying health agency data collection methods result in inconsistent severity and prevalence of the problem (Marcellus, 2002). Consequently, a lack of clear and consistent information is distributed to families and communities.

Some children accessing the CDBC program have been exposed to substances during gestation. There is limited research on the prevalence of prenatal drug exposure in Canada (Marcellus, 2002). Previous research has mainly focused on prenatal exposure to tobacco and alcohol in urban settings (Marcellus, 2002). Health services in Canada, including those for substance-exposed, infants, and their families have become regionalized to ensure access; however, many families are unaware of the services available (Marcellus, 2002). The CDBC program is recognized as an innovative service for substance-using mothers and their children (Marcellus, 2002).

Diagnostic Substitution

The diagnosis of autism has increased in the past decade throughout North America and specifically in British Columbia (Coo, Ouellette-Kuntz, Lloyd, Kasmara, Holdren & Lewis, 2008). This increase in prevalence is attributed to several factors, including a greater awareness of the diagnosis, widely spread screening tools for teachers and educational institutions, and funding and services available for children and their families and educators (Coo et al., 2008). Coo, Ouellette-Kuntz, Lloyd, Kasmara, Holdren and Lewis (2008) identified that previously undetected cases and diagnostic substitution accounted for the majority of the recent cases and the increased prevalence. Coo et al. defined diagnostic substitution as cases where academic institutions previously coded the child as needing additional education support other than autism but then later coded them as requiring educational support related to an autistic diagnosis. While Coo et al. argued that further investigation into the nature of previously undetected cases and diagnostic substitution require further examination, an actual increase in autism may also exist. It will require new research on the particular environmental causes and risk factors that have caused this increase.

Social Work within the Interdisciplinary team

Social work within the field of healthcare exists within interdisciplinary or multidisciplinary teams (Dewees, 2005; Supiano & Berry, 2013). These terms are used interchangeably, however, there are important differences (Dyer, 2003). The level of collaboration is the distinguishing factor between these two team approaches (Grossman & McCormick, 2003; Bronstein, 2000). Each method has merit and challenges. In a multidisciplinary approach, team members operate independently, and information is communicated through medical records (Supiano & Berry, 2013). Systems are streamlined, but there is potential for service users to receive conflicting information (Supiano & Berry, 2013). Interdisciplinary teams, on the other hand, collaborate actively to formulate a comprehensive plan of care and communicate in unison (Supiano & Berry, 2013). Collaborative team approaches are less likely to a employ innovations within respective professional fields that are not as easily communicated to the team (Bostock, Lynch, Newlands & Forrester, 2018). An interdisciplinary approach has more significant benefits for vulnerable populations such as children and seniors, where there are complex social considerations (Bostock, Lynch, Newlands & Forrester, 2018). Interdisciplinary approaches can create more significant conflict between team members (Bostock, Lynch, Newlands & Forrester, 2018; Dewees, 2005). Interdisciplinary team members need to mitigate conflict and support productive negotiation to a shared end through trust and respect (Bostock, Lynch, Newlands & Forrester, 2018; Dewees, 2005). The efficacy of an interdisciplinary team requires members' shared understanding of ethical issues and this process takes time to integrate into meaningful shared practice (Dewees, 2005).

Social work is well-positioned to support ethical and value-based decision making in this setting (Joseph & Conrad, 1989). Supiano and Berry (2013) argued that, given the prevalence of interdisciplinary approaches in healthcare settings, social work students benefit from opportunities to acclimate to these teams as part of their education. Educators can support social worker influence, agencies, and the social work students' competence in ethical problem solving (Joseph & Conrad, 1989). Acclimation to interdisciplinary teams provides the student the opportunity to gain confidence in working within an interprofessional group, greater competence, and a better understanding of their scope of practice (Supiano & Berry; 2013). Educators must prepare students for the multifactorial and unpredictable social work environment both through placement experiences and formal curriculum (Grossman & McCormick, 2003). Experience and orientation can reinforce the social worker's role within the interdisciplinary team, establish competence in collaboration and influence, and mitigate conflict in situations where there are conflicting values (Abramson, 1993).

According to Dewees (2005), the social worker within the interdisciplinary team must learn to advocate for a strengths perspective, social justice, and human rights. The social worker is an active participant in negotiating the team's shared knowledge and experience (Dewees, 2005). In the interest of social justice, Dewees (2005) suggested a passive approach will not challenge traditional views of professionalism, which continues to dominate the disenfranchised. Supiano and Berry (2013) identified that social workers can not only achieve a critical but trusting and respectful balance through experience and practice. Bronstein (2003) identified that social workers and other team members need to participate and influence collaboration. Bronstein identified five core components to interdisciplinary collaboration; interdependence, newly created professional activities, flexibility, collective ownership, and reflection on the process. External influences on collaboration include each member's professional role, structural factors such as manageable caseloads, personal relationships within the group, and the group's history of working together (Bronstein, 2003). Other external factors to collaboration, noted by McCaillin (2001), are agency management style and characteristics of the specific service user and their relationship with the team.

Practices in Assessment

Assessment is a critical component of effective social work practice. Assessment practices, specifically within the bio-medical and child protection spheres, have traditionally been deficiency-based with a focus on safety. Traditional assessment practices place limited emphasis on contextualizing the service user within their environment, their community, and culture (Walreth, Mandell, Holden & Santiago, 2004). Both, Gerlach (2012) and Kirmayer, Brass and Tait (2000) recognized traditional approaches as alienating and culturally unsafe barriers to accessing service. Cultural safety is critical for Indigenous peoples who have fallen victim to more traditional assessment practices and policies (Kirmayer et al., 2000). Immigrant populations in Canada also experience alienation. Assessment practices must be culturally safe, collaborative, and non-oppressive with great attention to the internal strengths of children, and within the contexts of their families, communities, and culture. Strength-based assessment approaches are increasingly incorporated into more traditional, deficiency-based approaches (Walreth, Mandell, Holden & Santiago, 2004).

Clement and Mc Kenny (2019) purported that listening is the fundamental component of effective social work assessment. They recognized that ethical practice includes non-judgemental listening and an awareness for existing power structures that affect the client. Consideration of the child's capacity and preferred modes of communication is part of the process of listening to children (Dhaeses, 2011; Landreth, 2012). Children have different ways of communication, depending on their age, level of development, exposure, and culture (Landreth, 2012). Children prefer alternative modes of communication, such as play and art (Landreth, 2012). Practitioners will gather richer data from their assessment if they can continually aim towards this type of communication. Dhaeses (2011) advocated for a holistic approach to listening to children that values derived meaning from all forms of expression.

The Portage Model

The portage model is a community- based approach that recognizes the caregivers and families as critical components to early development and learning (UNICEF, 2007; Cameron, 1997). The model was initially intended for rural communities with limited outside health resources but has since been used in urban settings (UNICEF, 2007; Cameron, 1997). The success and confidence of the family members supports positive development for the child. In this model, services are geared to help family members and strengthen bonds within the family unit through knowledge and support. The portage model was popular in the early 2000s because it was highly adaptable and an inexpensive home-based approach (Cameron, 1997). Limitations emerged, however, such as a lack of oversight to quality and outcomes and a normative understanding of the family that does not consider cultural variations and other spaces for learning and development (Cameron, 1997). Additionally, the model is steeped in a problem-based approach that focuses exclusively on the family and fails to consider other systemic and environmental factors (Cameron, 1997). Finally, the portage model overlooks the child's need for social and community participation (UNICEF, 2007).

The Life Needs Model

King, Tucker, Baldwin, Lowry, LaPorta, and Martens (2002) put forth a life needs model for pediatric and health services provided within a community setting that considers the developmental and socio-economic needs of children and youth with physical conditions and developmental delays. King et al. (2002) argued that service delivery must consider the complex needs of these youth and how these needs may change overtime as they continue to develop through different social experiences. To adequately meet the needs of children and their families, practitioners need to attend to family and social contexts that acknowledge the interdependence of individuals to achieve better outcomes (King et al., 2002). The Life Needs approach recognizes the strengths of the individual and their support system (King et al., 2002). The ultimate goal is to support the individuals' ability to participate and enhance their overall quality of life (King et al., 2002). Services are considered on the individual, family, and community level. According to King et al. (2002), the most significant barriers for children with disabilities and their families are the beliefs, assumptions, and attitudes that exist within their communities. The life needs model is grounded in the community through a family centred approach to individuals who are recognized as individuals within their community (King et al., 2002).

Ventegodt, Morad, Vardi, and Merrick (2004) identified five essential needs to healthy development through a holistic lens: the need for attention, respect, love, acceptance and acknowledgment. Holistic practices facilitate the identification of unfulfilled needs and support the caregivers in activating new methods to meet these needs (Ventegodt et. al, 2004). Social workers need to consider development disabilities when assessing the child's' capacity and modes of communication (Landreth, 2012). Ventegodt et al. (2004) supported consciousness-based medicine as a more effective mode of practice with adolescents and children which prioritizes family needs (Palisano, Almarsi, Chiartello, Orlin, Bagley & Maggs, 2010). Combining a family-centred approach, such as the portage model, with a life needs Model suggests that a family’s priorities and needs will change depending on the age of the child (Palisano et al., 2010; King et al. 2002). Palisano, Almarsi, Chiartello, Orlin, Bagley and Maggs’ (2010) research on the needs of families of children with Cerebral Palsy indicated that a child’s gross motor functioning was the greatest indicator of family need. Families with children with more severe mobility impairments expressed a greater need for resources, such as mobility aids, home modifications to support the child, equipment, respite care and opportunities for participation within their community (Palisano et al. 2010). The social worker is more effective when they are knowledgeable of governing forces, community, health services, and current research (Ward, 2000).

Palisano, Almarsi, Chiartello, Orlin, Bagley and Maggs’s (2010) identified the need for social activation as the highest reported need amongst children and families using mobility aids (Palisano et al., 2010). Knowledge and information about the diagnosis and the services available are the most commonly expressed need of families (Palisano et al., 2010). Support services are the second most commonly expressed need, specifically regarding services available in their specific community, family support services, and support explaining the diagnosis to other people (Palisano et al., 2010). Additionally, Starke and Moller (2002) identified support groups and connections to parent groups to help alleviate feelings of isolation and personal loss. The social worker is well placed within the interdisciplinary team to address these needs (Ward, 2000).

Murphy, Christian, Caplin and Young (2007) identified five common themes in the experience of caregivers of children with disabilities; greater stress, negative impacts on the caregiver’s health, the need for additional community and extended family support to “share the burden,” worrying about preparing and anticipating the future and their child’s needs as they change, and their coping strategies and self-care. Caregivers were more likely to put the needs of their children ahead of their own needs and chronic conditions. Lack of time and qualified alternative care resources were barriers to parental self-care.

Mindful Parenting

Benn, Akiva, Arel and Roeser (2012) identified caregiving style as a determinant for positive outcomes for children with disabilities. Health care provisions must include interventions and education for parents and educators to support children with specials needs more effectively. Providing resources and support can also support the well-being and efficacy of the caregiver and their family units. Benn et al. (2012) identified mindfulness training as an effective strategy that can benefit both the caregiver/educator and child under care. Mindfulness is the awareness and ability to be attentive and accepting of our experiences in the present moment, both in terms of our internal experience and the behaviour and experiences of others (Benn et al., 2012). Mindfulness is intended to guide our thoughts from the abstract and make space to understand our perceptions, feelings and thoughts in the present moment (Benn et al., 2012). Mindfulness creates space for emotional regulation and creative problem-solving.

The ultimate goal of mindfulness is to perceive and feel our identity beyond our immediate experiences of concern, worry, fear, and regret. In mindful parenting, one seeks to break from the scripts of learned parenting styles and past traumas and achieve non-judgemental acceptance of traits, attributes, and behaviours of the practitioner and the children under their care (Benn et al., 2012). Practitioners of mindful parenting have also reported a greater sense of compassion and empathy in their caregiving role (Benn et al., 2012). Singh, Lancioni, Winton, Singh, Curtis, Wahler and McAleavey (2007) confirmed that mindful parenting practices can support the greater capacity for managing challenging behaviours of children. Singh et al. (2007) highlighted that mindful parenting practitioners reported a greater capacity to manage autistic children's aggressive behaviours, increase the child's social skills as well as greater parenting satisfaction and decreased parental stress .

The effectiveness of mindful parenting supports a bidirectional understanding of the child-parent relationship congruent with a transactional model of development where the growth of both parties is understood to be reciprocal. While following the nature of the parent/ child relation and its connection to development is informative, it does not replace a more ecological perspective that recognizes systemic and social factors, such as poverty and stigma that may impact the parent/child bidirectional relationship (Singh et al., 2007). The documented link between parental stress, coercive parenting, and children's maladaptive behaviours supports mindfulness parenting and other non-reactive parenting approaches in supporting social skill development and establishing a deeper bond between the child and their caregiver. Macdonald and Hastings (2010) identified that fathers have less therapeutic involvement than their maternal counterparts. They supported the need for further research on fathers’ use of mindful parenting skills. Van de weijer-Bergsma, Fornsma, De Bruin and Bogels (2012) identified an increase in reactive parenting by fathers of adolescents with ADHD post mindfulness training. Van de weijer-Bergsma, Fornsma, De Bruin and Bogels (2012) also indicated the need for maintenance strategies because the positive effects of mindfulness training diminished in their 16 week follow up. These findings are similar to those of Singh, Lancioni, Winton, Singh, Curtis, Wahler and McAleavey, (2007), where positive gains in social interactions occurred in the practice phase with little change during the training phase. Cognitive behaviour therapy approaches have also been identified to support parental well-being but with limited benefit for the child (King et al., 2002).

Outcome Evaluations

Outcome evaluation and follow up are an important part of individual service delivery. They help determine if a person or family requires additional and available services and guide future policy and service provision (Tunstill & Blewett, 2015).Tunstill and Bewett (2015) supported outcome evaluation and longitudinal studies of mental health and family support services as a necessary element to effective service provision. Barriers to outcome evaluations include universal metrics of outcomes, the overall cost of evaluation design, cut-backs within the health care system, the rise of managerialism within the healthcare sector and benchmarking, which may oversimplify outcomes and may lead to further reduction of services provided within a community (Tunstill & Bewett, 2015). Overemphasis on outcomes may also hinder service performance. Parker (1998) described the process of determining child-care outcomes in assessment as complex and suggested researchers analyze outcomes in five domains: public outcomes, service outcomes, professional outcomes, family outcomes and child outcomes. These five outcome domains are aligned with Brefenbrenners ecological model of analysis and provide a more comprehensive and contextualized outcome evaluation (Tunstill & Bewett, 2015; Santrock et al., 2014). Branch, Homel and Frieberg (2013) expanded on the ecological model and purported a developmental systems model. A dysfunctional developmental system exists when levels of organizations (family, school, community, health care system) are unable to collaborate effectively. Rather than focusing on the pathology of the client as the child and their diagnosis, children with developmental challenges are recognized to exist within dysfunctional developmental systems. This approach focuses on support and solutions provided by the circle of care systems that surround the child rather than the child themselves to create more effective solutions and outcomes. Halfon et al., (2012) stressed the importance of multi-level organization collaboration in collecting accurate data on the prevalence.

Chapter Four: Learning goals and activities

I developed these goals by considering my personal and academic journey, the spaces I had not yet been , and the purpose and service provision of the C.D.B.C. program at Sunnyhill health centre. The considerations are rooted in my knowledge of the capacity of social work.

1) Orientation to Sunny Hill Centre
    a. Review agency literature, policies and scope of services.
    b. Become familiar with the services provided by each department that makes up the interdisciplinary team.
        Attend interdisciplinary team and family meetings.
        Shadow social worker.
        Shadow other professional departments.

    c. Become familiar with the Assessment and services delivery process with specific attention to the role of the Social worker.
        Attend interdisciplinary team meetings and family meeting.
        Shadow social workers and other departments.
        Weekly meeting with Supervisor.
        Manage a caseload with the support and guidance of my Supervisor.

2) Develop my skills working with families
        Attend family meetings.
        Utilize strengths-based assessment tools within practice.

3) Develop my skills within an institutional interdisciplinary team.
        Shadow Departments.
        Attend all relevant meetings.
4) Develop my Assessment Skills- including holistic and strengths-based assessment approaches.
        Shadow assessment process and attend all relevant meetings.
5) Gain a deeper understanding of the experience of youth with developmental. Behavioural diagnosis and that of their families and caregivers.
        Shadowing and on-going support and mentorship of my Supervisor.
        Attend all relevant meetings.
        Working closely with families.
6) Become familiar with the external and community services available for service users.
        Explore opportunities for community referral on a case-specific basis and with the guidance of my supervisor.

Review agency materials

7) Maintain self-care routines to support a successful practicum experience.
    - Maintain a record of reflection on placement experience.
    - Debrief with Supervisor regarding challenges.
    - Implore mindfulness exercises in my own.

A masters level placement has been a formidable opportunity to expand my knowledge, work with diverse service users, deepen my understanding of the interdisciplinary team and cultivate greater confidence in my skills.

Chapter Five: Learning Experience from the Practicum

Beginnings and Immersion: Orientation and the CDBC program

Part of the job of being human is just to try to spread light, at whatever level you can do it. "- Bruce Cockburn

The first period of my placement at Sunnyhill was one of immersion where much of my time was spent shadowing, both my supervisor, and other professionals from each department within the program. I feel grateful for each person's time and willingness to include me in their work. Their willingness to support my learning typifies the CDBC interdisciplinary approach. Their professional knowledge and expertise showed me how each assessment fits into the larger final comprehensive assessment. Each discipline has differing assessment approaches and, in some cases, particular formats for how the assessments are carried out and scored. My experience at Sunnyhill has helped me recognize each professional in the interdisciplinary teams' opportunity to develop rapport and trust with the family and to communicate their professional expertise. Even standardized testing methods are guided by the clinicians' approach and their ability to develop a rapport with the child and family. A strong rapport can facilitate the assessment in two ways: it will help establish a relaxed environment for the child to perform assessment tasks at an optimal level so the professional can obtain accurate information regarding the client's ability. Additionally, rapport building supports a safe space for parents and caregivers to speak openly about their concerns and needs.

I have witnessed the collective passion amongst the team members in the diagnostic process, their professionalism in the service they provide, and a shared desire to reach people and support the child whatever the outcome. In this system, the pediatrician determines the diagnosis with the support of the psychologist, and in some cases the occupational therapist and speech-language pathologist. The social workers' role is to review and confirm the family's current concerns and context of the problems, including family history, financial considerations, strengths, and involvement of separate governing bodies such as the Ministry of Children and Family Development. The social worker also confirms the incidents of prenatal exposure that may have taken place during the pregnancy. In some incidences, where there are mental health concerns and a diagnosis is unable to be confirmed, the CDBC team is able to refer the family to a psychiatrist in the community or Child and Youth Mental Health Services, for additional assessments.

The opportunity to shadow other professionals helped me understand children and families' assessment experiences, as well as how the social work interview fits into the final assessment. Once assessments have been completed, the team comes together to discuss the diagnosis for the child and fine-tune the wording for the final document to present to the family. The team advises the family to share this document with their school and the children's medical practitioners within the community. The family's unique circumstances, including educational background, social position, trauma, and cultural background, are considered in the phrasing of the document. The diagnosis and assessment outcomes are described in a clear and meaningful way. This process is a collaborative effort to ensure relevant information is included by the respective clinicians. The social worker is positioned as the final voice to ensure information is effectively communicated to provide support and discuss available services.

My practicum experience expanded my conception of my social location. I became more aware of characteristics of my social location through my interactions with a diverse cross section of parents and families; specifically, those with limited resources and those living in rural communities. My self-conception was challenged when interactions with clients were not as restorative or meaningful as I intended. These challenging moments were opportunities for humility, reflection, and elaboration on my social location, and their implications. While I had considered my, comparatively, resource-rich location, living in an urban setting with relative affluence, I was guilty of overlooking the degree of the disparity between me and clients. I fear that my overlooking was perceived by clients as arrogance. In the end, I found focusing on humility, gratitude, and openness as helpful guides to my meaningful and authentic interactions.

Understanding the experience of families: The importance of checking-in

The average wait time for clients from the time of referral is close to a year. Additionally, further delays can take place due to the availability of professionals and families' schedules. Over this period, situations or factors can change drastically. This can frustrate families who may have differing expectations of the program. Many families have been struggling for many years with their child’s behaviours and concerns. They have limited information and understanding of their child’s social, emotional and academic struggles. Parents are eager to gain a definitive understanding and diagnosis and to access the right supports to meet the needs of their children . Gaining this insight has guided me in many ways. It has allowed me to recognize the importance of checking in with clients at each encounter. The practice of checking in creates a space for families to provide updates regarding recent events and ensure accuracy of the collected information. Checking in also creates space for parents to vent frustrations or concerns they might have during the assessment process.

Diverse reactions: Coming to terms with a diagnosis

Many families are relieved to have definitive information regarding their child's challenges from the family conference. For others, it is distressing. Responses to a diagnosis depend on several factors: how they perceive the problem when they enter the assessment, the prognosis for the specific diagnosis, public awareness, stigma regarding the particular diagnosis, and the available supports moving forward. Parents are more relieved when their child is given a diagnosis of autism and most distressed when the child is given a diagnosis of an intellectual disability. I speculate the contributing factors to the differences between these two diagnoses are the degree of social awareness, the degree of ease communicating the diagnosis to others, the degree of prevalence, and the degree of stigma. Other contributing factors are the levels of community support, government funding, and resources for individuals. Intellectual disabilities are a more generalized and invisible diagnosis. Unlike autism, there is less social awareness on the prevalence of intellectual disabilities and greater stigma, especially for certain cultural groups. The diagnosis is not known at the time of the social work assessment, and it is not a best practice for the social worker to speculate on possible diagnostic outcomes with the family. I have learned that culturally respectful and inclusive communication is a critical skill for the social worker in this position and requires flexibility, tact, sensitivity, and respect for the scope.

The social worker remains mindful of all possible outcomes, considers possible reactions before the family conference, and begins to prepare the family as best as possible. Assessing the family's readiness for a diagnosis can help the team deliver the information in a way that is sensitive and specific to the family's needs.

The social worker and team do their best to positively focus on next steps and available resources rather than on contributing factors. The team focuses on how the description of the child's learning style and ability will better support their learning through additional supports and school funding, as well as their social experience. This will help the child’s overall self-esteem and self-confidence through the setting of realistic goals and expectations. Reframing in this manner provides the opportunity to affirm the parents' commitment and love for the child.

A future-focused reframing of a diagnosis does not undermine the parent’s experience of loss. In the cases where there was a difficult diagnosis, I felt profoundly moved when the team was able to identify the childs’ strengths and characteristics and assure the parent that their child was still the same with or without the diagnosis. Upon reflection, I am sure making such a statement is not a miraculous *fix-all*, but is rooted in a strength-based approach that demonstrates respect and value for the child.

Diverse Cases and the Skill of Flexibility

My time at Sunnyhill has highlighted the diversity of cases this organization supports. In my limited experience, no two cases have been alike. At times, this was disconcerting because it was hard to conceptualize generalized themes of learning or gain confidence in my ability. Positive assessments early on in my placement could easily be explained by the natural ease and willingness of the family and did not assure me that I could handle more resistant families. I had many conversations with my supervisor to discuss the uniqueness of the families and the amount of flexibility required by the social worker. I learned that flexibility, a readiness to connect, and simultaneously collect critical information for the assessment are essential skills for a social worker. Over time, my confidence developed, not from drawing general conclusions but, in developing an ability to remain flexible, trust in my skills, and a firm understanding of the scope of practice. Understanding the scope of practice has been an incredible part of my learning, even in the final days of my placement.

The Art of Working backward

A specific and useful skill of the diagnostic team is their ability to work backward through a diagnosis. Diagnostic findings are determined based on pathology requirements and how a diagnosis will be supported in school, in the community and throughout their lives. An excellent example of this was a case where the child, who is now 18 years of age, was diagnosed with Digeorge syndrome when they were young. Digeorge syndrome is a rare de novo genetic disease that can cause a range of physical and developmental problems, including learning and behavioural issues, ADHD, and autism, and requires ongoing medical and social support from the time it is diagnosed. The parents, in this case, had been very supportive and involved in the childs' development, academic endeavors, and interests. The parents' finely attuned scaffolding allowed the child to flourish in all areas, but the child was still struggling with more challenging subjects as well as unrealistic academic and career goals. Ultimately, there was a discrepancy between the child's ability and desires. The youth was brought in for assessment to query a mild intellectual disability (a diagnosis that is usually made at a younger age). The child test scores were too close to the threshold to confirm an intellectual disability. Discussion took place amongst team members on how to proceed considering diagnostic accuracy, the family's reaction to a diagnosis, and, most importantly, how the diagnosis would provide an opportunity for the client to access additional supports as they enter the post-secondary school system. The team's decision had to be impactful as they acknowledged that, as an 18-year-old, they would not have the ability to assess the youth again. This ability to consider the benefits and hindrances beyond pathology was illuminating and outside of my expectation of the assessment process.

The Importance of Language

Language and cultural background were significant considerations in my time at Sunnyhill. I participated in assessments where speaking different languages was a barrier to establishing a good rapport with the family. The team's ability to overcome these barriers was essential to the success of these family conferences. This barrier was highlighted for me during a family conference with a Cantonese speaking family. The majority of the staff in attendance also spoke Cantonese. Even with a Cantonese interpreter in attendance, it was decided that the conference would be conducted in Cantonese. This experience provided moments of reflections for me in two areas: my own experience as a non-Cantonese speaking individual in the meeting; and the family's shift in openness. My personal experience of not understanding most of the conference discussion except for what was translated by the interpreter allowed me to appreciate the experience of other non-English speaking families when conferences were held in English. At moments, I felt lost and disconnected from the conversation. I felt frustrated that I did not understand the subtleties in communication. I found myself relying more heavily on facial expressions and tones, which were also hard to interpret. This experience had serious implications for my practice working with non-English speaking clients. It supported the need to find ways to bridge the gaps due to language, a more in-depth consideration for their experience, and a more profound empathy for the challenges families face.

There have been other assessments where the inclusion of an interpreter has effectively bridged the language barrier and allowed a stable connection to form. One of my first assessments was with a Syrian family who had recently immigrated to Canada. This meeting included a community worker and an interpreter. At first, I had reservations that the number of attendees would distract from the interview. I was surprised, however, when social dynamic revealed that everyone was integral to the process. The family had limited supports in Vancouver, but the casual and effective manner of the interpreter, as well as the approach of the community worker, put the family at ease. The community social worker was able to highlight the family's strengths and ensure that information was communicated in a way that was accurate, respectful, and comfortable for the parents. Additionally, at the end of the interview, the community worker spoke about the ability of the interpreter. This experience not only helped me understand the importance of a competent interpreter to develop a rapport with a family, but also that, especially in a case where there are cultural needs, a team and community approach can make a challenging assessment proceed with ease and comfort for the family.

Asking the Difficult Questions

As previously stated, a critical part of the role of the social worker in this context is to ask the more sensitive questions regarding abuse and prenatal exposure. Asking biological mothers about prenatal exposure was one of the most challenging questions I had to ask. There is implicit stigma and blame in this question that I had to reflect on. I recall hesitating during my first assessment with a biological mother where I asked about prenatal exposure to alcohol. I sensed that the client was uncomfortable discussing the subject with me and in that moment, chose to default to my supervisor to ask the difficult question. During my debriefing my supervisor stressed that delving into these challenging topics is critical to the role of the social worker. Gaining confidence in my own ability to re-approach and come back to questions during an assessment interview were important skills for discussing difficult topics.

Acknowledging mothers' ability to overcome addiction during pregnancy as a strength

In most cases the biological mothers disclosed their alcohol substance use during pregnancy with me, despite stigma. Upon reflection, I recognize their openness as a testament to their resilience and their commitment to their children. For most, the realization of a pregnancy becomes the tipping point for a change in behaviour and abstinence. In many cases, these mothers were recovering from childhood trauma and were raised by family members who also suffered from addiction, neglect, and abuse. Their determination to break the intergenerational cycle of addiction, abuse, and trauma reflects their internal strength and resilience.

Coming to terms with Family Reunification

Working with foster families and children was another essential learning process during my time at Sunnyhill. Reviewing charts where the child was moved several times or reunified only to be removed again was heartbreaking. These children, who had experienced neglect or abuse, and then removal from their homes and placed with a foster family suffered from separation anxiety along with other behaviours. It was difficult to determine the primary cause of their anxiety; the experience at home or the experience of being in care. Even in complicated family situations, involved agencies remained open to the possibility of family reunification. One example was a case where the child was currently living in care but had visitation with his verbally abusive and erratic father. The legal guardian social worker, who had countless stories about the father, suspected the father of having some underlying trauma or mental health issue and was frustrated to see similar behaviours presenting in the child. Despite the social worker's frustrations with the biological father, the social worker was committed to the opportunity for family reunification in the event the father was able to access the necessary supports and change. It seemed as if the child was in a better place in his current foster home, and I was challenged by the mandate to reunify the family. Upon reflection, I acknowledge there are no easy answers to this question, just the conundrum of family preservation, child well-being and non-maleficence.

Gaps and Opportunities for Connection

One affirming experience with a foster family was an assessment where the foster family and biological mother were able to attend. This meeting provided an opportunity for the two parties to come together and discuss the well-being of the child in an open and positive space. The foster family was open, and supportive, and made themselves available to include the biological mother in upcoming school events and meetings. This experience gave me an awareness of other gaps that exist within the care system. From discussion with my supervisor, I understand that the space for these types of meetings does not currently exist within the child care system. Perhaps it is not always possible, but this meeting was a testament that, in some cases, it can be positive and useful to have a space for both parties to meet.

Opportunities of translating personal triggers into empathy

Learning how to work within a pediatric environment was a meaningful aspect of my experience at Sunnyhill. I knew entering into this placement that relating to parents would be a new skill that would require some time. Upon reflection, it was a humbling learning curve where at first, I felt timid; and over time and experience, I gained confidence in establishing a useful connection with the families. As a parent of two children under the age of five, I knew that working in an environment of diagnosing children may be a source of anxiety and impact the way I understood and viewed my children. Indeed, at one point during my placement, I inquired with our family practitioner regarding a concern I had with our daughter and was assured that it was not a cause for concern and was, myself, diagnosed with what our general practitioner called "first-year medical student syndrome." Upon reflection, I understand how this type of work can trigger any parent-professional in this environment. Many professionals I worked with had similar experiences and continue to muddle through as best they could. Upon deeper reflection, I realize the triggering aspects of this type of developmental assessment work can become a distraction and a hindrance to practice. However, if taken one step further, they are also opportunities to better understand the experience of the parents who are accessing diagnostic programs and how the assessment approaches may also be triggering for them. Ultimately, channeling personal anxieties around diagnostics to a deeper degree of empathy for the child and family was an important part of my learning process.

The Importance and Power of Documentation

Assessment documentation and the ability to read chart records were another critical aspect of my learning. As previously stated, assessment information collected during the social work interview is intended to confirm information obtained from other disciplines and go deeper into more social contexts of the child's history and current situation. Good documentation is written in a way that is sensitive to the possibility that assessed documentation could be requested by the family, court-ordered, or requested by the child when they are of age. The social worker writes about family history and prenatal exposures carefully and considers the experience of the child if they were to read them. Discussions with my supervisor highlighted the importance of this sensitivity. For instance, a parent explained her decision to continue drinking after finding out she was pregnant because she intended to terminate the pregnancy. The prevalence of drinking was an essential factor to communicate to the team and provided some additional context for why the drinking continued, but could be harmful for the child if they reviewed the documentation at a later time. This kind of mindfulness around documentation manifests in other areas too. In a separate case where the mother was no longer involved, birth records were reviewed to confirm alcohol exposure. However, these records did not provide specific information regarding exposure as one would expect. The reason for this was to protect the confidentiality of the mother. My supervisor was able to provide some additional context. Depending on the unit where the child was delivered, the social worker and nursing notes would reflect a higher sensitivity for the mother's confidentiality in the effort to create a safe, anti-oppressive space that placed the woman's right as paramount. While this was frustrating from a diagnostic perspective, it did highlight the contextual factors that can impact documentation as well as the power and subjectivity of documentation (Pease, 2006).

Chapter Six: Implications for Personal Professional Practice

I will now discuss some of the implications for practice that surfaced during my process of learning and reflection. I have enjoyed a wealth of experiences during this placement, and still find myself reflecting and uncovering new learning related to the general discipline of social work. This knowledge will enhance my professional practice moving forward. Social work practice provides opportunities for developing useful clinical perspectives and practice wisdom.

My learning during this placement has contributed to my understanding of the role of the social worker within a health care interdisciplinary team. I have learned both through my literature review and my time at Sunnyhill that the social worker within an interdisciplinary medical team has the opportunity to promote social justice and ethical practice. The presence of the social worker does not suggest these features are absent from the team perspective, rather that the social worker has a vital role in ensuring these values remain a consideration within the team dynamic. The social worker can align these values and the other values of the team with the values and principles of social work. Social workers have the opportunity to positively reframe information based on individuals' strengths and self-determination. Communicating in a direct and strengths-based manner, the social worker can promote the benefit of the role of social work within interdisciplinary practice. An essential distinction in realizing this opportunity is to recognize the strengths that already exist. I believe these values and beliefs are more powerful and more deeply integrated when multiple sources voice them. It is important for the social worker to create space, and respect the capacity, and scope of the other professional practices involved within the team. A balance is achieved by promoting the benefit of the discipline of social work and also leave the space for others. An imbalance may cause either a team dynamic where the social worker can be seen as overbearing or disrespectful of other disciplines or conversely seen as redundant and unnecessary. To the credit of the Sunnyhill CDBC teams and it's social workers, this devolution of the role of social work was not something I witnessed during my placement but is discussed in the literature I reviewed on interdisciplinary teams, in conversations with my supervisor, and my previous work experience.

Effective social work practice recognizes the contributing factors of behaviours, impairments, and mental health issues. Structural social work is positioned to focus on structural and contextual contributing factors to mental health almost exclusively. It must also recognize factors beyond experiential factors to identify genetics and family history of mental illness. The nature and nurture dichotomy have never been simple, and certainly, these elements engage in an ongoing interplay that shapes an individual over time. Having an understanding of this interplay is a tremendous benefit to my social work practice as it will better guide intervention strategies.

Understanding the importance of dwelling in the space of discomfort to be with clients has tremendous implications for my future practice. Social workers are well-positioned to be present within that unsettled space with clients. The use of self and silence does not require the social worker to reframe or redirect the family's experience but simply share space with them. Accepting non-judgemental presence can deeply validate the family members' experiences, and demonstrate acceptance for where they are emotionally, establish a deeper rapport, and respect their autonomy.

Affirming the strength and value of the family seems to be the most significant implication for future practice. My experiences have highlighted the importance of understanding the individual and their challenges within the context of their family and broader support systems. I have a profound respect for the challenges family members have faced and how individuals, specifically parents, have been able to rise from cycles of violence, neglect and addiction in order to meet the needs of their children. I aspire for my social work practice to affirm these strengths and values.

Social work practitioners must understand the social and community resource implications for a specific diagnosis and how to best support families in accessing these services. The diagnostic team demonstrated a fantastic capacity to work backward from a diagnosis to have an accurate picture of what their assessment outcomes will deliver in social supports and resources. This consideration aligns with social work values of equity, beneficence, and social justice.

Through experience and learning, I have increased my awareness of the social stigmas people face both within their community and healthcare service provision, most often in cases of FASD and consanguinity. With these more complex factors, it is important for social work practice to remain client-centred and maintain a judgment-free and strengths-based setting. This can be achieved through honest reflection of personal biases, education, the examination of information, and raising awareness within the culture of service provision.

In my future practice, I aspire to have a deeper understanding of the implication of language barriers and the importance of culturally sensitive practice within the health care setting. Overcoming cultural barriers played a critical role in assessment practice and the sensitive communication of a diagnosis and recommendations. Given the growing diversity within our population, there are new opportunities for social workers and others to explore overcoming those barriers.

Finally, an essential part of my learning was how a clear scope of practice and resources within an agency can enhance services and also expose gaps. This piece of learning has tremendous implications and hope for effective practice. It enables the social worker to refer the client to the necessary services effectively. It also allows the social worker to understand how all the community and social resources fit together to create a full circle of care for people in need. Gaps in services and opportunities for advocacy work are more readily identifiable with a strong knowledge base of the available services and the specific needs of clients.

Chapter Seven: Conclusion

My experiences working within the social work field have been productive and meaningful to my own personal and professional development. The opportunity to cultivate practice wisdom through action, reflection, and guidance has benefitted me in both personal and professional development. Meaning-making is as an essential aspect of reflexive professional practice and the source of practice wisdom (Meihls & Moffatt, 2000). According to Sommer (2008), a professional's ability to construct meaning from their work can increase their resilience and positively alter their worldview.

I consider myself fortunate to practice and learn within the field of social work. The service user must remain as the primary focus with deep regard for individuals' whole self, their values, their self-determination, and their autonomy in social work practice (Mullaly, 2006). These elements are often overlooked for professionalism and the mandates of our service agencies (Mullaly, 2006). However, as I have learned in my studies of First Nations ways of knowing, holistic practice within my own work experience, everything is connected. My practice will impact and change my worldview. Conversely, the way I choose to care for myself and my family will affect the way I practice, the way I see (assessment), the way I can venture into areas of discomfort and my ability to extend myself and create a space for trust, understanding and acceptance with the people I serve.

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