

**MANITOBA SOCIAL WORKERS AND THE PHARMACEUTICALIZATION OF  
CHILDREN AND YOUTH IN CARE**

by

Sheri Denise Bell

Submitted in partial fulfilment of the requirements  
for the degree of Master of Arts

at

Dalhousie University  
Halifax, Nova Scotia  
August 2013

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***Dedication:  
For Colm and Owen***

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## **Abstract**

In Manitoba, as elsewhere, there is a growing trend towards the use of pharmaceuticals and medical technology (pharmaceuticalization) on children and youth in care (C/YIC). As legally mandated guardians and trained experts on children and youth, social workers in Manitoba may play pivotal roles in the decision to medicate C/YIC with psychotropics. Yet there are no studies on Manitoba social workers' experiences with medicated children/youth or on their perceptions and attitudes towards medicating C/YIC with psychotropics. Using a multilevel Social Structure and Personality analytic, I explored what Manitoba social workers from various fields of practice have to say about this trend. Data consisted of five in-depth interviews and 29 self-completed questionnaires. Findings highlighted that social workers in Manitoba are dealing with increasingly complex cases within a system of residual social welfare. Funding and resource constraints, lack of skilled medical professionals and educators quick to refer all contribute towards medicating C/YIC.



## **List of Abbreviations Used**

AANDC – Aboriginal Affairs and Northern Development Canada

AJI – Aboriginal Justice Inquiry

AJI-CWI – Aboriginal Justice Inquiry – Child Welfare Initiative

ARND – Alcohol Related Neurodevelopmental Disorder

BSW – Bachelor of Social Work

CAMH – Child and Adolescent Mental Health

CASW – Canadian Association of Social Workers

CFS – Child and Family Services

COHROU – Criminal Organization High Risk Offender Unit

FAE – Fetal Alcohol Effects

FAS – Fetal Alcohol Syndrome

FASD – Fetal Alcohol Spectrum Disorder

INAC – Indian and Northern Affairs Canada

MIRSW – Manitoba Institute of Registered Social Workers

MSW – Master of Social Work

RSW – Registered Social Worker

SSP – Social Structure and Personality

## **Acknowledgements**

There are a number of people who have helped me with this vast undertaking. First and foremost, I would like to express my sincere gratitude to my advisor, Dr. Emma Whelan, for her guidance, patience and for pushing me to be better. As well, for their continuous support and expertise, I would also like to thank the wonderful members of my committee Dr. Yoko Yoshida and Dr. Merlinda Weinberg. I'd also like to thank the external/internal reviewer, Dr. Chris Murphy for his comments on the thesis.

I am indebted to Dr. Jane Ursel, Dr. Kendra Nixon, Dr. Brad McKenzie, and Dr. Don Fuchs at the University of Manitoba for all the help they provided me for this project. Without their timely and tireless assistance, this thesis would never have been completed.

I would also like to extend heartfelt thanks to my amazing co-workers at the Centre on Aging at the University of Manitoba and in particular to my boss and mentor, Dr. Verena Menec. Verena provided me with an office to write my thesis and with resources to keep me going. In addition, she was a sounding board for my ideas and listened patiently and guided me when I had problems. Without the daily, "So, how is your thesis going?", "How much have you done on your thesis?", "Are you finished yet?", "Don't worry about work. Your thesis comes first" from Verena, Catherine, Rachel, Sheila, Lucelia and Jim at the Centre on Aging, I am not sure I would have stayed sane, let alone so focused. You all know how amazing I think you are.

Similarly, I want to thank my family and friends for also being great cheerleaders. I couldn't have done it without you. In particular, I need to thank my amazing cohort, the original SOSApaths (in alphabetical order, not order of importance because you all are important): Ashley, Chloe, Dan, Dee, Eric, Jennifer, Julia, Lachlan, Mashabi, Rosi, Sam, and Shannon. All of you are so very brilliant and I am lucky to have met you.

I would also like to acknowledge the financial support of the Canadian Institutes of Health Research (Canada Graduate Scholarship), and the Killam Trusts (Killam Pre-Doctoral Scholarship). These awards were greatly appreciated and facilitated the timely completion of my program.

Finally, I would like to give a very special thanks to the 34 participants in my study who had the courage to share their thoughts and stories with me during a particularly difficult time for social workers in Manitoba. I hope that this thesis does justice to all of your passion and dedication to your work.

## Chapter 1 – Introduction

I am guided into the office and the door is closed behind me. The office is dark and smells of coffee; stacks of bankers' boxes overflowing with tales of tragic lives lay strewn haphazardly around the room. The more I look around, the more the boxes seem to be strategically placed, almost as if someone were playing a game of chess. One stack near the corner spills over, apparently trying to capture the other stack *en passant*.

Colleen<sup>1</sup> rummages through a large pile of papers on her desk until she finds what she is looking for – her case list. She is a middle-aged Manitoba Child and Family Services front line social worker with 27 children and youth under her watch. With the love and pride of any parent, she tells stories about each of their accomplishments. However, when the conversation turns to the medications they are on, her eyes start to flash with anger. She tells me about one of her 'kids'.

*There was a child, a four year old that was administered Concerta<sup>2</sup> by a doctor. And the foster parent called me and said that she's gone bonkers and is climbing the walls, you know. And so I said, what is this? You are supposed to let me know before medication is prescribed to a child. Why didn't you call me or leave me a message? But anyway, Concerta is not supposed to be prescribed under the age of 6. So I don't understand how the doctor prescribed these drugs. And then I called a meeting and I felt like I was interrogated by the doctor and the foster parent. "So where did you get this information?" [They asked me] I looked it up on the internet plus I went to this, um, I forget, it is like a clinic, uh, that deals with these kinds of mental disorders and I found this booklet there "Concerta". And I showed it to them. Why would they have this [booklet], you know what I mean, at a mental health clinic? And it says not to give it to a child under six. She's only four. Come on, like, you know her brain isn't formed yet...I left [that agency] shortly after that because nobody would validate me while I'm trying to advocate for this child. I wrote a letter to, um, my ED,*

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<sup>1</sup> All names used are pseudonyms.

<sup>2</sup> Concerta, also known as Methylphenidate or Ritalin, is a stimulant medication used to treat Attention Deficit Hyperactivity Disorder. It should not be used in children under six years old, since safety and efficacy in this age group have not been established. Treatment emergent psychotic or manic symptoms, aggression, and long-term growth suppression, seizures, and visual disturbances are reported side-effects (National Institute of Health, 2007).

*the director, and I had meetings. I had meetings with the doctor. And it seemed like nobody, nobody was listening. And I even wrote a letter to, um, the medical profession, the College [of Physicians and Surgeons]. Nobody responded to me. So I don't want to be in a place that was not doing what is best for the child. Do you know what I mean? I didn't want to work for an agency that didn't want to [do anything]. And we are children's advocates! That is what we are supposed to be doing!<sup>3</sup> [Emphasis in original]*

I left the interview feeling extremely troubled by Colleen's story about the child on Concerta and her subsequent resignation from the agency because she was not being heard. I wondered just how many other social workers have experienced the same level of frustration. I did not have much time for reflection, however, because I had to hurry to do my next interview.

Over the phone, Amanda identified that she is a child and adolescent mental health<sup>4</sup> social worker. In her late-twenties, she seems eager and excited to talk about her work with children and youth in care.

*The doctors with whom I work are very, very careful about how they prescribe medications and I feel very comfortable with the work that they are doing [...] I do find that they [the doctors] respect our [social work] voices here, that they value our voices [...] and it is a bit of a relief [...] when the proper medications or combination of medications has been found for [the child]. [...] It is very rewarding to see them head home and they've gone from barely functioning, for instance, like sitting under a desk crying or being unable to wear clothes, something like that that's been debilitating them to just being normal kids heading off to go play with their friends, go back to school.*

After Amanda's interview I felt even more conflicted. It appeared that there were many dimensions and layers to Manitoba social workers' experiences and perspectives on the use of psychotropic medication on children and youth in care. While Colleen and

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<sup>3</sup> This comment, like all comments recited in the reporting of the data, is reproduced verbatim except in the case of square-bracketed ellipses written as [...] which signifies that part of a quote has been omitted. Furthermore, quotations from participants are found in italics to differentiate them from literature quotations.

<sup>4</sup> From this point forward, child and adolescent mental health workers are referred to as adolescent mental health workers.

Amanda had different views on the benefits of psychotropic medication, what was not in dispute was that a large number of the children and youth in care in Manitoba are taking these medications.

Pharmaceuticalization, or the growing use of medications in society, has permeated all aspects and walks of life, including the healthy and sick, rich and poor, and older and younger (Williams, Gabe & Davis, 2009). It has also penetrated the child welfare system. For instance, research estimates that between 40 to 70% of the 75 to 100,000 youth in the Canadian child welfare system are prescribed psychotropic medications<sup>5</sup> (Lambe & McLennan, 2009; Philip, 2007; Ontario Expert Panel, 2009). This means that these youth are receiving psychotropic medications at a rate between 2 and 3 times that of youth not in care (Raghavan et al., 2005). While medication may be an important step in treating the depression, anxiety and behavioral issues of these youth, there is growing evidence that the use of psychotropic medications can also have a number of long and short term negative effects (Lambe & McLennan, 2009; Moses, 2008). Some of these effects include an inability to concentrate, fatigue, weight gain, an inability to adjust to life, organ damage, and addictions issues (Floersch, 2003; Hamilton et al., 2011; Lambe & McLennan, 2009).

As legally mandated guardians and as provincially and territorially legislated substitute medical treatment decision makers, social workers play a pivotal role in the decision to medicate children/youth in care (Psychiatric Patients Advocate Office, 2007). For my thesis, I explore this issue from the social workers' perspective. More specifically,

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<sup>5</sup> Psychotropic medications act primarily on the central nervous system where they alter brain function resulting in temporary changes in perception, mood, consciousness, and behavior. Common classes of psychotropic medications include antipsychotics, anti-anxiety medications, anti-depressants, stimulants such as ADHD medications, and mood stabilizers (Bentley & Walsh, 2006).

I examine what social workers say about structural factors in their work that may be affecting the trend towards the use of psycho-pharmacologic treatment of children and youth in care (C/YIC). I also explore the roles that social workers play in the medication assessment and treatment process and examine the experiences that they have had working with medicated children and youth. As well, I look at social worker attitudes and feelings about the medication process.

While academic research has addressed several of these dimensions of inquiry (see, for example: Bentley & Walsh, 2006; Bentley, Walsh & Farmer, 2005; Floersch, 2003; Moses, 2003; Moses & Kirk, 2006; Moses, 2008), none of the research has addressed Canadian social worker perceptions of the psychotropic treatment of C/YIC. More precisely, no public research has addressed the perspectives of Manitoba social workers on this topic. The child welfare system and social work practice in Manitoba are unique. First, Manitoba is the only province in Canada that does not regulate the professional ‘social work’ designation thereby allowing anyone to call themselves a social worker. Second, the child welfare system in Manitoba has been restructured so that the jurisdictional powers of First Nations communities have been expanded to provide off-reserve child and family services to band members and a mandated Métis Child and Family Services Authority has been established.

To be clear, the focus of this thesis research is not whether medicating children/youth in care with psychotropics is problematic or whether there is a need to medicate children/youth in care with psychotropics. The focus is on what the Manitoba social workers have to say about the trend towards medicating children and youth in care with psychotropics. This is important because as trained experts and as legally mandated

guardians, social workers may have unique insight into the use of psychotropic medications on children/youth in care.

## **Project Overview**

Getting hold of the difficulty *deep down* is what is hard.

Because it is grasped near the surface it simply remains the difficulty it was. It has to be pulled out by the roots; and that involves our beginning to think in a new way.

~ Ludwig Wittgenstein (1980, p.48e), *Culture and Value*

Mutual insularity between macro and micro theories and approaches to sociological research can often impede a scholar's ability to grasp a "difficulty *deep down*". This, in turn, hinders scientific and intellectual development. As a way to combat this insularity and get a more complete picture of social worker perspectives on the trend towards medicating children/youth in care with psychotropics in Manitoba, I am using a Social Structure and Personality (SSP) or psychological sociology approach (see House, 1977; Kohn, 1989). According to House, a Social Structure and Personality approach "refers to [a] sociological variant of social psychology which relates macrosocial phenomena (e.g. organizations, societies and aspects of the social structure and processes thereof) to individuals' psychological attributes and behavior" (1977, p. 161). In this approach, the researcher begins with the large-scale social world and examines the ways that the structure influences the individual while keeping in mind that structure and agency are mutually constitutive. In other words, the social world of the participant can be conceived of as a series of embedded circles with the individual at the core, and an SSP researcher peels away the layers to grasp the difficulty "deep down".

Based on this underlying SSP approach, I developed a framework that would examine social workers' experiences and perceptions and draw systematic linkages between three levels of analysis: macro structural, meso situational, and micro attitudinal levels. For this, I executed a mixed-mode data collection process that involved both interviews and email surveys using an 18 item questionnaire. The target participants were Manitoba-based social workers with a Bachelors (BSW), Masters (MSW), or Registered Social Work (RSW) designation who work with children/youth in care<sup>6</sup>. The responses were compiled and two stages of analysis occurred: one primarily quantitative (counting occurrences of comments and themes) and one primarily qualitative (examining underlying meanings and thoughts).

In my analysis I investigate the linkages between structure, situation, and attitude by asking the following questions: 1) What are the structural factors that social workers say affect the trend towards the use of psychotropic medications on children/youth in care (Macro structure)?; 2) What roles do social workers describe playing in the medication management of children/youth in care? What experiences do social workers describe having when working with medicated children/youth in care (Meso situation)?; and 3) How do these experiences and roles affect their values, their orientations and their thinking processes in relation to medicating children/youth in care with psychotropics (Micro attitude)? This leads to a focus on situational conditions as an important intervening link between society and the individual (Turner, 1988). The underlying model that developed out of the research is that social structures (e.g., residual social welfare and pharmaceuticalization) affect individual behavior (e.g., social worker roles in the

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<sup>6</sup> Only individuals with BSW, MSW or RSW designations were included in the study to ensure they were comparable to one another as professionals with similar training. This was done in order to eliminate that as a factor in differences among them



medication process and experiences with medicated youth) and disposition (e.g. social worker attitudes and beliefs regarding medicating C/YIC) only as they are experienced in particular situational contexts (institutions/agencies) and, further, that attitudes have the ability to go back to reinforce or change the social structure.

## **Research Context**

As many of my key informants and participants explained, I probably could not have chosen a worse time to try to recruit social workers in Manitoba for my study. At present, the Manitoba child welfare system is undergoing a period of intense public scrutiny which is setting the social work community on edge. Social workers have been under fire by the media, government, and the general public since the 2005 death of Phoenix Sinclair, a 5 year old girl. Public hearings into Phoenix's death began in Winnipeg on September 5th, 2012 (See, Phoenix Sinclair Inquiry Commission, 2013)<sup>7</sup>. These hearings are tracing what child welfare services were or were not provided to Phoenix and her family under the Manitoba Child and Family Services Act; other circumstances related to Phoenix's death; and why her death went undetected for nine months.

To briefly outline the events, for most of her life Phoenix Sinclair lived in foster care or with her biological father. However, in 2004, Phoenix's biological mother regained custody. On June 11th, 2005, Phoenix finally succumbed to the horrific torture and abuse that her biological mother and step-father inflicted upon her for over a year. It took nine months for anyone within the child welfare system to notice she was missing.

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<sup>7</sup> All public transcripts of testimony and further information on the inquiry can be found on the inquiry website at <http://www.phoenixsinclairinquiry.ca/>

Finally, in March 2006, her body was found in a shallow grave near the Fisher River First Nation garbage dump.

Ever since Phoenix's body was found, charges of negligence and malfeasance have been levied towards Manitoba social workers by the media and general public. Questions have been swirling as to how Phoenix's mother regained custody, why Phoenix's case file was closed, and why social workers did not adequately ensure she was safe. For instance, in her weekly news column in the Winnipeg Free Press, Lindor Reynolds wrote, "There were no consequences when Phoenix Sinclair was failed to death by the child-welfare system. No CFS worker was fired, disciplined or reprimanded. [...] There should have been charges laid" (Reynolds, Winnipeg Free Press, February 5, 2013). As a result of commentary like this, many social workers operating within the child welfare system have stated that they feel as though they are under attack.

In order to stem the public tide of anger and blame, the union representing Manitoba social workers has publicly released letters that were written to the Manitoba Ministry for Child and Family Services between 2002 and 2005<sup>8</sup>. These letters depict an overburdened system and highly stressed social workers. One of the letters describes rising caseloads and the fact that many frontline workers are quitting because they are overwhelmed. It reads in part: "It is for the above reasons that we feel we must put this government on notice that children and families who require protection services in Winnipeg are at risk and we as workers feel unable to ensure their safety" (Henley, Toews, Manteuffel & Wilson, 2002).

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<sup>8</sup> These letters can be viewed here:  
<http://www.mgeu.ca/files/File/uploads%202012/psi%20letter%20dec2002.PDF>  
Here: [http://www.mgeu.ca/files/File/uploads%202012/psi%20letter\\_feb2005.pdf](http://www.mgeu.ca/files/File/uploads%202012/psi%20letter_feb2005.pdf)  
And here: <http://www.mgeu.ca/files/File/uploads%202012/psi%20letter%20july2005.PDF>

Perhaps even more indicative of the social work environment in Manitoba is found in the online commentary on news items about Phoenix Sinclair. For example:

Troubled parent writes (Feb. 17<sup>th</sup>, 2013):

*MacDonald [the former program manager with Winnipeg Child and Family Services] helped murder this child with neglect to her job and later the cover up, jail her (CBC, February 5, 2013).*

Barbarossa writes (Jan. 25<sup>th</sup>, 2013):

*I didn't hear any of the social workers complaining about the fat government paycheque they were taking home. If you're so 'stressed', quit your job and find a different line of work...perhaps one that doesn't end up in dead kids when you don't care enough about your job to do it right (Sanders, Winnipeg Free Press, January 25, 2013).*

Ami2much writes (Jan. 8<sup>th</sup>, 2013):

*too bad the corrupt social workers only go after people they can harass, as opposed to the kids that need help (Lambert, Huffington Post, January 8, 2013).*

While online commentary may not be the best indicator of the current general public perception of social workers in Manitoba, it is important to acknowledge that social workers may be feeling under-appreciated and may be enduring a lot of stress. Social workers in Manitoba appear to be caught between institutional structures that severely constrain their work; a general public which lambasts them for their actions; and their own moral and ethical struggles about appropriate modes of practice. And it was into this climate that I waded in order to do my research.

During recruitment and interviewing, I was told by my key informants that social workers in Manitoba may not want to participate in my study because of what is happening with the Phoenix Sinclair inquiry. Several social workers I spoke with expressed discouragement and said they felt they are being used as scapegoats for a failing child welfare system. As one of the participants explained to me:

*It comes across [in the news] that [we] always say [we] are doing the best that [we] can, but [we] are. And with lack of resources, systemic problems, things happening that you have no control over [...] and the decisions we make and how far reaching they are. It is a lot and it can be very stressful. And yet you've got great people and every day they are going to see families and they're going to check and see how things are going, they're going to see their kids in care, they are trying to come up with the best plans they can within the reality of what's available to us. And I think that that is forgotten. And I think there is a lot of blame. [People think] that workers are supposed to be psychic and that workers are supposed to innately know that little Johnny is in trouble 'cause his mom and dad are drinking and fighting and it is going to turn bad. We're not [psychic]. Unless we're given that information, we don't know that little Johnny might be in trouble. Workers can go out and see the family regularly, but if, when they go, nothing really bad is happening and 6 hours later mom and dad have a raging drinking party and no one calls us to check on them, nobody calls us, nobody calls the police, not a neighbor, no one, we can't be expected to know that [...] And knowing that yeah you think this family is in trouble but you don't have enough yet. You don't have enough information yet. You are pretty sure, but you have no proof. How do you manage that? [...] and you get blamed. Phoenix Sinclair is thrown in our faces every week. Every single week someone is out in the field and people will tell us we killed Phoenix (Karen, CFS).*

It is possible that conducting this thesis research at a different time and in a different place would have vastly increased the sample size.

## **Thesis Outline**

In the next chapter, I outline the methodology of the project, explaining how the research was conducted and introduce the study sample. I also explain how the data were coded and categorized and finally, I reflect on the research limitations.

In chapter three, I present my analytical framework, outline the past and present context of Manitoba's child welfare system and then move into the literature and theory pertaining to social workers and the medicating of children and youth in care. The literature and theory is divided into the three analytical levels relevant to the project: Macro/Structural; Meso/Situational; and Micro/Attitudinal. More specifically, at the

macro level I examine the concepts of *residual social welfare* (Hick 2010) and *pharmaceuticalization* (Williams, Gabe and Davies, 2009). At the meso level I examine the theoretical constructs of *definition of the situation* (Thomas & Thomas, 1928) and *pastoral power* (Foucault, 1979). Finally, at the micro level I examine the cognitive, affective and behavioral dimensions that constitute individual *attitude/disposition* (Fishbein & Ajzen, 1980) so as to demonstrate how meaning is both derived and reinforced by prior roles, experiences and situations and is shaped by and shapes the social structure (residual welfare and pharmaceuticalization).

The purpose of the next three chapters is to report on the study's findings and, in particular, to provide detailed description of social workers' working context, roles in the medicating of C/YIC, experiences with medicated children and youth, and attitudes towards treatment. Each of these chapters presents findings and discussion for the three levels of analysis: macro-structural, meso-situational and micro-attitudinal.

The final chapter brings the three levels together in a succinct summation of the findings. Due to my belief in the importance of a public sociology, I also provide a list of suggestions for how to improve the Manitoba child welfare system gleaned from participant responses. I end by investigating the limitations of the study and recommending future directions for research.

### **Significance of the Project**

This study has conceptual, practical and policy significance. First, the appropriateness of pharmaceuticalization, definitions of the situation and social psychological conceptualizations of attitude as interpretive analytics for this topic are weighed. Second, at a practical level, this study fills a gap in research on the context,

roles, attitudes and experiences of Manitoba social workers in dealing with C/YIC who are taking psychotropic medications within a system of residual social welfare. Finally, this project provides information for policy-makers within the child welfare system; particularly in the area of psychopharmacological treatment of children/youth in care that can be used to make changes to the child welfare system.

## **Chapter 2 – Methods and Methodology**

This chapter outlines the methods and methodology I employed to learn about and explore Manitoba social workers' working context, roles in the medication process, experiences with children/youth in care who are on psychotropic medications, and attitudes towards medicating. In this chapter I begin by explaining how the research was conducted and introduce the study sample. From there I explain the analytical framework I used to code and categorize the data and I end by reflecting on the research process and its limitations.

### **How the Research was Conducted: Data Collection Process**

The data for my thesis was collected in Manitoba, Canada between October 2012 and December 2012. Data are drawn from 34 qualitative surveys conducted with Manitoba social workers who work with children/youth in care (C/YIC). Qualitative research is well-suited for developing an interpretive understanding of the social world and, in this case, the world of social workers in Manitoba who work with C/YIC. My purpose was to disentangle the complex nature and experience of social work practice with C/YIC on psychotropic medications within the overarching system of child welfare. This meant exploring three overlapping dimensions of the participants' world: the social structure, their situational contexts, and their attitudes.

During data collection, I utilized a mixed-mode survey approach: cross-sectional, self-administered questionnaires and semi-structured interviews. Participants were able to choose between completing an interview, email survey, or paper survey (returned via letter post). Regardless of which approach was chosen by the participants, the questions remained the same. The only difference between the interviews and email/post surveys

was that during interviews I was able to probe for clarification and/or further information. All of the interviews were recorded and transcribed and later the information was entered into a survey document to allow for more consistent examination. My concern was to ensure rigorous and accurate comparisons between data and between participants. Thus, of the 34 total participants, 5 took part in interviews, 17 completed the survey through email, and 12 returned the survey through letter/post.

The survey/interview included closed- and open-ended questions (See Appendix A & B). The questions were designed to address the three main areas of interest in my study: 1) to uncover the structural context of social workers who work with C/YIC in Manitoba; 2) to map out the varying roles social workers play in psychotropic medication management and experiences they have had with medicated C/YIC; and 3) to delineate the dispositional attitudes of social workers towards medicating C/YIC with psychotropics. Qualitative questions were used to elicit this information. However the survey also incorporated questions to screen and eliminate participants who did not fit the parameters of the research. Additionally, to develop participant profiles, demographic questions on age, sex, theoretical orientation and field of practice were also included.

Using multiple methods of data collection was important for recruitment because it allowed participants to decide when and how they wanted to get involved in the study. Social work in child welfare settings can be highly demanding and stressful; “caseloads are often large and there are chronic shortages of needed resources, both within the child welfare system itself and in community agencies that support it” (CASW, 2008, ¶7). I hoped that by providing multiple ways to participate, some of the inconvenience the research posed for the busy participants might be reduced.



The interviews provided a lot of rich, contextual detail that complemented the shorter email and letter/post surveys. Many participants were eager to share their experiences while others were somewhat hesitant about the research. Four participants were upset about the inclusion of quotes from a newspaper article (see Question 18, Appendix B). They stated that its inclusion slanted or biased the research towards negative portrayals of social work practice. In response I explained that their reaction to the article and what they have to say about the article is exactly why it was included.

### **Who Took Part in the Research: The Study Sample**

I focused my recruitment on Manitoba social workers since Manitoba is where the majority of my key contacts within the child welfare system are based. Immediately an important issue arose with the first question on my survey: “Are you licensed, certified or registered to practice social work in Canada?” A number of participants felt this meant that they could only participate if they were registered (RSW) with the Manitoba Institute of Registered Social Workers (MIRSW). This would have eliminated a number of eligible participants, so for clarification, I explained to each participant that even if they answered “no” to question 1, as long as they had a Bachelors or Masters of Social Work Degree (BSW or MSW), they could participate.

It was important to clarify this with participants because social work regulation remains voluntary in Manitoba. *The Social Work Profession Act*, which was passed by the Manitoba Legislature in 2009, has not yet been brought into force by the provincial government. Therefore, at this time, anyone can call themselves a ‘social worker’ in Manitoba. Only the title ‘Registered Social Worker’ is protected by the current (1966) legislation – the *Manitoba Institute of Registered Social Workers Incorporation Act*.

Persons must be MIRSW members in order to use the title ‘RSW’. Experience in the field is enough to gain membership to the MIRSW and so RSWs do not necessarily have a BSW or MSW. That is, if the individual's knowledge, skills and abilities are determined by the MIRSW Registration Committee “to be substantially equivalent to those acquired through a Social Work degree program, the candidate will be eligible for registration” (MIRSW, 2013). Thus, Manitoba is the only province in Canada that does not regulate use of the title ‘social worker’ and how social work practice is carried out (See also Chapter 4). Regulation of social work practice means legal accountability, training and ongoing professional development, all of which requires an investment of resources. Without this regulation, the necessary training, accountability, supervision and ongoing professional development may not occur. This may have a direct impact on the quality of care the children/youth receive (for more implications, see Chapter 4, *The Residual Approach to Social Welfare* and Chapter 7, *Suggestions and Recommendations*).

Though my sample has varying levels of experience, education, and training, the common, uniting factor is that they all have a professional designation that conveys an impression of expertise. In other words, participants may be more trained than the average ‘social worker’ in Manitoba. This is important because as one of my participants explained during an interview:

*The difference between us and the child’s biological parents is that they are not considered experts. Like, how could we justify removing a child or working with a child if we don’t have that expertise or expert standing?*  
(William, CFS)

To ensure adherence to the sampling (population) parameters of my study, I rejected individuals who indicated that they did not have a BSW, MSW, or RSW. I wanted to ensure my sample had common professional designations that reflect similar

levels of experience and/or education and training. Of the 34 participants, 8 participants stated that they were not registered by the MIRSW. Seven of those 8 participants work at Aboriginal CFS agencies. While I cannot be 100% sure that any of the participants have a BSW or MSW short of asking them to produce their parchment, I did inform participants that this was a requirement for participation. By delimiting participation in this way, however, I feel that I may be missing important information from front line ‘social’ workers. As well, I probably would have gotten a larger sample if I included front line workers without a BSW, MSW or RSW designation. Trying to get participants with these designations who work frontline in Child and Family Services (CFS) was extremely difficult – particularly from Aboriginal mandated agencies. Those with BSWs/MSWs were usually in managerial positions and were less directly involved with working with children/youth.

To attain my sample, a dual chain referral method was employed. The dual chain method involved concurrently contacting members from the Canadian Social Work Discussion List (CSWD) and key informants to ask for referrals to members of the target population. I did not receive any referrals from the CSWD. All of my participants came through key informants and snowball sampling. My informants are all personal acquaintances (social workers and faculty members) who have contact with social workers within the Manitoba child welfare system.

Since I wanted to recruit as diverse a sample as I could, I asked my informants to help me gain access to Manitoba social workers from multiple organizations, agencies and private practices. I did this because my interest lay not only in the perspectives of child and family services or child welfare social workers, but in the perspectives of social workers practicing in the many fields that may come into contact with children/youth in

care. I wanted to get as large a picture of the varying experiences, attitudes, and opinions of social workers as possible so as to better understand the commonalities and differences within and between fields of social work practice. As such, my sample includes social workers from CFS agencies, child welfare organizations, child and adolescent mental health organizations, the education sector, private practice, and child/youth outreach.

**Sample Characteristics.** The 34 participants who make up my sample consist of 29 females and 5 males (See Table 1). Of the 34 participants, 67% are between the ages of 25 and 44. Twenty participants (58.8%) work in child and family services or child welfare. Since Manitoba has Aboriginal and non-Aboriginal child and family services agencies it was important to get participants from both types of agencies. Of the 20 participants who work in CFS or child welfare, three participants (15.0%) work for private institutions that provide service for both Aboriginal and non-Aboriginal children/youth; thirteen participants (65.0%) work within Aboriginal mandated CFS agencies (on and off reserve); and four work within non-Aboriginal mandated CFS agencies or in non-Aboriginal child welfare settings (20.0%). This percentage is similar to the percentage of overall CFS frontline workers and supervisors within non-Aboriginal agencies throughout Manitoba in 2012 (22.5%) (Manitoba Family Services and Labour, 2012).

The majority of participants (22) began working with children/youth in care after 2000 and the most commonly mentioned theoretical underpinning to social work practice was narrative/solution focused social work (mentioned 17 times). Narrative/solution focused social work assumes that clients socially construct their world. Social workers who adopt this approach to practice focus on a client's narrative to help the client recognize patterns in their life that can be changed and thereby address the issue at hand

(Myers, 2008). Narrative or solution-focused practice encourages the examination of problems when those issues have temporarily abated and extending exceptions to the problems as solutions. In other words, by examining problems carefully, solutions to the problems can be found in the clients own narrative. Social workers who adopt this approach to practice focus on patterns in a client's story that can be changed (Myers, 2008).

The next most mentioned theoretical approaches were strengths based approach (mentioned 10 times) and ecological/systems (mentioned 8 times). The strengths based social work approach focuses attention on a client's strengths (such as talents, skills, and life experiences) that will allow them to address and manage a particular situation (Laurson, 2000). The ecological systems approach, outlined by Bronfenbrenner (1979) is a holistic approach to social work that advocates looking at many dimensions of the situation such as a client's biology, environment and psychology when trying to address an issue.

**Table 1: Sample Characteristics**

Demographic Profile		Frequency	Percent
No. of participants		34	100.00
Sex	Female	29	85.29
	Male	5	14.71
Age Range	25–34	16	47.06
	35–44	7	20.59
	45–54	8	23.53
	55+	3	8.82
Field of work	Mental health	4	11.76
	CFS	16	47.06
	Child Welfare	4	11.76
	Other*	10	29.41
Period of work with C/YIC	Before 1980 to the present	1	2.94
	1980 to the present	4	11.76
	1990 to the present	7	20.59
	2000 to the present	22	64.71
Aboriginal/Non-Aboriginal CFS and Child Welfare Agencies	Aboriginal agency	13	38.24
	Non-Aboriginal agency	4	11.76
	N/A	17	50.00
Theoretical Model of Practice (Note: Several participants expressed using more than one theoretical model to guide their practice)	Narrative/Solution Focused	17	37.78
	Strengths Approach	10	22.22
	Systems/Ecological Theory	8	17.78
	Medical Model	5	11.11
Total caseload	Critical Theory	5	11.11
	<10	3	8.82
	10–19	7	20.59
	20–29	7	20.59
	30–39	8	23.53
	40–49	2	5.88
	50+	4	11.76
No dedicated caseload	3	8.82	
No. of C/YIC in caseload	<10	10	29.41
	10–19	13	38.24
	20–29	5	14.71
	30–39	2	5.88
	40+	1	2.94
	No dedicated caseload	3	8.82

*\*Note: Other field of work includes community outreach, housing/homelessness, private practice and school social work.*

Twenty-seven of the study participants carry a dedicated caseload that ranges from a low of 4 cases to a high of 42 cases. It is important to understand that social work caseloads can be made up of families, individuals, children/youth and children/youth in care. For those in the study who carry caseloads, the number of children/youth in care in their caseload ranges from a low of 1 to a high of 31.

It was not my goal to get a representative sample of social workers in Manitoba, although my sample does contain some representative characteristics. For instance, as mentioned earlier, the percent of sample participants representing Aboriginal agencies is quite similar to the actual percent in Manitoba. As well, according to the Canadian Institute of Health Information (CIHI, 2011, pp. 237–247), 84% of Manitoba social workers are female with 40% of all social workers practicing in child and family services. Similarly, my sample is 85% female with 47% of participants working in the field of child and family services.

### **How the Data Were Analyzed: The Coding Process**

My approach to the qualitative research process is what Creswell (2007) describes as post-positivist. According to positivists, the universe operates in relation to the laws of cause and effect which can be discerned through rigorous methods of scientific inquiry. The underlying idea is that if we know the world well enough we may be able to predict and control it. Post-positivism, however, rejects the idea of singular universal truths, unbiased scientific inquiry, and objectivity. According to post-positivists, all observation is fallible. Due to the fallibility of observation, emphasis in research is placed on triangulation and using multiple measures to better understand reality (see Payne, 1991, pp. 44–50). In other words, post-positivist research emphasizes multiplicity and complexity in researching the social world rather than binary oppositions. As such, I adopt a Social Structure and Personality approach as a way to bridge dualistic thinking. Furthermore, a “post-positivist stance asserts the value of values, passion and politics in research” (Ryan, 2006, p. 18). In other words, while attempting to uncover the whole picture, the researcher also demonstrates a desire for justice while remaining reflexive

about their own position in the research. When presenting findings, post-positivist researchers often use an evocative/narrative style that is balanced with theoretical interpretations (Ryan, 2006). In my thesis, therefore, I engaged in a systematic, scientific approach that emphasizes empirical data collection, rigorous methods of analysis and belief in multiple participant perspectives (see Creswell, 2007 for a further description of post-positivist qualitative research). For added precision, I used multiple levels of data analysis and used computer software to manage the data and for coding.

Due to a gap in the research on the common or shared experiences of Manitoba social workers in working with medicated C/YIC, attitudes towards medicating C/YIC and the structural context that social workers operate within, I started by adopting an inductive approach to analysis. This allowed me to learn what it is like for social workers to work with medicated children/youth, as well as what the meaning of that experience is in certain contexts. It also provided a deeper understanding of the structural features of the medicating phenomenon and social workers' roles in and perspectives on the phenomenon.

**Data Preparation.** The data required quite a bit of formatting prior to importation into ATLAS.ti 7.0, a qualitative data analysis application that allows for methodical coding and STATA v.12, quantitative data analysis software. Below are the steps taken to format the data into two data sets – one for quantitative demographic analyses and one for qualitative thematic and comparative analyses.

***Step One: Linking Demographic Attributes to Open-ended Responses.*** Each survey was individually saved as a word document and each participant was given a unique code identifier. The major socio-demographic indicators were categorical/numeric. These included questions on: age range, sex, field of work, period of work, caseload,



number of C/YIC and number of C/YIC on psychotropic medications. An added demographic indicator that was not on the questionnaire was “type of agency”. This information was gathered through contact information with CFS agencies. All of the responses to the socio-demographic questions were coded/re-coded to eliminate non-response and/or small category size.

Next, a worksheet was created in Microsoft Excel with a row for each respondent and socio-demographic data (including respondent identifier) in the columns. Missing data were coded as N/A (not applicable); D/K (don’t know); or N/R (no response). Once all of the socio-demographic data were entered, the “concatenation” function in Microsoft Excel was used. This function combines the contents of two or more separate cells into a single string. Therefore, a unique identifying text string can be produced for each respondent comprising the relevant attribute variable information. This allowed me to make use of ATLAS.ti’s autocoding function.

Since I wanted to compare participant responses to individual questions, I next created a separate Microsoft Excel worksheet for each open-ended question. Each worksheet had three columns of data: one with the participant IDs, the other with their response texts in full, and finally the correct attribute string for that respondent (produced as described in the above paragraph). Missing data were once again coded as N/A (not applicable); D/K (don’t know); or N/R (no response).

Once all of the worksheets were created, the individual spreadsheet data were copied into Microsoft Word documents for formatting, converting to text, and saving in Rich Text Format. Each document was assigned to ATLAS.ti and a code was created for each demographic attribute value identified above. Thus, I had 8 attributes (e.g. sex, age range, etc.) with a total of 36 attribute value codes (e.g. male, female, etc.). The autocode

routine was run separately for each code (36 times) which then linked the demographic attributes to the open-ended text. By doing this, I was able to use the query tool to examine subsets of my sample by carefully selecting the desired attribute codes (for instance I could examine all the responses for positive experiences with psychotropic medications by females aged 25 to 34).

*Step Two: Data-set for Descriptive Analyses and Cross-Tabulations.* To better produce a general descriptive profile of my sample and their working conditions, I created a second data set for performing descriptive analyses. In Excel, the demographic attributes data already used to create the attribute string for ATLAS.ti were recoded and other variables were added. Each string variable was transformed into a numeric variable (for instance, Sex: female = 1, and male = 2, or Missing data/no response = 999; don't know = 888; N/A = 777, etc.). This new Excel data set was imported into STATA v.12 for analysis.

*Analysis: Coding and Re-Coding.* There were two strategies employed during coding: open-coding and comparative coding. First the data were analyzed question by question and line by line, with every sentence and word examined. During this examination, concepts and categories emerged from the data and were later grouped into conceptual ideas. Next I engaged in comparative coding where I looked at the similarities and differences between the emerging categories, constructed sub-categories and deconstructed themes. This allowed me to group the conceptual ideas into thematic analytical levels to better capture the wide variations in and complexities of the data. Within the thematic analytics, I began to compare my data with conceptual analytics. This was a continuous procedure to confirm and/or discount the potential of major theoretical constructs as well as to develop new constructs that would help to explain the context,

roles, experiences and attitudes of social workers. I therefore engaged in a process of coding and recoding, categorizing and re-categorizing; moving back and forth through the data in order to form code clusters, themes, and concepts. What materialized during my coding process was a descriptive, overlapping framework comprised of a previously determined multi-dimensional (macro, meso and micro) analytic that echoed the conceptual themes and coded categories that emerged from the data.

### **Reflections on the Research and Study Limitations**

My study follows an exploratory qualitative research approach, involving the use of a mixed-mode survey: cross-sectional, self-administered questionnaire and semi-structured interview with Manitoba social workers who work with children/youth in care. The self-selection of participants and snowball sampling means that the extent to which the sample reflects the attitudes of the broader population of social workers is not clear. However, the information does provide a descriptive overview of the pharmaceuticalization phenomenon from the perspectives of my sample of social workers in Manitoba.

Another important point, and one that I made earlier in Chapter 1, is that I had great difficulty in recruiting participants. While this may have occurred because social workers in Manitoba are overburdened and have high caseloads, two other factors may have come into play: the current social work climate in Manitoba and the after-effects of a previous study. First, as indicated in Chapter 1, the general public, media, and government have been lambasting Manitoba social workers for their failure to protect Phoenix Sinclair. Second, many social workers in Manitoba participated in a previous study in 2010 on psychotropic medications. The findings from that study have been

embargoed by the provincial government which has led many potential participants to feel as though their time had been wasted. These persons are now rather wary of taking part in any research.

In the next chapter, in order to contextualize findings, I delve further into Manitoba's child welfare history and literature. I also present the theoretical analytics that help give the data meaning and value. In this way I hope to avoid the "formal & empty ingenuity" of abstracted empiricism (Mills, 1959, p. 75).

### Chapter 3 – Literature and Theoretical Framework

The problems of our time—which now include the problem of man’s very nature—cannot be stated adequately without consistent practice of the view that history is the shank of social study, and recognition of the need to develop further a psychology of man that is sociologically grounded and historically relevant. Without use of history and without an historical sense of psychological matters, the social scientist cannot adequately state the kinds of problems that ought now to be the orienting points of his studies.

~ C. W. Mills (1959, p.143), *The Sociological Imagination*

In 1959, C. Wright Mills argued that neither individuals nor society can exist independently of one another and that, therefore, both the micro world and macro structure must be taken into account in any research project. Mills proposed that this can be done by understanding the “intersections of history and biography” (1959, p. 175). Thus, sociologists must look at how individual “troubles” are reflected in macro “issues,” and how macro issues are reflected in individual troubles (1959, p. 175). In light of Mills’ sociological research edict, to link the individual to the social world, I follow a Social Structure and Personality (SSP) framework in my thesis.

House (1981) has advanced three principles that guide SSP research. First, researchers must examine the *specific components of the social system* (macro-structure) that are most relevant to understanding the phenomenon of interest. As McLeod & Lively explain, “Structural explanations emphasize current material conditions of life as they constrain and enable action and thereby generate characteristic psychological and behavioral responses” (2003, p. 82).

The second principle is what House (1981) refers to as the *proximity principle* (meso-situation). The proximity principle asserts that the properties of social structures

are transferred to individuals through, “the smaller structures and patterns of intimate interpersonal interaction or communication that constitute the proximate social experiences and stimuli in a person's life” (House, 1981, p. 540). These are the meso-arrangements or situations that include practices, roles, experiences and constraints found in social life in institutions, groups, and dyadic relationships (McLeod & Lively, 2003). These arrangements guide interactions which then affect attitudes, feelings, and behaviors. This, in turn, may go back to reinforce the social order (McLeod & Lively, 2003).

The third principle is the *psychological principle* (micro-attitudes) (House, 1981). Here individual psychology (dispositions, attitudes, and feelings) is assessed so as to better account for how macro structures and meso arrangements affect individuals. As McLeod & Lively suggest, “it is not enough to understand how macro-structures shape the proximal environments of individuals; we have to also understand how those environments become integrated into individual thoughts and actions” (2003, p. 92). For this, I foray into the arena of social psychological conceptions of attitude where knowledge and emotion acquisition are tied to social context through experiences (Howard, 1994).

Several examples of scholarship may be useful in clarifying the three principles that underlie an SSP approach. For instance, when developing his concept of alienation, Marx examined the relationship between the social system (capitalism), proximate arrangements (institutions and labour roles), and individual beliefs, motives and actions (see Marx, 1844/1959). Drawing from Marx, Hochschild likewise followed an SSP approach when she developed her concept of emotional labor (see Hochschild, 1983). In psychology, Freud argued that society demands the suppression of sexual instincts in individuals in exchange for security; thereby linking the social to the person (see Freud,

1899). Finally, in anthropology, emphasis on cultural relativity also illustrates a link between structure and the individual (see, for instance, Franz Boas, 1911/1938).

There are a number of strengths in using an SSP framework to guide my research (for a more thorough discussion of strengths see Ryff, 1987). For instance, SSP research questions whether findings reflect a particular cultural phenomenon (Ryff, 1987). SSP research acknowledges that we cannot understand people without reference to the sociocultural and historical structures of their everyday lives. As such, it focuses on both description and explanation to achieve a more thorough understanding of the phenomenon of interest. It emphasizes moving back and forth from broad descriptions (such as of social class) to explanations that articulate how the social is translated into individual dispositions and values. As well, SSP research combines several levels of analysis to strengthen the research. As Ryff explains, “Psychological studies benefit from paying greater attention to large sociocultural influences, whereas sociological studies gain from attending to the cognitive processes that influence” social processes (1987, p.1200).

In the rest of this chapter I will explore four areas of literature and theory that tie into the social structure and personality approach being used to frame my analysis into Manitoba social worker experiences and perspectives on the medicating of children/youth in care with psychotropics. First, I will examine the historical context in which social work is embedded in Manitoba. Next, at the macro-level, I will examine the broader societal context in which social work practices takes place, by referring to pharmaceuticalization and the residual approach to social welfare. At the meso-level, I will examine literature and theory which may be applied to describe potential roles social workers play in the medication assessment and treatment process and to explain the

experiences that social workers have when working with medicated children/youth in care. Finally, at the micro-level, I will examine scholarly work on the opinions and attitudes of social workers regarding the medicating phenomenon. Here I delve into social psychological theories of attitudes including the theoretical construct of cognitive schemata.

### **Historical Overview of Manitoba's Child Welfare System**

Historically the Canadian child welfare system has concentrated its attention on two areas: protecting children from poor parenting and protecting society from delinquent children (see, Bell, 2011). The first child protection system in Manitoba was established in 1898 when the provincial government passed the Children's Protection Act. As part of this act, the Children's Aid Societies (CAS) and the government office of the Superintendent of Neglected and Dependent Children (SNC) were added to the mix of private child care services and orphanages. The CAS provided protective services and found placements for apprehended children in municipalities. The SNC provided the same services as the CAS in rural and disorganized municipal areas of Manitoba (see Hurl, 1984).

Due to confusion between public and private responsibilities, the provincial government established the Public Welfare Commission in 1917. Out of the Commission's findings, the Manitoba Child Welfare Act was proclaimed in 1924. This Act amalgamated the Children's Protection Act, Illegitimate Children's Act, Infants' Act, Public Health Act, the Humane Societies Act, and the Factory Act (Hurl, 1984). Additionally, it created a central government authority called the Department of Public Welfare with a Child Welfare Division. As Hurl writes, "The overall purpose of the new



legislation was to establish government responsibility for the care and well-being of all neglected, dependent and defective children” (1984, ¶20).

Prior to the Second World War, Aboriginal communities were not affected by provincial child welfare legislation and policies (Bennett, 2001). This was due to the British North America Act of 1867 and the Indian Act which made Aboriginal peoples and Indian Reservations exclusive federal jurisdiction (Manitoba, Hamilton, & Sinclair, 1991, v.1, ch. 14). For the federal government, residential schools acted as the primary mechanism of First Nations’ child welfare in Canada (Milloy, 1999). However, in 1947 the Canadian Welfare Council and the Canadian Association of Social Workers presented a report to parliament which outlined huge disparities in living conditions, rights, and protections for Aboriginal and non-Aboriginal children (Manitoba, Hamilton, & Sinclair, 1991, v.1, ch. 14)<sup>9</sup>. One of the proposed solutions was to expand existing provincial child welfare programs onto federal Indian reserves, yet neither the Manitoba government nor federal government wanted to extend or fund services on reservations (Manitoba, Hamilton, & Sinclair, 1991, v.1, ch. 14).

In 1951 the federal government amended section 88 of the Indian Act to provide provinces with the legal capacity to administer provincial child and family services to people outside their constitutional jurisdiction (Bennett, 2001). This relinquished federal responsibility for enacting First Nations child welfare legislation. Provincial responsibility for providing child welfare services onto reserves was confirmed in 1976

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<sup>9</sup> The Aboriginal Justice Inquiry (Hamilton & Sinclair, 1991) pointed out that child welfare expansion into Aboriginal communities was led by a burgeoning social work profession looking to cement its niche, increased visibility of Aboriginal peoples migrating to urban centres for employment, and a lack of understanding of Aboriginal culture. As Chief Judge Kimelman explained, “Cultural bias in the child welfare system is practiced at every level from the social worker who works directly with the family, through the lawyers who represent the various parties in a custody case, to the judges who make the final disposition in the case” (1985, p. 185)

by the Supreme Court of Canada (*Natural Parents v. Superintendent of Child Welfare*, 1976, 60 D.L.R. 3rd 148 S.C.C.) (see Bennet, 2001). Despite increased responsibility, the federal government did not provide the provinces money for the new child welfare responsibilities (Bennett, 2001).

The expansion of child welfare and protection services into Aboriginal communities has led to an explosion of Aboriginal children/youth placed into care. Prior to 1960 only 1% of children/youth in care were Aboriginal (Bourassa, 2010). Present numbers indicate that 85% of youth/children in care in Manitoba are Aboriginal (Kozlowski et al., 2011). This dramatic rise in Aboriginal children/youth in child welfare placements has led to the contention that the child welfare system is taking the place of residential schools. For instance:

Gradually, as education ceased to function as the institutional agent of colonization, the child welfare system took its place. It could continue to remove Native children from their parents, devalue Native custom and traditions in the process, but still act “in the best interests of the child.” Those who hold to this view argue that the Sixties Scoop was not coincidental; it was a consequence of fewer Indian children being sent to residential school and of the child welfare system emerging as the new method of colonization (Johnston, 1983, p. 24).

To counteract these claims and in recognition of the inequities in numbers of Aboriginal and non-Aboriginal children/youth in care, several inquiries into the child welfare system have occurred. Most damning have been the 1982 inquiry by Judge Kimelman which concluded the child welfare system is guilty of “cultural genocide” and the 1991 Aboriginal Justice Inquiry (AJI) which concluded that the child welfare system

is “paternalistic and colonial in nature, condescending and demeaning in fact, and often insensitive and brutal to Aboriginal people” (Manitoba, Hamilton, & Sinclair, 1991, v.1, ch. 14).

The 1991 AJI report made several recommendations for major changes to Manitoba’s child welfare system including mandating a province-wide Metis agency and expanding the authority of Aboriginal agencies to provide service to members living off-reserve (Manitoba, Hamilton, & Sinclair, 1991, v.1, ch. 14). It was not until a decade later, in 2000, that the Manitoba government established the Aboriginal Justice Inquiry-Child Welfare Initiative (AJI-CWI) to restructure the child welfare system based on the 1991 AJI findings (Kozlowski et al., 2011). Through the efforts of the members of the AJI-CWI, new legislation, *The Child and Family Services Authorities Act* accompanied by *The Child and Family Services Authorities Regulation*, were proclaimed in 2003 (see Manitoba Family Services and Labour, 2013 for links to legislation). This created a new governance and service delivery model for child and family services in Manitoba. In particular it established four Child and Family Services Authorities and devolved a number of powers and duties that were formerly held by the provincially appointed Director of Child Welfare to the authorities. These included all powers and duties directly related to child and family services (CFS) agencies and foster homes.

As well, service provision shifted from a geographic model to a mixed “geographic” and “concurrent” jurisdictional model (see, Department of Family Services and Housing, 2006). In the traditional geographic model, service provision depended on location of the families. In the mixed model, initial intake is based on geography; however, with concurrent jurisdiction in place, families are not required to receive service from any one specific authority. Families have the ability to select the authority from

which they wish to receive child and family services through completion of a questionnaire called the *Authority Determination Protocol* (ADP). The ADP serves two purposes: it identifies the culturally appropriate authority of service and identifies the authority that the family selects as the service provider (Child and Family Services Authorities Act, 2003). Ultimately, however, the choice of which Authority to receive services from is left to the family regardless of whether the Authority is culturally appropriate or not.

During the overhaul of Manitoba's entire child welfare system, workloads increased and many social workers feared they would lose their jobs (Bourassa, 2010). At this time, several high profile child deaths occurred, including the death of five year old Phoenix Sinclair. In response, three external reviews were conducted into Manitoba's child welfare system. The reports produced from these reviews led to the 2006 document called "Changes for Children: Strengthening the Commitment to Child Welfare" (Department of Family Services and Housing, 2006). One of the key recommendations in this document was the development of a new *differential response* model of service delivery where families are assessed at the point of intake to determine eligibility for services (Department of Family Services and Housing, 2006, p. 8). Once eligibility is determined, a Differential Response worker will work with families to reduce their dependence on the child welfare system. The idea is to intervene early and offer services in accordance with the presenting situation and assessed needs.

Another important historical issue has been the jurisdictional disputes between the federal and provincial government in providing child welfare resources for Aboriginal children and youth. Child welfare is a provincial responsibility; however, Aboriginal peoples fall under the jurisdiction of the federal government. In 2011, Manitoba moved to

an *Enhanced Prevention-Focused Funding* federal formula (Kozlowski et al., 2011). This new funding model sees core and service delivery funding to First Nation CFS agencies as a shared responsibility with core items funded at 60% province and 40% federal (See, AANDC, 2010).

However, allegations continue to mount that supports and services for Aboriginal children/youth in care are underfunded compared to their provincial counterparts. On February 25, 2013, the Attorney General of Canada appeared before the Canadian Human Rights Tribunal to face allegations by the First Nations Child and Family Caring Society of Canada (FNCFCS), Assembly of First Nations and Canadian Human Rights Commission of racial discrimination for the inequitable funding for First Nations child and family services (FNCFCS, 2013). The Canadian government is arguing that the new Enhanced Prevention-Focused Funding formula is addressing the inequities; however the Auditor General of Canada (2008) and the Standing Committee on Public Accounts (2011) have “reviewed the enhanced prevention focused approach and found it to be flawed and inequitable” (FNCFCS, 2013, ¶3).

### **Macro-Level: Social Context and Trends in Medicating Youth in Care**

At the broader level, studies indicate an increasing trend towards the prescribing of psychotropic medication to children and youth (Raghavan et al., 2005). However, there has been only one cross-national study completed to date on the use of psychotropic medication on children and youth in care (C/YIC) in Canada. This study, by Lambe & McLennan (2009), found that over 70% of their sample was prescribed psychotropics while living in the system. A panel of experts convened in Ontario in 2009 supported this finding. These experts, which included child welfare social workers, acknowledged that

the use of psychotropic medications on children and youth in care is quite common and that new child welfare protocols need to be developed (Ontario Expert Panel, 2009, p. 2).

The increasing trend towards prescribing psychotropics to children/youth in care is indicative of pharmaceuticalization. Pharmaceuticalization is the expanding use of medicine and medical technology for reasons that may or may not have been decided by physicians and the medical profession (Busfield, 2010; Williams, Gabe & Davis, 2009). As the clamour for more and better medical knowledge intensifies in the consumer driven economy, information and biotechnological research has exploded (Rose, 2003). Since 2000, there has been a dramatic rise in the individual pursuit of health and consumer influence, an expansion of medical markets, and increased importance placed on science, biotechnology, genomic research and pharmaceutical innovation (Conrad, 2005; 2007, pp. 16–19; Timimi, 2002, p. 32). During this period, a diverse array of individuals, organizations, and groups have been making claims about illnesses and medicalizing conditions (Lee, 2006).

Chemical solutions are sought not only by doctors and psychiatrists, but also by educators, social workers, parents and individuals themselves. By changing brain chemistry through medication, individual thoughts, feelings, and actions can be adjusted. This has led to the development of *neurochemical selves* where everyday feelings and behaviors are recoded in terms of their neurochemistry and this recoding causes individuals to understand their “minds and selves in terms of [their] brains and bodies” (Rose, 2003, p. 46). For example, being shy is now understood as a disorder called social anxiety caused by a chemical imbalance in the brain. This, in turn, can be adjusted and treated with pharmaceuticals.

Research has also established that psychotropic medications are increasingly prescribed to youth in care off-label, i.e., for unapproved indications. For instance a study by Lyons and colleagues found that youth in care, “without evidence of psychosis [received] antipsychotic medications” (2004, p.102). Further, a 2007 study on the prevalence of mental disorders among children/youth in care in Ontario discovered that the rate of conduct disorders was lower than expected (5.1%) and that none of the children/youth were diagnosed with psychosis (Burge, 2007). These findings suggest that even though prescriptions for psychotropic medications are high, the use of these medications for approved indications may be low. However, it is well documented that children/youth in care have often suffered so many traumas and so much abuse, grief, and stress that social workers see a very real need for medical intervention (Green, Hawkins & Hawkins, 2005; Lambe & McLennan, 2009; Moses, 2008). The child/youth may be depressed and anxious and, therefore, psychotropic medication may be viewed, not only by the worker but also by the child/youth and the placement household, as a necessary and reasonable way to ameliorate the difficulties the child/youth is having in dealing with their life issues (Lambe & McLennan, 2009). In order to change negative behaviors and combat these children/youth’s emotional issues, social workers and others interacting with the children/youth may pharmaceuticalize the issue and recommend medical assessment and/or treatment. Modifying moods, thought, and conduct can then help the social workers integrate these children/youth into what is deemed normal society and to manage the risk they pose to themselves and others (Rose, 2003).

Disorders of thought, mood and conduct come under the purview of medicine through the increased salience and knowledge of health within society. Furthermore, medicine and pharmaceutical corporations claim that differences in biology and

neurochemistry trigger deviations in actions and thoughts which can be controlled and modified by medications (Rose, 2003). Societal acceptance of the knowledge claims of medicine and pharmaceutical corporations has led to individuals routinely using and demanding medications to alter behavior and thought (Rose, 2003). This has created what Rose (2003) calls the *psychopharmacological society*, or a society dependent upon psychopharmacologic treatments for all disorders of mood, thought and conduct. However, the increased use of psychotropic medication on children and youth in care in Canada is not just the result of the growing power of individuals, professions, and groups to demand more and better medications; it is also reflective of the reduction in supports and services characteristic of a residual approach to social welfare.

**Residual Approach to Social Welfare.** The 1943 Marsh Report heralded a period of universal and comprehensive social welfare and the introduction of an institutional model of social policy in Canada (Graham, Swift, & Delaney, 2009). In an institutional approach, the state is responsible for developing social policy and programs that meet the needs of its citizens and welfare services are considered normal. Thus, individuals have a right to welfare services if needed so that they can reach their full potential. However, in the late 1970s and early 1980s, with the advance of the neoliberal agenda, Canada's approach to social welfare began to change.

Neoliberalism is a political ideology strongly associated with the economic doctrines of *laissez-faire* which asserts the importance of a free and competitive market, deregulation of industry, and privatization of services (Navarro, 2007). Neoliberalism is reflected in the erosion of social policies and programs throughout the 1970s up to the present in Canada. The 1970s saw cutbacks begin in education, health and welfare programs, while the 1980s saw the growth of punitive social programs, food banks, and



workfare (Hick, 2010). From the 1990s to the present, there have been even more attempts to dismantle the welfare state and transfer costs to the provinces and municipalities through privatization of universal programs, greater movement towards workfare, regressive taxes, and cuts to women's, immigrant's and Aboriginal peoples' programs (Hick, 2010).

The growth of neoliberalism has led to the adoption of residual social welfare, where state assistance is “temporary, minimal, requiring evidence of need, and available only after all other avenues of help have been exhausted” (Hick, 1989, ¶1). Residual social welfare policies and programs are stigmatizing, coercive and there are strict eligibility criteria (Hick, 2010). In light of the current retrenchment of social services and the emergence of a residual approach to the welfare state, social workers in Canada are facing added pressure in their assessments and calculations for intervention.

The growing emphasis on future possibilities of harm and risk requires social workers to exhibit actuarial expertise in their responsibilities towards children and youth in care (Smith, 2010; Weinberg, 2010). This is readily apparent in Manitoba's shift towards a Differential Response model for child welfare service delivery. Differential Response uses a casework model to determine eligibility for services. Families are deemed eligible for services through the use of assessment tools that determine risks to children and youth. In other words, social workers must evaluate carefully to ensure the safety of the child/youth, themselves, their profession, and society. In making their calculations and assessments, social workers must be able to measure and “specify the nature and the extent of the threat offered from a particular source, and the most appropriate means of taking action to eliminate it” (Smith, 2010, ¶8.7). Thus social work

practice may have shifted from a focus on the needs of the youth to the “assessment and management of risk” (Healy & Meagher, 2004, p. 95; Warner, 2008, p. 34).

Decreasing financial support, higher caseloads and greater administrative responsibilities leave less time for social workers to spend evaluating and helping the children and youth in their care (Hick, 2010). This may lead social workers to a greater predilection for medical intervention and seeking medications for the child/youth. For instance, several studies argue that part of the reason why there is such widespread use of psychotropic medications in the child welfare system is that it is an easier, quicker, and cheaper approach to controlling behavior, enforcing compliance, and restraining perceived aggression than counseling (Green, Hawkins & Hawkins, 2005; Lambe & McLennan, 2009; Moses, 2008; Zito et al., 2008).

A residual approach to social welfare also means that government involvement in child welfare and protection occurs after all other avenues of support and intervention have failed (Hick, 2010). The residual approach adopts the philosophy of *apprehension as a last resort*<sup>10</sup>. Apprehending as a last resort often means that youth enter the system later, after having experienced a lot more trauma and neglect (Moses, 2008)<sup>11</sup>. This leads to the possibility of more dysfunctional behavior and mental health problems (Moses 2008).

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<sup>10</sup> The residual approach to welfare is not the only reason the philosophy of apprehension as a last resort is adopted. It is also seen as more cost effective for the provinces and territories and less disruptive for the youth (Hick 2010).

<sup>11</sup> While entering the system later may mean that the youth has suffered more trauma(s), apprehension as a last resort is often seen as a more family-centered, rather than state interventionist, approach. The “Sixties Scoop” serves to illustrate one important reason why this approach has been adopted by child welfare authorities. Patrick Johnston coined the term “Sixties Scoop” to describe a national phenomenon where provincial child welfare social workers apprehended many Aboriginal youth and placed them in non-Aboriginal homes for adoption. Johnston noted in his 1983 report that Aboriginal children were 4.5 times more likely than non-Aboriginal children to be in the care of child welfare authorities. As a result of the interventionist approach, many Aboriginal youth lost a connection to their culture and language; in what Aboriginal leaders have called a form of “cultural genocide” (For more information see Volume 1, Chapter 14, of the November 1999 Report of the Aboriginal Justice Inquiry of Manitoba).

Medication, then, becomes an extremely important and necessary method of helping these youth deal with their pain, distress and mental health concerns (Moses, 2008).

### **Meso-Level: Roles and Experiences**

I am unaware of any studies that focus explicitly on Canadian social workers' experiences with children/youth in care on psychotropic medication. The 2009 Canadian cross-national study by Lambe & McLennan did examine front line workers' experiences with medicated children and youth in care, but it is unclear how many of these participants were social workers with a professional designation rather than support or service workers. However, in this study, participants described a vast array of positive and negative experiences they have had, including medication being used to control the child or youth, medication being used inappropriately, and the benefits of the medication for mental illness. In another study of US social workers, Moses (2008) found that social workers feel psychotropic treatment has more beneficial than harmful effects on youth in their caseload; in an earlier study by Moses and Kirk (2006) a majority of the social workers felt that medication is not being used as a method of social control and is an important part of their work with troubled youth.

From a social psychological perspective, how social workers define an experience or situation with a child or youth in care on psychotropic medication, shapes what meaning the experience has for them. The social worker then acts on the basis of this definition. Therefore, the experience of the social worker with the child or youth that guides their action is both a subjective and shared reality. It is subjective when they mentally represent the situation to themselves and then choose their course of action based on their assessment. It is shared in that the social worker will act, "on the basis of a

definition that more or less resembles the definition held by others” (Hewitt, 2007, p. 144). Meaning depends on the individual’s perception of the situation and the perception of the situation depends on the configuration or pattern it is placed in.

Perception of the situation also guides the role that one will assume. Here a role can be viewed as a group of duties, rights and obligations associated with a particular social position (or status). However, used by itself, this definition is quite deterministic. Instead, a role is also a “configuration of ideas and principles about what to do in a situation” (Hewitt, 2007, p.63). For instance, the social worker role would not just consist of a list of things a social worker must do, but would also consist of more general ideas about how a social worker relates to clients and others in various situations in which they interact. By incorporating this idea of ‘configurations’ into a definition of roles, both structure that influences actions and the pragmatic and creative aspect of individuals are emphasized. In other words, roles are not just imposed, fixed or ascribed; rather they are also fluid and something that can be achieved (see Hewitt 2007, pp. 66–69 for a discussion on roles).

There is ambiguity in the literature, however, regarding what role social workers should or ought to play in the mental health treatment. For instance, some authors have argued that social workers must act as support for and collaborators with the physician or psychiatrist (Levine & Dang, 1977; Mizrahi & Abramson, 1985). Others suggest that social workers should, first and foremost, attend to the wants and needs of their client (Mullaly, 2007; Parton, 2004). Thus, according to the literature, tension exists between acting as a physician’s assistant and a client’s advocate.

Concomitantly, there are debates regarding the sphere of social work practice. Some literature suggests that social workers dealing with clients’ mental health issues

should use a predominantly medical model in their practice (Kane, 1982). Other authors argue that social workers must turn away from the medical model and focus solely on the environmental, psychosocial concerns of the client (Cohen, 1988; Murphy, et al., 1994). In terms of the roles that social workers play in the medication treatment process, Bentley, Walsh & Farmer (2005) found that 72% of their sample of social workers in the United States said they refer a client to a prescriber “often or very frequently” in a typical month. Similarly, in a 2006 study by the Ontario Association of Social Workers, 87% of the 339 mental health social workers surveyed said that their major role in treating mental health issues was assessment and referral for treatment, while 60% stated that advocacy also played a key role. However, neither of these studies focused specifically on the mental health needs of children/youth in care.

Bentley and Walsh (1996; 2006) suggest that social workers can engage in several medication-related roles, including being a physician’s assistant, a monitor, a consultant/collaborator, an advocate, and an educator. In 2006, Bentley and Walsh added the role of counselor to their list of roles social workers may play in medication management. According to Moses (2003), the social worker’s role as physician’s assistant entails accepting the physician’s medication decision and helping clients follow doctor’s prescriptions. Meanwhile, the role of monitor entails observing and tracking compliance, symptoms, and effects of the medication. The role of a consultant/collaborator refers to the ability of social workers to screen potential cases for the need for medication. The role of advocate conforms to the underlying values of social work wherein it is the duty of the social worker to protect the client’s interests and rights. The role of counselor is one where social workers provide practical help and teach problem solving skills to the client. The counselor provides information and advice about medications to the client, identifies

alternatives, and assists in making decisions (Bentley & Walsh, 2006). Finally, social workers can also play the role of educator when they take on the job of explaining to the client the reason they were prescribed psychotropic medication and the potential side effects of medication (Moses, 2003).

In order to perform certain actions or roles, one needs to perceive that they have the power and control to do so. Thus, to better understand the roles social workers may play in the medication treatment and assessment process, I turn to Michel Foucault's concept of *pastoral power*. Decision-making about the risks and benefits of psychotropic medication and the role one plays in these determinations takes place within a set of pastoral power relations (Rose, 2001). In these power relations, the duty of the pastor is the salvation of the entire flock; and, at the same time, the pastor has a duty to watch over each member of the flock separately (*omnes et singulatum*) (1979, p. 237). While this may seem as though the role is pre-determined, as previously outlined, the social worker has individual agency in choosing the role that they play within a set of guiding principles and based upon how they have defined the situation.

Contemporary pastoral power is not necessarily administered by the state or institution of medicine. Rather it operates through criteria established by organizations and agencies, through psychological testing and assessments and through ethics committees and professional associations to name but a few (Rose, 2001). As such, pastoral power can be seen as operating between treatment gatekeepers and potential patients. In other words, pastoral power is an intermediary power that corresponds to professional boundaries of social work practice.

Social work is a profession that acts as an important and socially valued conduit between the lay world and the world of the expert. It has been referred to as a profession

of “interstitiality”; one that occupies the space between professions (Abbott, 1995, p. 549). For Foucault (1984), when the family fails to maintain and develop the child’s body, the child welfare and protection system steps in and takes over, acting as the foot soldiers of the state. These power techniques endowed to workers within the system and oriented towards the child or youth allows the child/youth to be ruled in a continuous and permanent way. This is what Foucault has referred to as a *pastoral modality of power* (1979, p. 227).

If we apply the concept of pastoral power to the child welfare system, the children and youth in care can be understood as the pastorate with social workers playing the role of pastors. The role of the social worker is to ensure the well-being of all of the children and youth in their caseload while also remaining concerned with the development of each individual child or youth. Part of their role may include observing them, utilizing psychological risk assessments and determining whether medical intervention is needed.

Foucault observes that, “the pastor must really take charge of and observe daily life in order to form a never-ending knowledge of the behavior and conduct of the members of the flock he supervises” (2007, p. 181). This too may be reflected in the work that social workers are asked to perform. The goal of the social worker is to help youth in care emerge as functional members of society. By combining the elements of observation, individualization, and classification, social workers can begin to alter and shape the youth’s behavior and induce them to engage in disciplined ways which may include referral for medical treatment and assessment.

To summarize, social workers have many potential roles that they can play in the medication assessment and treatment process for youth in care, including acting as physicians' assistants, monitors, consultants/collaborators, advocates, and educators.

Further, social workers operate within a pastoral modality of power where they are charged with the task of integrating the children/youth in their care into the wider social system through corrective training. One aspect of this may be monitoring, assessing, and evaluating the need for medical intervention and thus the social worker may be an assistant, educator, monitor, collaborator or advocate singularly or simultaneously. However, the potential roles and spheres of social work practice in terms of the medication management of children/youth in care are not only determined by their position within their field, but is also guided by their individual interpretation of the situation and what meaning the situation has for them.

### **Micro-Level: Attitudes About Medicating**

Social workers in Canada can potentially have many different experiences with medicated children/youth in care and can potentially play many different roles in the medication assessment and treatment process. The roles that social workers play have both cognitive and affective components. In other words, people's actions are grounded in both thoughts and feelings and these thoughts and feelings make up one's attitude.

Attitude consists of an internalized interpretive framework of cognitive, affective and behavioral dimensions that are conditioned by position in the social structure (involving individual roles and status sets) (Breckler, 1984; Scherer, 2005). Attitude influences how people perceive their circumstances and determines the value of certain practices compared to other practices (Dumais, 2002). Thus, as the social structure influences individual attitudes and ways of understanding, so too do practices contribute to the perpetuation of the social structure.



Attitudes develop through *configurations of cognitive structures* (formed through personal experience or from an external source such as a valued friend who shares one's beliefs and experiences). To better understand the cognitive dimension of attitude, we can draw upon the social psychological concept of *schemata*. Schemata are outlines or conceptual frameworks that contain information and guide interpretations of individual experiences, situations, objects, and ideas. They structure how we know the world, remove what is irrelevant and allow "sense to be made of partial information" (Hodkinson & Sparkes, 1997, p. 34). They also help individuals predict the behavior of others and choose a course of action (Hewitt, 2007).

When the situation is ambiguous, individuals will use a *schema*, typically an exemplar (or best example). For instance, social workers may see an Aboriginal youth acting out and immediately come to the conclusion that it is FASD. Behavior is highly dependent upon memory—the storage and retrieval of information about a past situation, idea, or object that is part of one's cognitive schemata (Hewitt, 2007). Schemata can be, therefore, modified incrementally as new information and experiences are encountered and, as such, are not static (Hodkinson & Sparkes, 1997).

Attitudes can also be shaped by affective reactions to situations. Typically emotions are conceptualized as an internal response that individuals have little control over or, in other words, are a "nonreflective emotional experience" (Denzin, 1984). However, emotions are also objects to interpret, define and act upon (Charon, 2010). Individuals interpret stimuli which trigger internal responses (e.g. death). They then they define it (e.g. sadness), evaluate it (e.g. negative), and act upon it (e.g. express or repress the emotion or store it for future recall) (Charon, 2010, p. 132). Individuals may also *manage* their emotions and make oneself feel or not feel through a process that

Hochschild has referred to as “emotion work” (1983). Emotions, therefore, are an important part of our attitudinal structure, particularly as we correlate different situations with various emotions which then become judged as positive or negative.

Finally, attitudes are also formed or changed by reflecting on past behaviors or habits. According to Bem’s (1972) theory of self-perception, we come to know ourselves and our attitudes by recalling our earlier overt behavior. So for example, a social worker may be unsure how they feel about medicating children/youth in care with psychotropics. They may then examine their memories for how they behaved in a previous situation with a child in care prior to being able to infer whether or not they are positively or negatively predisposed towards medicating. Thus, if they remember taking a child to the doctor for medication, then they are more likely to state that they feel positively about medicating children/youth.

Furthermore, people strive for consistency in their cognition, feelings and attitudes and as such they may alter their attitudes so as to align them with their behavior. In other words, the discovery of inconsistency creates a state of cognitive dissonance (Festinger 1957/1962) which motivates people to restore consistency (with themselves). For instance, a social worker may, in the present, feel they are negatively predisposed towards medicating C/YIC with psychotropics, but their past actions have not reflected this. Therefore, even though they now have a negative attitude towards medicating C/YIC, they are motivated to change their attitude so that it aligns with their past behaviors. Or, on the other hand, they may decide to reinterpret their past behavior so that it aligns with their present attitude.

Individuals categorize, create boundaries, differentiate between objects and frame their beliefs in accordance to things they like and things they do not like (Zerubavel,

1991). Attitudinal framing involves surrounding a situation, act, or object with a mental bracket to differentiate between positive or negative feelings, thoughts and behaviors (O'Brien, 2006). These distinctions between positive and negative also go back to systematically influence feelings, thoughts and behaviors (Eagly & Chaiken, 1998).

Through its influence on behavior, attitude may modify the social structure while at the same time, the social structure, through its influence on experience, can alter attitude. In terms of social workers, attitudes towards medicating C/YIC are linked to the roles social workers play in medication management, the experiences they have with medicated C/YIC, and the overall child welfare structure. The question is, therefore, how do Manitoba social worker attitudes towards medicating C/YIC go back to affect the pharmaceuticalization trend? Further, are Manitoba social workers attitudes towards medicating C/YIC more positive or negative?

Johnson and colleagues (1998) found that more than two thirds of their sample of social workers felt that drugs are “often helpful” in treating youngsters' emotional disorders. However, more than half of their sample (n = 177) disagreed or strongly disagreed with the statement “For many psychiatric disorders in children and adolescents, medication is necessary”, whereas 45.5% (n = 152) agreed or strongly agreed with this statement. This led Johnson and colleagues to conclude that in their study some of the social workers felt that “medication is helpful but not necessary; others believed that it is neither necessary nor helpful; and still others agreed that medication may be both helpful and necessary” (Johnson et al., 1998, p. 183).

Several other studies that examined social workers' attitudes towards psychopharmacologic treatment in the United States suggest that social workers feel more positive about drug treatment than other mental health professionals (Bentley, Farmer &

Philips, 1991; Raskin, et al., 1988). While the literature on opinions about medication is limited and in some respects contradictory, attitudes may ultimately be shaped by the type of roles social workers play in medication management and their experiences with medicated children/youth.

To summarize, social workers may have many different attitudes towards the medicating of children/youth in care. Cognitive and affective components and past behavioral habits underlie these individual attitudes. Attitudes are conditioned by structural position (roles) within a particular time and space (social structure and situational context). Attitudes also guide action which can transform a situation and alter the structure. Individual attitude can then serve as a vehicle for both the reproduction and change of the social structure.

### **Summary and Presentation of the Analytical Model**

Based upon the literature review and theory, we can understand Manitoba social workers and the medication phenomenon thusly (*see figure 1 below*):

**Social Structure (Macro).** There is evidence that children and youth in care in Canada are medicated at a much higher rate than youth not in care. This pharmaceuticalization of children/youth in care is in part reflective of a growing societal trend towards the increased use of medication (what Rose refers to as the development of the psychopharmacological society). However, children and youth in care may be more susceptible to pharmaceuticalization due to their terrible life experiences that may lead to more behavioral and/or mood disorders. With retrenchment of programs and services due to a residual approach to social welfare, social workers are charged with finding the most cost-effective and efficient solution to mood and conduct disorders. Further, in their

assessments, social workers are also charged with calculating future risks and benefits. As such, medication may be viewed as the best option available since counseling and alternative therapies are often time consuming and expensive.

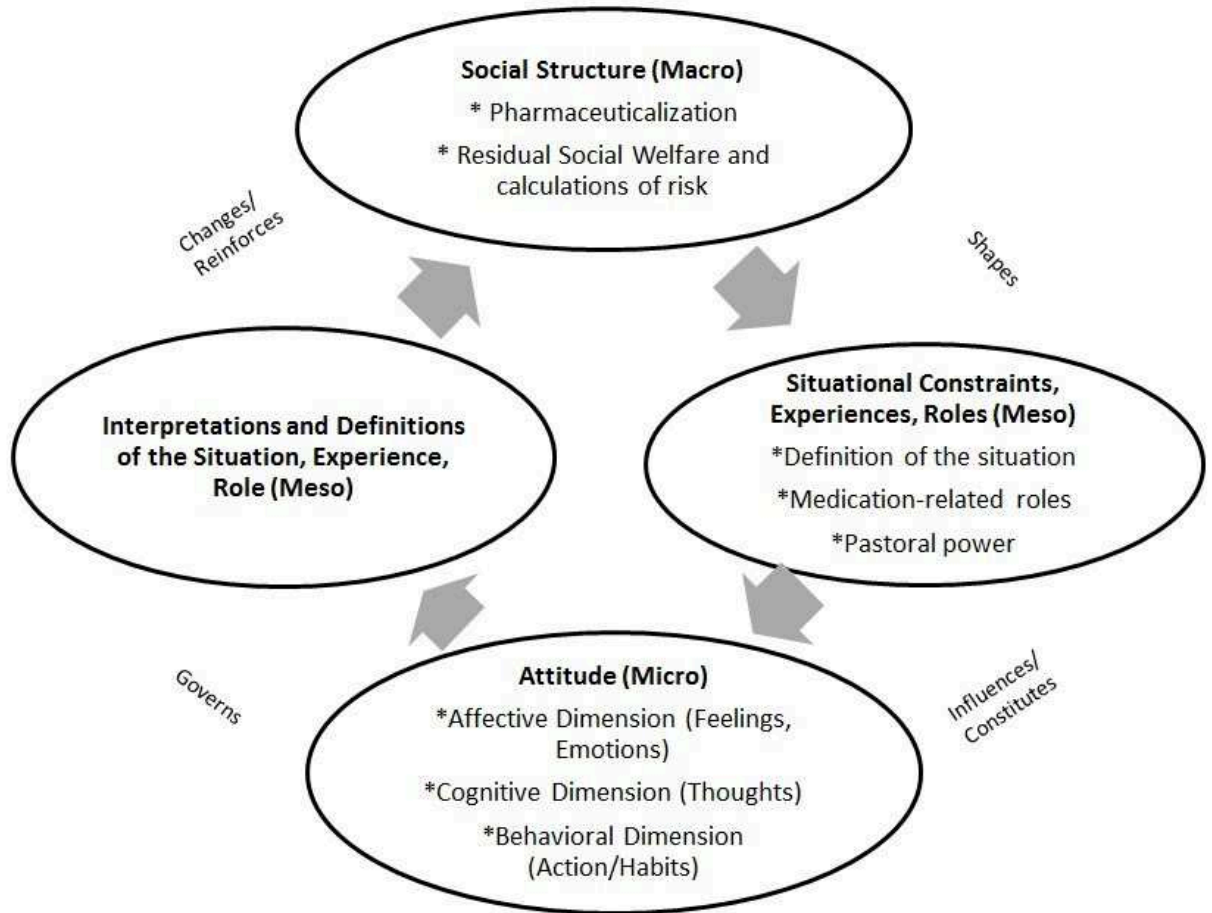
**Situational Constraints, Experiences, Roles (Meso).** Social workers must operate inside the constraints of a residual social welfare system which directly influences their available resources and actions. Within a social structure such as this, they may have a number of different positive and negative experiences with children/youth on psychotropic medication. How they define these experiences and situations both past and present determines how they will act and what role they will play.

Since the territory of social work with children/youth is between the child/youth, the state and other professions like medicine, social workers operate within a pastoral modality of power which also guides their actions. The social worker's duty is to help the child/youth become a functional member of society. Therefore, the decisions social workers make about psychotropic medications and the roles they play in these determinations takes place within a set of pastoral power relations in a society that increasingly relies on chemical solutions in a social welfare system that is being retrenched.

**Attitudes (Micro).** The actions, experiences and roles that social workers play are also grounded in their attitudes. These attitudes include cognitive dimensions (thoughts), affective dimensions (feelings) and behavioral dimensions (past habits and actions). Social workers make sense of their situation based on prior cognitive and affective schemata as well as habits that are shaped by past experiences and conditioned by their present position. Situational constraints, experiences and roles influence the attitudes of social workers. However, attitudes also govern the interpretations and

definitions of the situation, experiences and roles the social workers play. Therefore past and present collide within the individual and can either change or reinforce the social structure.

Figure 1: Analytical Model: Connecting the Three Levels of Literature and Theory



## Chapter 4 – Macro Social Structure and Social Worker Perspectives

Just as I turn to leave the small dark CFS office to make my next appointment,

Colleen calls out to me:

*You've gotta read this book, this Holocaust book. The author studied children of the Holocaust and found that kids who stayed with their biological parents, even if caught by the Germans and always on the run, those kids were better off. They were healthier and happier you know than kids who were given up by their parents to other families. What does that tell you? No matter the faults and flaws in a home, it is better to find a way to keep a kid with their family.*

I'm rather skeptical about whether or not it's true and make a mental note to look for the book later. She senses my skepticism and says:

*This system is not the answer you know. It's just causing a lot of pain for the children. They are feeling rejected and abandoned and those are big issues. Of course they lack attachment because they're not with their parents, you know what I mean? Maybe the parents are drinking and are neglectful but if we could just work with them more, you know?*

That evening I search for the book that Colleen recommended, but can't find it.

However, I do find several journal articles by Marianne Amir and Rachel Lev-Wiesel on Holocaust survivors. They write:

Recent studies [...] have shown that certain groups within the child Holocaust survivors have more psychological distress than others. For instance, child survivors that were in foster families were found to have a lower quality of life (QoL) and more psychiatric symptoms than child survivors who had hid in the woods and/or were in concentration camps (Amir & Lev-Wiesel, 2003, p. 295).

As I read through the articles, Colleen's words keep echoing in my mind, "This system is not the answer you know". I wonder what is not working in the system and whether these

issues are contributing towards the trend to medicate children and youth in care with psychotropics.

It is a basic sociological tenet that subjective interpretations are formed by location within social structures. Social structure is important to values, beliefs, attitudes, and dispositions because social structures affect more immediate conditions and experiences. Regardless of whether actors understand or notice them, situations often have consequences. Consequently, in this chapter I provide analysis for data related to Manitoba social worker perspectives on the broader social (macro-level) context that is affecting the trend towards medicating children/youth in care. More specifically I examine what participants say about: 1) the general trend towards medicating children/youth in care with psychotropics; and 2) how the overarching systems of education, medicine and child welfare are contributing to this trend.

### **The Pharmaceuticalization of Children/Youth in Care**

As previously described, pharmaceuticalization is the expanding use of medicine and medical technology in society (Busfield, 2010; Williams, Gabe & Davis, 2009). A number of different studies have indicated that well over 40% of children/youth in care in Canada are prescribed psychotropic medications (Lambe & McLennan, 2009; Philip, 2007; Ontario Expert Panel, 2009). In my study, there were 26 participants from varying fields of practice who knew the number of C/YIC in their caseload who are on psychotropic medication. The average percentage of C/YIC on psychotropic medication for these participants is 48.2%. This is substantially less than the 70% found in the 2009 Lambe & McLennan Canadian study, but it is still much greater than the 10 to 20% of children/youth not in care.



In my study the average number of C/YIC on psychotropics varies by field of practice, with CFS/Child Welfare social workers reporting the lowest average number at 35.0%. This number jumps to 89.5% of C/YIC for participants within the child/adolescent mental health field and 69.6% in the combined others field (see Table 2). It is understandable that participants in the child/adolescent mental health field have higher numbers of C/YIC on their caseload taking psychotropic medication than the other fields because the very nature of their work is to deal with the most mentally and behaviorally troubled children/youth. The combined other fields (including school social work, private practice and outreach social work) may not have as accurate recall as social workers within the child welfare system and mental health sector because they deal with a variety of clients besides children/youth and may not keep a case file that includes medication notations.

**Table 2: Percent of C/YIC on Psychotropics by Field of Work**

Field of Work	Average No. Caseload	Average No. C/YIC	Average No. C/YIC on Psychotropics	% of C/YIC on Psychotropics
CFS and Child Welfare (n=15)*	26.26	16.40	5.73	35.0%
Child and Adolescent Mental Health (n=4)	25.75	9.50	8.50	89.5%
Other (n=7)**	24.43	11.43	7.86	69.6%

*\*Note: 5 participants removed from analysis because they did not know numbers of youth in care or numbers on medication*

*\*\*Note: 3 participants removed from analysis because they did not know numbers of youth in care or numbers on medication*

An implicit assumption of the research is that there is a trend towards medicating children/youth in care. Therefore, participants were not asked whether or not they have noticed a trend to medicate. Instead they were asked to describe structural, institutional and organizational factors that may be affecting the trend towards medicating.

Interestingly, five of the 34 participants made it a point to mention that they have not noticed a trend. For example:

*I have not seen a trend [...] towards the use or increase in the use of psychotropic medication (Debra, Developmental Disabilities Worker).*

*[...] nothing is really a trend towards medicating children (Amanda, Adolescent Mental Health).*

The vast majority of participants (29), however, accepted that there is a trend towards medicating children/youth in care with psychotropics.

*We do see a lot of children on medication come through our program (Ellen, Child Welfare).*

*More kids in care are on these medications than in the general population (Maggie, Child Welfare).*

*I wouldn't be surprised if the number is higher than 50% of children in care to be medicated... (Joshua, CFS)*

*When I worked in a group home the majority of the youth were on psychotropic medication (Linda, Clinical Social Work).*

Several of the participants (23.5%), while agreeing that there is a trend to medicate C/YIC, also mentioned that medicating is understandable considering the amount of trauma and suffering that the children/youth experienced prior to coming into care.

*It does not strike me as unusual that we see higher rates of medication use because the problems that bring kids into care, often parents' mental illness and substance abuse, are likely to impact the children through FASD or genetic predispositions to mental illness (Maggie, Child Welfare).*

*Children in care have experienced psychological scars unknown to most of their peers, which contributes to high numbers of children in care who are medicated (Sally, CFS).*

*[...] more children in care are on medication than in the not in care child population. I think some of their issues are way more complicated because*

*of abuse, because of neglect. Like, you don't end up in care for no good reason which is a common misconception (Karen, Child Welfare).*

Grief can be an essential part of the separation anxiety experience of the child/youth in care as they react to separation and loss (Jacobs, 1999, p. 2). Attachment issues begin to arise when the child/youth is first removed from their family home. The child/youth may be removed because their parents are deemed “unfit” to care for them or because there is no one to care for them adequately, which, in turn, may cause further trauma. As Lambe & McLennan argue,

From the moment child welfare removes a young person from the family home, literally everything can change overnight. In addition to meeting their new social worker, caregivers and other children or youth living in the placement, they may have also been moved to a new community, necessitating a change of school, physician, and the list continues. This type of move can also interfere with their friendships, relationship with siblings and other family members. In short, the young person's identity has been altered (2009, p. 11).

All of the feelings and emotions that stem from the upheaval in the youths' lives, compounded with the previous traumas and attachment issues, may alter their behavior. However, participants suggested that this is not the only reason why psychotropics are being increasingly prescribed.

## **Perceptions of Social Structures Affecting the Trend towards Medicating C/YIC**

Participants mentioned three predominant, intersecting social structures which they feel are influencing the trend towards medicating C/YIC with psychotropics. These include the child welfare system, the education system, and the medical system.

**The Child Welfare System.** Study participants described two general areas of concern regarding the child welfare system and its involvement in medicating C/YIC. First, participants talked about a system focused on market economics and corporatist practices which suggest a return to a residual approach of social welfare. This, participants explained, causes greater reliance on psychotropic medications for the emotional and behavioral needs of C/YIC. Second, participants suggested that the children and youth who are entering the system today (as compared to the past) are doing so with more complex needs which increase the risk that these children/youth pose to themselves and others. Therefore, medication is often the only option social workers may have available to them to manage these risks.

***The Residual Approach to Social Welfare.*** Social work, as a profession, is not free from historically based cultural values or the political structure of society; rather it depends on these relations to guide its practices. The political turn to a residual approach to social welfare means that social workers must operate in a climate of minimal state intervention and place emphasis on market-based, corporatist methods of child welfare, including operating with reduced funding, reduced resources, reduced training, reduced salaries (see participant comments on page 55), and increased bureaucratization and administrative responsibilities.

*Reduced Funding.* Almost half of the study participants (47.1%) described a system whose very organization and funding structure leads it towards medicating C/YIC. Study participants felt that funding cuts, funding constraints and political mandates lead to a lack of resources that contribute to the medicating of C/YIC. For instance:

*Unfortunately it is not a problem that rests in the hands of the parents, case managers or employees working with the families but rather a larger issue that goes up to the mandates and funding decisions that take place at the political level. Decisions are being made about allocating funds, supports, training and services by people that are not directly working with the population accessing services. Unfortunately the untrained, unsupported and ill-equipped people working the front lines are the ones that have to work with at risk families and children. [...] Given the “tools” that they have at their disposal oftentimes the most appropriate [way] to them is medication (Brittany, Outreach).*

*I wouldn't say that the money is constricting us, but it is more so the CFS workers who are helping families with the other programs out there that we know would benefit from more funding [...] there is not enough funding I believe for child protection services with the different CFS agencies (Amanda, Adolescent Mental Health).*

*Most needy youth rarely receive the quality of care needed to address their hx [history]. [...] Political environment does not opt to ever fund adequate tx [treatment because] → kids don't vote (Dara, Adolescent Mental Health).*

Decreasing financial support, higher caseloads and greater administrative responsibilities leave less time and fewer resources for social workers to spend evaluating and helping the children/youth in their care (Hick, 2010). This may lead social workers to a greater predilection to seek medical intervention and medication for the youth.

Participants (23.5%) also emphasized that the lack of federal and provincial funding for child welfare means that salaries are kept low, thereby preventing organizations and agencies from hiring more experienced and skilled workers.

*...funding cuts prevent them from hiring adequately trained staff to work with at-risk families and children. Therefore they hire inexperienced employees with limited skills at a much lower rate of pay. These*

*inadequately trained employees work with these children only to find that they are ill equipped. The solution may be to put the diagnosed child on medication rather than train and hire experienced employees (Brittany, Outreach).*

*Often you have workers being employed for minimum wage and a high turnover in workers. This means that you have rotating unskilled workers in large environments with lots of kids who are living with some very deep-rooted issues-these issues are not being dealt with but instead being glossed over with medication. It is easier to sometimes give a child a medication than to implement an effective communication/behavioral strategy (Michael, Adolescent Mental Health).*

*Are [group home workers] paid enough? No. They are not in my opinion, especially based with the issues these children present with and the complicated things that they are facing, issues of trauma, regardless if it is neglect or abuse or whatever the issue was that led them to be in care [...] in my opinion they are not paid enough [...] And these are the children who need the help the most. So what I would love to see are most experienced, qualified people in those jobs. Paid more would probably get you the more qualified people. Yeah. But unfortunately that is not always the case [...] Nobody is doing this for the money. No one would. No one would ever, if somebody knew what it is we do and knew what it is we go through (Karen, CFS).*

These comments suggest that social work in Manitoba is being deprofessionalized and phased out by the encroachment of semi and non-professional service workers into traditional social work domains such as child welfare. The increase in generic positions such as “case worker” may have led to competition for these professional positions and wage reductions (Healy & Meagher 2004).

Other participants (14.7%) mentioned that the inexperienced workers may have more to do with the hiring criteria of particular agencies than a funding issue.

*It seems that some of the agencies, at least here in Manitoba, have more educated and well-trained staff than certain other agencies where people don't have social work degrees for instance or have kind of been grandfathered into positions. Some of the CFS workers that we work with do not appear very well educated for supporting their work in many different areas. Luckily a lot of them are, and seem like, really excellent people with good heads on their shoulders and their hearts are in the right place. [...] It is surprising someone with a totally unrelated degree can be*

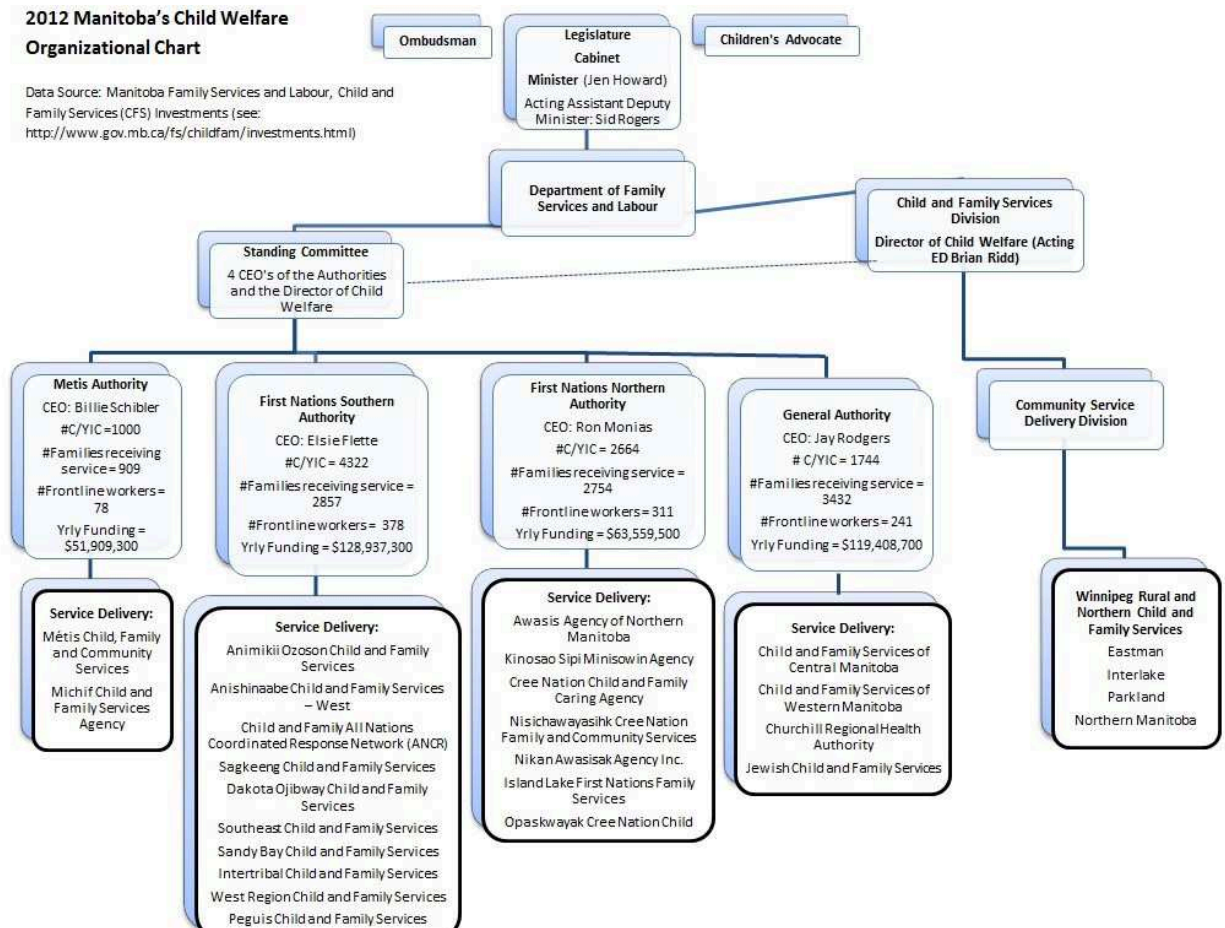
*working and calling themselves a social worker. So we're looking forward to it being a profession where you have to be registered hopefully [...] (Amanda, Adolescent Mental Health).*

*I've also seen some pretty damn dedicated people who don't necessarily [have] professional backgrounds and stuff but you know they can gather information too. They're not great at it but as time goes on they'll get better at it (William, CFS).*

The differences in skill and training of social workers at various agencies may, in part, be due to devolution. First, according to three participants working in child and family services who asked not to be quoted, there is a severe shortage of trained Aboriginal social workers for positions within Aboriginal mandated agencies. As such, individuals are hired for their racial background and personal experience over their education and training. Second, as described in Chapter 2, funding for Aboriginal and non-Aboriginal agencies are inequitable. Presently there is a case before the Human Rights Tribunal about these inequities. The First Nations Child and Family Caring Society and the Assembly of First Nations “allege that the Government of Canada is discriminating against First Nations families and children by inadequately funding child welfare services delivered on reserves.” They are arguing that these agencies receive 22 per cent less funding than off-reserve services (FNCFCS, 2013).

*Bureaucratization.* Bureaucratization is the organization of professional work into a complex hierarchy of positions (Freidson, 1984). For instance, in Manitoba the child welfare bureaucracy is as such:

Figure 2: Manitoba's Child Welfare Bureaucracy



In a bureaucracy, the need for efficiency leads to the adoption of managerialism in the workplace or the standardized regulation of work (Freidson, 1984; Smith, 2010).

Within a bureaucracy, adhering and conforming to rules and regulations may become the goal rather than the means to achieving a particular result (Merton, 1957).

Formalism, even ritualism, ensues [when primary goals are displaced] with an unchallenged insistence upon punctilious adherence to formalized procedures. This may be exaggerated to the point where primary concern with conformity to the rules interferes with the achievement of the purposes of the organization, in which case we have the familiar



phenomenon of the technicism or red tape of the official (Merton, 1957, p. 201).

Participants described medicating C/YIC as the consequence of bureaucratization and the eroding the autonomy of the profession. For instance a couple of participants working within Aboriginal agencies suggested that bureaucracy limits their ability to quickly and effectively attain treatment for children and youth in their care.

*Bureaucratic structure limits children of being diagnosed and assessed to provide children with proper medications... Child welfare has limitations on getting children properly diagnosed. [We] have to use FNIHB [First Nations and Inuit Health Branch] before getting services needed which limits on providing our children with appropriate treatment (Keri, CFS).*

Participants (17.6%) also mentioned a child welfare system that is bureaucratically top-heavy and that delegates more and more administrative responsibilities to the workers<sup>12</sup>.

*If you want to know where the funding goes, well this system is very top heavy (Sylvia, CFS).*

*Paper doesn't have feelings, you know, it doesn't have feelings. No matter how much paperwork, you still have to do the caseload. Paperwork should be the last thing. We have to go and make sure the kids are okay first. We have to make sure the kids are doing well [...] There is so much documentation now. We have to take photos of the children once a month and document everything. I also have all of these emails now. And I told my supervisor that's my case file right there. My e-mails those are my case files. Why write it down again? You know it doesn't make sense (Colleen, CFS).*

**Managing Risk.** A return to a residual approach to social welfare means that government involvement in child welfare and protection occurs after all other avenues of support and intervention have failed (Hick, 2010).

*We will do everything in our power not to [apprehend children], except sacrifice the safety of the child. If their immediate safety is at risk and we*

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<sup>12</sup> Participants did not discuss bureaucratization of other organizations

*have no choice, there is no family option that we can look at which is the first thing done or nobody is in a position to give us that or the situation is dire we can't entertain that, then we apprehend (Karen, CFS).*

To further illustrate the connection between apprehension and the retrenchment of services found in a residual approach to social welfare, I would like to extensively quote from an article written by Keith Black, a retired Manitoba social worker:

During my two stints on two different child-welfare boards, the message from government was essentially the same: reduce costs, don't take so many kids into care, and why are you in a deficit position? [...] Resources have continued to be hard to find, and the problems continue to escalate. Over the decades, hundreds and hundreds of dedicated social workers have gone out every day in an attempt to investigate and protect kids and families, praying that this won't be the day that the decision to check on Child A won't mean Child B is in jeopardy. And if brought into care because that jeopardy seems imminent, what alternative-care facility will there be? I've sat in ministers' offices and been told we were spending too much money and had to find ways to reduce costs. Which kids do we sacrifice? (Black, Winnipeg Free Press, 2013).

If intervention occurs after all avenues have failed, then the child/youth may be apprehended after having to endure much unrest, upheaval, and emotional turmoil. This can have a severe impact on their mood, behavior and conduct. Thus, once placed into care, the child or youth may require medication in order to ameliorate their trauma; as Sharron (CFS) explained, the “increase in complex cases plays a role” in medicating C/YIC. Further, as Connie (CFS) said:

*I think that there is a real need for medication. Half the children in care are also dealing with severe trauma and almost half of the kids I work with have FAS [Fetal Alcohol Syndrome]. I see my kids once every month and once again, I strive to also arrange for therapy for kids that have recurring issues. Medication, by itself, is not the answer, but sometimes it is a necessity.*

Part of the increase in complex cases that participants went on to describe was the tremendous number of children/youth presenting with Fetal Alcohol Spectrum Disorder (FASD) or Alcohol-Related Neurodevelopmental Disorder (ARND). FASD includes “physical characteristics, inhibited growth, and neurodevelopmental problems, as well as behavioral and cognitive difficulties that are inconsistent with developmental level” (Fuchs et al., 2009, p. 1). In a 2005 study, Fuchs and colleagues found that 17% of C/YIC in Manitoba were affected by a diagnosed or suspected FASD (Fuchs et al., 2009, p. 1). Over a quarter of participants in my study (26.5%) mentioned that they were concerned about the lack of resources for C/YIC with FASD, Fetal Alcohol Effects (FAE), Fetal Alcohol syndrome (FAS), and ARND<sup>13</sup>.

*Manitoba has a high population of children and youth with FASD, who almost all have focus and attention issues (Maggie, Child Welfare).*

*Almost half of the kids I work with have FAS (Connie, CFS).*

*When the issues are coexisting with the high rates of FASD and FAE that are prevalent, especially among children in care, it is that much harder - their behaviors and the impulsivity and there aren't enough resources. Even when we know children have FASD and FAE, you can't get them diagnosed. Even though it is clear, you still need to have maternal admission to using while pregnant. Not all moms are willing to do that [...] If we could get all of those children assessed then we are going to overwhelm any supports or resources that there are because the problems are so widespread and so prevalent. There just isn't enough support*

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<sup>13</sup> Constructivists such as Armstrong (1996) argue that Fetal Alcohol Syndrome was socially constructed in the early 1970s and that its label is just as much moral judgement as a medical diagnosis. Since the majority of C/YIC in Manitoba are Aboriginal, it is worth considering that the present focus on FAS, FASD, ARND, and FAE by social workers may be partially reflective of a wider cultural/moral concern with the lifestyles of Aboriginal peoples. It is also worth considering that it may be a strategy to get much needed funding and government resources for agencies.

*(Karen, CFS).*

As Fuchs and colleagues suggest in their study, it is important to improve the services for children and youth in care with FASD, as it is only through early intervention that adaptive skills can be developed among these children/youth (2009). Without these adaptive skills, the child/youth is at a much higher risk for poor life outcomes (Fuchs et al., 2009).

More complex cases and retrenchment of the welfare state (e.g. less funding and a lack of resources) leave medication as the best method of managing the risk a child's or youth's behavior and emotions pose to themselves and to others. For instance:

*I don't think that anyone would agree that [medicating] is best-practice, but that it is one of the unfortunate realities of the system as it stands right now (Greg, CFS)*

*In order to maintain a safe environment for youth/children in care it is necessary to medicate the ones that pose a safety risk in foster homes and group homes (Alyssa, Outreach).*

*Social workers often want meds for containment and control rather than medical benefit (Dara, Clinical Social Work).*

To further exemplify the emphasis placed on risk in the Manitoba child welfare system, at the Phoenix Sinclair Inquiry on January 29<sup>th</sup>, 2013, Lance Barber, a social worker and former CEO of Winnipeg Child and Family Services, testified that he was hired for his managerial skills. During his testimony, he stated that he is unsure whether there is a cure for children at risk and that the only thing that child welfare can do is “mitigate risk” (Sanders, January 30, 2013).

The growing emphasis on risk is forcing social workers to spend time doing cost-benefit calculations and risk calculations as part of their responsibilities towards children/youth in care (Smith, 2010; Weinberg, 2010).

*I try to examine children and youth's overall functioning in their environments and do a risk/benefit analysis. Are the risks of medication worth the potential benefits? (Maggie, Child Welfare)*

Social workers, in their calculations, try to ensure the safety of not only the child/youth but the foster families, other children in the schools, and so on; part of their evaluations involve determining whether the child/youth requires medical intervention.

Overall, over half of the participants (55.9%) suggested that the child welfare system as it stands now is untenable for the social workers and frontline workers who must practice within it.

*CFS social workers are feeling helpless at times when they ask for more help. These workers are also leaving their jobs and burning out because they feel defeated (Michael, Adolescent Mental Health).*

*And it gets personal. It is hard to explain except that it does get very personal when you are the person dealing with everything right when it is happening. And trying to figure that all out and do what you need to professionally in order to keep children safe and [...] after a while, you don't want to (Karen, CFS).*

**Summary.** In summary, the child welfare system has been shifting away from an institutional approach to child welfare, which emphasizes the government's responsibility to meet the needs of citizens, towards a residual approach. The residual approach emphasizes intervention as a last resort, cost-benefit risk analyses and cost-containment based on market-driven economics. According to the social workers who participated in my research, this is having a negative impact on those who work within the system and those whose lives are controlled by the system. More specifically, increases in complex cases, fewer resources, little training, bureaucratization and emphasis on risk analyses are contributing towards the trend to medicate C/YIC in Manitoba with psychotropics.

**The Education System.** Study participants described three general areas of concern regarding the education system and its involvement in medicating C/YIC with

psychotropics. Participants suggested that educators are quick to refer children and youth for medication; that they are biased against C/YIC which might lead to increased referrals for medication; and that the education system's funding formulas provide increased subsidies if students are on medication which can also lead to more referrals.

***Quick to Refer.*** McMahon (2012) has suggested that 'doctor as labeler' of child/youth illnesses has been replaced with 'teacher as labeler'. Once labeled with an illness, the children/youth are then referred for treatment. Twenty of the 34 participants said that the education system plays a large role in the trend towards medicating C/YIC and over half of the participants (55.9%) suggested that schools are quick to refer children and youth for medical assessment.

*As soon as a child is acting out in school, a referral is made, the child is on Ritalin or whatever form of, whatever the newest form of Ritalin is, 'cause it's easier. And it takes less resources and time and energy versus what is happening with the behavior, what's going on, what can we do to help manage, how can we help this child become successful? (Karen, CFS)*

*I find that schools very easily recommend medication to parents for "problematic behaviour" instead of dealing more effectively with difficult behaviours (Sherilyn, CFS).*

*Working with collaterals such as schools sometimes pressure [...] to consider medications (Sharron, CFS).*

This mirrors other studies in which general physicians and pediatricians suggest educators are over-referring children/youth for medical intervention (see, for example, HaileMariam, Bradley-Johnson & Johnson 2002).

An alternate view of the referral picture is presented by school social workers. They noted that schools may lack involvement in the medicating process for C/YIC since many of these children and youth are already on medication.

*I do however see that many of the students in care who come to the education system are medicated and have significant issues due mainly to their experiences with trauma and loss (Kelly, School Social Work).*

This participant suggests that it is not educators who are referring the children/youth for medication; rather the children/youth are already entering the education system on medication.

***Bias in the System.*** Regardless of who refers the child/youth for medication, CFS and child welfare social work participants indicated frustration with the education system in relation to the treatment of C/YIC. For instance, a number of participants (20.6%) felt that schools are prejudiced towards C/YIC. Participants specified that C/YIC often have gaps in their education from moving around. These gaps can lead the child/youth to become discouraged in their classes which can cause them to misbehave. The child/youth soon learns that misbehaving can get them kicked out of class thereby relieving the uncomfortable feeling they have being in class. It becomes a vicious circle with children/youth in care acting out and teachers' labeling the children/youth trouble and in need of medication. For instance:

*Schools are biased towards children in care. The Education system automatically assumes that because the children are in care, they were traumatized and are troubled children (Joshua, CFS)*

*Well some of the teachers at school can be stereotyping them because they are children in care, right? They stereotype them but I address it at the meetings. I say 'look, it's not about us, it's about a child' (Colleen, CFS).*

The fear among these participants is that this bias may lead to the tendency to automatically refer these children/youth for medications.

Additionally, CFS and child welfare social workers stated their concern about teachers refusing to allow a child/youth in the classroom if that child/youth has not taken their medication. As one participant explained:

*I have heard from foster parents and parents who still have their children in their homes that schools try to say that they can't come to school if they are not on their meds. Well, you can't do that. Your job is to educate them until they're 16. But typically that is what happens. [...] They boot them as soon as they have a behavioral problem. Well, these children probably have some gaps in their education because of chaos in the home, mental health disorders, possibly a number of moves, possibly apprehensions and coming into care, moving from school to school. School is not going to be the most comfortable place for them because they are going to be behind. And they know they're behind. [...] What education is that child getting? None! And this child needs education more than some of the other kids in the class because of those gaps... (Karen, CFS).*

These concerns regarding gaps in C/YICs' education is also reflected in the findings of a 2012 report commissioned by the Manitoba Children's Advocate (Burnside, 2012). This report found that 30% of a sample of Manitoba C/YIC were not in school in September 2010. Furthermore, another study of Manitoba children/youth found that being a child/youth in care was associated with a high school completion rate of only 57% (Brownell, Roos, MacWilliam, Leclair, Ekuma & Fransoo, 2010).

**Funding Constraints.** Despite describing their various frustrations with the education system, participants also recognized that Manitoba schools are operating with limited funding and resources.

*It appears that schools are ill equipped to deal with children who come with "issues" and often lean towards medicating children to help keep them focused and on task. There are [...] large classroom sizes [and...] unfortunately most schools have limited resources including people and equipment needed to assist children that are hyper, unfocused or easily distracted and medication seems to help (Terry, CFS).*

*...schools [are] seeking out quick fixes as alternate funding, supports, services and resources are limited (Brittany, Outreach)*

School social workers suggested that schools may be quick to refer children/youth for medication because of the provincial funding formulas for education. Schools in Manitoba receive increased level 2 or 3 funding through the provincial government for



students with severe behavioral or emotional difficulties (Manitoba Education, 2012) (See Appendix C on Manitoba Education Funding Formula). As one school social worker explained:

*Because of some of the successes my school teams have seen in students who have tried medications, it is often a method they are looking at trying when dealing with a student with behavioural difficulties. However, it certainly isn't the only method that they encourage parents to try. The other factor includes the need for a diagnosis or use of medication when applying for categorical funding from the department of education. The department is VERY reluctant to look at supportive funding for students without formal diagnoses and/or the use of medication (Kelly, School Social Work).*

**Summary.** In summary, participants felt that the Education System is a main contributor to the trend towards medicating C/YIC with psychotropic medication. Social workers in the study stated that educators are quick to refer and appear to be biased towards C/YIC in their classrooms. Furthermore, participants suggested that it is easier to prove that the child requires level 2 or 3 funding if the child/youth is on medication. This may possibly have a role in teachers/educators referring more quickly for medication.

**The Health Care System.** Study participants described four general areas of concern regarding the medical system and the trend towards medicating C/YIC. First, participants felt that Manitoba health care is highly skewed towards acute medical care rather than alternative, long term psychotherapeutic care. This, of course, means emphasis is placed on medication and cure. Second, participants felt that within the medical system there is a shortage of skilled professionals who can accurately diagnose the difficulties and disorders of C/YIC. Participants explained that this results in over-reliance on general practitioners who may not have the knowledge to treat the issues facing C/YIC and may therefore lead to the over-prescribing of psychotropics. This may also account for the third general area of concern for participants; that is, the growing use of medication to

treat behavioral issues rather than biological disease/disorder. Finally, participants suggested that the growth of medical knowledge is another contributing factor in the emergent trend to use psychotropic medication on C/YIC.

***Organization of the Health Care System.*** In the early 1900s, Sir William Osler, a noted Canadian physician, observed that “it is much more important to know what sort of a patient has a disease than to know what kind of a disease a patient has” (in Dubos, 1987, p. 123). With this statement, Sir Osler emphasized that when a disease occurs, it happens to a whole person in a particular environment, and not just an organ. However, the health care system in Manitoba focuses on objective (observable, quantifiable, and measurable) biophysical phenomenon. Several participants (32.3%) suggested that this way of organizing the medical system slants it towards medicating C/YIC rather than seeking alternative options.

*The system is tipped towards medicating and doing basic maintenance rather than doing traditional psychotherapy. In this case if Manitoba Health would make it more a system where psychiatrists could offer more therapy that would be a much more seamless psychological mental health system. 'Cause then your family doctor, in theory, would refer you to a psychiatrist who would provide you with therapy for a certain amount of time. Then if they thought you needed more, they would refer you on. But they could provide the therapy (William, CFS)*

*Western medical practice is the only option provided to CFS workers. It is the only one validated and recognized (Mica, CFS).*

As one participant explained, the medical system is geared towards acute medicine and not necessarily the long term care that the children/youth may need.

*Treatment plans are driven though a medical lens - there is no “outside the box” --concepts and treatment interventions are based on mostly individual pathology and diagnoses [...], stabilization, and a quick return to the community. Mental status stabilization is often equated with medications [...] There is very little time to focus on other treatment interventions (Michael, Adolescent Mental Health).*

Another participant described the reaction of C/YIC to the mental health system thusly:

*[they] are often frustrated with the mental health system in general and in some cases feel as though meds are being pushed on them, rather than having someone just sit and listen to their issues/concerns (Kelly, School Social Work)*

When alternative treatments are available, however, they are often still beyond reach because of funding issues:

*Alternative systems of treatment are not affordable (Alyssa, Outreach).*

Several participants (11.8%) underlined their frustration with the lack of appropriate mental health care available for children/youth in care and suggested that change is necessary.

*I'll say that just like other things in the Canada Health Act, or the original incarnation of what would become the Canada Health Act, a lot more services would have been insured like dentistry and medications in general. It would have been nice if the Canada Health Act had included a stronger emphasis on psychotherapy, whether that was covering psychologists or covering psychiatry to do psychotherapy. That would be nice, eh? (William, CFS).*

*Realizing the importance of mental health and responding correctly is what should be focused on (Rosalind, CFS).*

Only one participant described the role the pharmaceutical industry plays in medicating C/YIC. This participant stated:

*The pharmaceutical companies are contributing to this trend [to medicate]. For example, when I was working in the hospital, they would come in with the new drugs and they would say this is good and [... they] cover-up the side effects [...] Mainly, absolutely, it is the pharmaceutical companies (Tonda, Outreach).*

There were over 3.4 million visits by pharmaceutical sales representatives to physicians in Canada in 2000 (Norris et al., 2005), with the primary motive of these visits to sell drugs (Lexchin & Wiktorowicz, 2009).

***Growth of Medical Knowledge.*** Participants (14.7%) also described medical advancements and the expansion of medical knowledge as key to the increasing trend towards medicating C/YIC with psychotropics. The development of better medical screening allows physicians to determine more quickly whether or not a child or youth is in need of medication.

*The development of new systems is accurate. In addition to increased resources for assessment and treatment, there is a broader acceptance that children and adolescents have mental health problems. The field of treatment has grown tremendously, esp. family focused (Rachell, Adolescent Mental Health)*

*I don't feel that [psychotropics are] prescribed for no apparent reason. With the testing and studies and knowledge the medical profession have, they are able to determine if a child does need medication (Keri, CFS)*

Participants also suggested that the development of new medications that have better efficacy also increases the prescription rates. For example, when asked what broader factors affect the trend towards medicating C/YIC, Sharron (CFS) replied “new systems of treatment.” As Amanda explains:

*My understanding from the doctors is that new meds that are being researched and then put out are hopefully better for the kids. Of course you don't have the long term research on them. But it's [...] good to have alternatives (Amanda, Adolescent Mental Health).*

A major aspect of pharmaceuticalization is drug promotion. Pharmaceutical industry promotional strategy often involves providing informational packets describing the greater efficacy of the newer medications. Research suggests that physicians often use pharmaceutical promotion as a source of information for medicines (Norris et al., 2005). Though physicians deny being influenced, studies indicate that doctors exposed to company representatives “prescribe less appropriately, prescribe more often, and adopt new drugs more quickly” (Norris et al., 2005, pp. 54–55).

***Prescribing for Behavior.*** The temptation to medicalize behavior is great not only for those wishing to maintain social order but also for individuals preferring to enter the ‘sick role’ rather than being labeled ‘bad’ or ‘deviant’ (Parsons, 1951). However, it must be noted that medicalization can have a profound effect on individual subjectivity. For instance, a child in care who acts out and constantly argues with his/her foster parents may be diagnosed with Oppositional Defiance Disorder. This child now has a powerful negative social stigma that has real consequences, both socially and subjectively. That is, if the child is only thought of as behaving badly then being good is possible, whereas, if the child is labeled diseased or disabled, the child now is placed into a category of exclusion from normal and change is viewed as difficult.

*Some youth have reported feeling like they have lost a certain part of their personality. Medications are meant to help individuals better cope with their emotions, however there needs to be a boundary as at what point do you need to start teaching ways to process and cope with negative thoughts, emotion and behaviors without focusing so much on changing/increasing medications. I have found this pattern can lead to individuals in the end developing an even lower coping capacity because any small emotion or trigger can set them off as they are no longer used to feeling like they have any internal control without the use of medications (Michael, Adolescent Mental Health).*

Research has established that psychotropic medications are increasingly prescribed to youth in care off-label, i.e., for unapproved indications such as for controlling behavior (Lyons et al., 2004).

*Social workers often want meds for containment and control rather than medical benefit (Dara, Clinical Social Work).*

*Many foster parents, schools and doctors use medication as the first attempt to change behaviours instead of an alternative solution (Joshua, CFS).*

Participants (17.6%) stated that medications are often prescribed to manage behavioral issues because it is “easier”.

*Without the use of sedatives and other psychotropic medication, the behaviors of these children are unmanageable. Other forms of treatment are too time consuming, expensive and no one has a high enough commitment level to the child/youth to help them. This instability creates further psychological distress and trauma also increasing their need for medication or treatment (Alyssa, Outreach).*

*Medications sometimes are too easy of an answer to effectively address a youth population with a complex level of need. Especially youth who are behaving erratically or in an oppositional fashion-medicating bad behavior does not appear to help youth long-term as the memories, emotions behind these “bad behaviors” do not go away (Michael, Adolescent Mental Health).*

*[...] it can be easier to just give children medication so that they are easier to handle (Greg, CFS)*

As can be seen by these comments, in defining the behaviors of these children/youth as illness which needs to be treated with medications, the focus shifts to the biophysical and the cause becomes framed as pathological (Carpiano, 2001). Medicating to control behaviors also reflects the development of what Rose (2003) calls the psychopharmacological society where individuals and groups seek out medication to adjust thoughts, behaviors and feelings.

*Many of the kids in care have had very difficult lives and have been subjected to many forms of abuse. Children have developed anxiety disorders, depression and PTSD [Post-Traumatic Stress Disorder] which need to be treated by medications in conjunction with therapy (Sherilyn, CFS).*

***Lack Of Skilled Professionals.*** According to the Manitoba Association of School Superintendents (September 2012), “The current resources for mental health services in Manitoba are insufficient, resulting in inequities in service, lack of collaboration and communication between systems, and lengthy wait times. The needs have increased while resources have not.” Several participants (23.5%) shared this view.

*There is a huge, we know there is a huge shortage of psychiatrists, or adolescent psychiatrists ... And we have a general shortage of specialists. So yeah, it is getting to be a big problem (William, CFS)*

*There really are no child psychiatrists in the province that are accepting new patients unless they are attached to the child through some sort of hospital program. These psychiatrists have heavy caseloads-often they depend on the Family Doctor for medication monitoring. Often you have to wait months sometimes to see your Family GP (if you are lucky to have one at all!) and medication side effects and outcomes are not being properly assessed for and dealt with (Michael, Adolescent Mental Health).*

*Trying to get the youth that we see to see a psychiatrist is nearly impossible due to shortages and long wait times (Evelyn, Outreach).*

The Canadian Psychiatric Association (CPA) released a policy paper detailing wait time benchmarks for psychiatric practice in 2006. These benchmarks include less than a 24 hour wait time for those with the most pressing needs, less than a 2 week wait time for those whose conditions are deteriorating, and less than a 4 week wait time for those who are stable. However, there is a complete paucity of Canadian data on actual wait times for child and adolescent mental health services. Several participants (11.8%), however, suggested that the long wait times for mental health professionals means a greater reliance on primary care physicians for the mental health needs of C/YIC. They also suggested that due to their lack of expertise in mental health issues, primary care physicians are more prone to prescribe psychotropics.

*Currently, in Winnipeg, there is a wait between 3 and 8 months to access support services (ie: individual therapy, support groups, psychiatric assessments, psychiatric medication reviews, etc.). Due to this fact alone, parents resort to taking their child to their family doctor who often prescribe medications there rather than waiting to be seen by a mental health clinician. Sometimes we see positive effects from this, but again, the emphasis becomes about the medication as opposed to other methods for coping with mental illness (Kelly, School Social Work)*

One participant stated, however, that C/YIC have better access to mental health professionals than other youth.

*Youth in care have more access and more easy access to therapy and therapy services. Well, aside from families who are very well off, but in general therapeutic services are more available to them. So it is easier for me to get counseling for someone who is in care versus someone who is not (William, CFS)*

The question is, though, does greater access to mental health professionals translate into better health and less need for medication, or does it translate into more prescriptions?

Unfortunately, this was not made clear by the participant.

Regardless of access, physicians were often described in negative ways by participants. For instance, participants said that physicians are heavy handed with prescriptions and/or deficient in their listening skills.

*I feel like kids in foster care don't get to build relationships with their doctors and often whatever doctor they end up seeing just prescribe medication as a quick, band aid fix [...] I've observed youth attend a doctor appointment with a new doctor and the doctor just took their word for what medications and dosages they were on before and wrote another prescription without even doing an examination/assessment (Linda, Clinical Social Work)*

*You go to the doctor and he doesn't listen to you. Like you say I'm sad and maybe it is because it is cold or because you don't have a job and there are many things that contribute to you being depressed. They hear that you're sad and so right away drugs are prescribed (Tonda, Outreach).*

*My experience is that, once discussed, a prescription is written; there don't seem to be many doctors that will say that they don't think a prescription is needed. (Maggie, Child Welfare)*

*Doctors shouldn't just be seeing a child then saying, "look, this is the prescription. Get out of my office." You know what I mean? They shouldn't be doing that. And I'm not saying all doctors do that, but you know what? There are some doctors and they're just so, well, just like there's some bad social workers, you know? (Colleen, CFS).*

**Summary.** In summary, participants felt that several aspects of the medical system are contributing to the trend of medicating C/YIC with psychotropic medication, including the way the medical system is organized towards to the treatment of acute



disease rather than long term holistic health care. Participants also suggested that there is a lack of appropriate health care professionals to treat C/YIC; this results in heavy-handed prescribing for psychotropics by general practitioners. These prescriptions, as several participants expressed, are often written for behavior problems rather than emotional or physical issues because it is easier and quicker than talk-therapy. Finally, participants also indicated that the expansion of medical knowledge and advancements in treatment are another reason why C/YIC are increasingly being prescribed psychotropics. As participants explained, better diagnostic criteria means the mental health issues of more children and youth in care are being recognized and treated<sup>14</sup>.

## **Conclusion**

In terms of the broader trend towards medicating children/youth in care with psychotropics, 14.7% of participants stated they have not noticed a trend towards medicating C/YIC. However, almost half (48.2%) of the children/youth in care that make up the caseloads of the participants are medicated with psychotropics. Further, almost a quarter of participants (23.5%) mentioned that children/youth are entering the system with complex needs and tremendous amounts of trauma that must be dealt with. Therefore, medication may be an understandable way to begin addressing the psychological scars and underlying issues that are affecting these children/youth.

In terms of what participants said about different macro contexts which may be influencing the trend to medicate C/YIC, three intersecting social structures were

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<sup>14</sup> There appears to be a contradiction here. On the one hand, participants say that physicians are inappropriately medicating C/YIC and, on the other hand, they say that they are better at diagnosing and medicating. The contradiction can be resolved thusly, both situations can lead to more C/YIC being medicated with psychotropics, i.e., one physician may be prescribing inappropriately and giving too many prescriptions for psychotropics while another, with better mental health training, recognizes the symptoms of disorder and provides appropriate treatment with psychotropics.

discussed: the child welfare system, the education system, and the medical system.

Participants described a monetarist and corporatist child welfare system that is over-taxed and under-resourced, particularly with funding, training, and time. The residual approach to social welfare suggests that children and youth enter care later and are, therefore, entering care after experiencing more abuse and/or neglect. This means that the cases are more complex and these children/youth have high needs. This compounded with the lack of resources in the system means that social workers are left trying to mitigate risks for the children/youths, for the system, and for themselves. When put together we find a child welfare system that may be leaning towards medication as the fastest, most efficient method of treating the behavioral issues of C/YIC.

The education system intersects with the child welfare system when the C/YIC attend school. In my study, social work participants asserted that educators play a very big role in the trend towards medicating children/youth in care with psychotropics. Participants described an education system that can be biased against C/YIC. That is, participants felt C/YIC are automatically labeled as “trouble” which causes teachers, who are already hasty in referring children and youth for medication, to refer even more quickly. Participants also acknowledged that the overall funding system for education may be a contributing factor in the trend towards medicating C/YIC. Provincial funding for education is based on evidence of a child/youth’s need. Therefore educators, in order to increase the resources and supports available for that child/youth, may feel the necessity to refer the child/youth for medical intervention (See Appendix C).

The medical system overlaps both the education system and the child welfare system. Participants explained that the present structure of Manitoba’s health care system is highly oriented towards biophysical rather than holistic treatment. This means that

medical interventions tend to be medication-based instead of alternative-focused therapies such as counseling. Part of the continued orientation towards a biophysical approach to health care is the growth in medical knowledge and advancements in treatments.

Participants suggested that this can lead to a greater propensity to treat many issues as medical issues and to prescribe medications. What makes the issue even more complex according to participants is that, within the Manitoba medical system, there is a shortage of skilled professionals able to do proper diagnoses of child and adolescent mental health concerns, as well as a lack of appropriate professional treatment by primary care physicians.

The lack of skilled physicians leads to longer wait times for children/youth in care to receive care. This means that social workers may instead bring these children/youth to a general practitioner for treatment. Participants described the care provided by these general practitioners as a revolving door of medicine where the children/youth are in and out quickly with prescription in hand.

Though it may seem that the individuals who work within the child welfare system, education system and medical system are all painted in a negative light in my study, participants often stressed that individuals acting within these systems are only operating within the constraints of that particular system. In other words, social workers practicing within the child welfare system are constrained by a system that lacks funds and resources. Teachers within the education system are constrained by a system that lacks funds and resources. Physicians within the medical system are constrained by a system that emphasizes treating the biophysical body and a system that lacks available, skilled professionals. In the next chapter, I examine more closely participant descriptions

of occupational situations and constraints within child welfare which they suggest may be affecting the trend towards medicating children/youth in care with psychotropics.

## Chapter 5 – Meso Situational Conditions that May Be Affecting the Trend to Medicate

Over the phone I ask Karen, a CFS emergency response worker, about the roles she plays in medication management for children/youth in care. She starts describing the expectations the hospitals have when a child in care is waiting to be seen by the psychiatrist.

*They want us to send someone down right away and sit with the child. [...] We don't always have someone. So they get mad at us. We say we are doing the best that we can. The hospital will sometimes say, well why don't you come down. Well I can't. I am a social worker. I am answering the phones. I am going to check on the welfare of babies. I know you guys don't like doing it, but you are going to have to keep security there if you are concerned or utilize some of your resources. They say they don't have resources so they get mad at us. And we also have a lack of resources so we can't do much [laughing]. So people get frustrated with each other.*

I tell her that it sounds quite stressful. She laughs.

*Lots of people yell at us [laughing] we're okay with it. We're used to it. [...] You get used to it because it is the nature of our work, because we are crisis oriented. Everybody's in crisis, everything's in crisis. And things get frustrating and that's okay. It is understandable. And when I am going to people's houses, I'm typically not going there when everything is shiny happy. I'm going when there is a possible immediate concern and I need to assess the well-being of a child. Nobody is happy to see me at that time. Especially if there are concerns going on. They're not happy to have us there. So I am used to it.*

After I hang up the phone, I sit in my office and try to imagine working at a job where the lives and future of children and youth are at stake. I imagine what it must be like to deal with educators, medical professionals, police, and families in crisis. I think about being yelled at all the time. I picture coping with a lack of resources and vast administrative responsibilities. I wonder how the constraints, experiences, and expectations of the position would affect how I would act or respond to the medication management of a child in care. Then I shudder at the seemingly impossible weight of it all.

Behavior (roles that individuals play) depends on the creation and maintenance of shared and subjective meaning. Meaning is created, maintained and transformed as individuals define the situations they are in. For instance, Karen defines her role as checking “on the welfare of babies”, “crisis oriented”, and acting “when there is an immediate concern”. According to Karen’s definition, a child/youth in care who is already at a hospital does not fall into a situation demanding her immediate attention and action. However, Karen’s definition of the situation is problematic for hospital staff. According to staff, the hospital lacks resources to have staff sit with the child. Conversely, according to Karen, CFS also lacks resources to have someone sit with the child.

In a problematic definition of the situation, the actors challenge the definition of the situation of the other. In this case hospital staff believes that it is the role of a CFS social worker to sit with the child. Karen, however, disputes this. Both Karen and the hospital staff try to altercast one another into roles that they want them to play regardless of the resistance of the other. Altercasting is a way to exercise power and control over the situation and it depends upon authority and jurisdiction. In this particular instance, Karen has ultimate authority over the child in care and has the power to determine what is in the child’s best interest. That is, based upon possession of a pastoral type of power (power over a flock; see Chapter 2, Meso-level), Karen determines that the child is safe at the hospital and so she has no need to interfere. Furthermore, over time Karen’s actions and definitions become habit. She becomes used to dealing with these types of conflicts and “frustrations” because “it is the nature of [her] work” (Individual habits and attitudes will be explored further in Chapter 6).

In this chapter I provide analysis for data related to Manitoba social worker perspectives (definitions of the situation) on the situational (meso-level) context, roles

and spheres of social work practice that may influence the trend towards medicating children/youth in care. These meso-structures traverse multiple areas of participant occupational situations, including constraints, positional roles, and experiences with children/youth in care who are medicated with psychotropics. Each encompasses multiple contexts that define the settings in which macro-conditions derive tangible and symbolic reality for the participants.

More specifically, I address participants' descriptions of and perspectives on: 1) the organizational constraints social workers operate within which may be affecting the trend towards medicating children/youth in care with psychotropics; 2) the roles social workers play in the medication treatment and assessment process for children/youth in care in their organizations; and 3) experiences of Manitoba social workers when working with children/youth in care medicated with psychotropics.

### **Organizational Constraints Manitoba Social Workers Operate Within**

Participants who work within the child welfare system as well as those who work outside the system cited two general areas of concern for social workers working with children/youth in care. Those outside the system described what they know about the daily struggle of CFS frontline workers. Participants who work within CFS and child welfare expressed their distress and frustration with various aspects of their work. The two areas of concern which participants feel are influencing the trend towards medicating C/YIC with psychotropics are: 1) caseloads and burden and 2) foster parents and placement issues.

**Caseloads and Burden.** When asked to name the institutional/organizational factors that are affecting the trend towards medicating children/youth in care with psychotropics, almost half of the participants (41.2%) mentioned high caseloads<sup>15</sup>.

*It is a high caseload. We do carry a high caseload here. They said it was supposed be 25, the ideal caseload, but that is not possible [...] I personally have a very high caseload (Colleen, CFS).*

*You know we see the child protection workers with whom we work so stressed and with such humongous caseloads that we really feel for them. And we wonder how much more care all the kids and families could be receiving if they weren't stretched so far. The vast majority of them [CFS workers] have such good intentions yet it is difficult, it is difficult to deal with the little they have (Amanda, Adolescent Mental Health).*

*Caseworkers have a caseload overload which minimizes their abilities to strongly advocate for their kids (Kelly, School Social Work).*

The underlying message was that high caseloads are a factor in the increased use of medications.

Caseloads vary from worker to worker and also from agency to agency, with some workers and agencies having much higher caseloads than others.

*But some of [the caseloads] are high and I think it varies agency to agency. I think people try and cap the caseload, and try and spread the work around. I know at my agency there are certain units that have certain caps (Karen, CFS).*

*You know you have 50, this agency has 30, and they have 20. And also too, as I said to coworkers, I said sure, give me 50 cases just don't expect anything. You know, just expect the bare minimum of help or bare minimum of case management or welfare. And, you know when they have cutbacks, go ahead and give them 600 cases. Just don't expect anything in return (William, CFS).*

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<sup>15</sup> Participants did not provide much insight into why high caseloads may be influencing the trend to medicate. While they noted that a lack of time is associated with the trend, they did not specify how or why a lack of time increases the tendency to medicate. I hope to explore this theme in greater detail in future research.



And, as one participant pointed out, even if you have a high caseload, it is impossible to turn down another case if that child/youth needs help.

*You can't say "well, I'm not going to help." So that's how the caseloads skyrocket. There are so many families, so many kids. You can't say "well no, I am not going to help you." And even within the agencies, I know there are financial issues for resources; not enough support staff, support workers, social workers to help with some of the burden. So, I do think [we are] overburdened [...] (Karen, CFS).*

Of the 14 participants who work for CFS and who know their exact caseload size, 50.0% stated their caseload is higher than 25 cases. When the caseloads “skyrocket”, participants say that the worker has less time to spend with the C/YIC. When clarifying how caseload size affects the trend towards medicating C/YIC with psychotropics, participants underlined that large caseloads, not enough resources and a lack of time converge.

*[There is] not enough time to have patience or manage presenting behavior in a different way (Cathy, Private Social Work).*

*Other forms of treatment are too time consuming, expensive and no one has a high enough commitment level to the child/youth to help them (Alyssa, Outreach).*

*The time just isn't there. The system just isn't directed in that way (William, CFS).*

One CFS social worker mentioned that since she does not have enough time to visit her clients during her scheduled hours, she does extra, unpaid work on her own time.

*And you need to go to the home, once a month for a face-to-face; usually half an hour and sometimes only 20 minutes. We don't have time to spend all day. It is impossible. At times when I'm on holidays I'll go to the home and I will go sit in the homes because that's my own time and I am still their worker. I will do it. And I have that time. But that's my own personal choice. If I am worried about a child and I'm on holidays and I'm in the city, I will go sit there. I will do that observation. But the thing is, yeah, like I said I have a high caseload [...] so maybe that's why we get a bad image too, sometimes, because social workers are not following up. You know what I mean? We have to do it on our own time (Colleen, CFS).*

**Placement Issues and Foster Parents.** When asked about other institutional/organizational factors that are affecting the trend towards medicating C/YIC with psychotropics, participants said placements and foster parents. Participants felt that the lack of adequate placements means C/YIC are not getting the attention or care they require. This, in turn, opens the door to medication. For instance:

*The system is overwhelmed by the number of youth/children in care and there are not [enough] adequate placements available for the youth/children. The majority of these youth/children are high needs. There are a lot of kids currently residing in hotels where respite workers change weekly because the youth/children are too difficult to manage long term. Without the use of sedatives and other psychotropic medication, the behaviors of these children are unmanageable (Alyssa, Outreach).*

*[There are] inadequate placements to manage youth with extremely high needs [this leads to] medicalization (Dara, Clinical Social Work).*

Due to the lack of placements for C/YIC in Manitoba, social workers said they feared losing a placement for one of their children/youth. As such they do what they need to in order to keep the child/youth in the placement, even if it means agreeing to medicate with psychotropics.

*Drugs are cheaper and easier [...] I feel like foster parents want kids' behavioural issues dealt with as quickly and easily as possible and social workers will appease them because they don't want the placement to break down (Keri, CFS)*

Participants, when describing placements, made mention of 'problematic' foster parents and foster homes. To illustrate, a couple of participants suggested that foster parents are motivated to ensure children/youth placed in their care are medicated – not so much because the youth needs it, but because the foster parents will receive additional, special rate funding above and beyond the basic rate of \$24 to \$35 per day per child/youth (Fuchs et al., 2009).

*Some of the foster parents are in it just for the money so there is no push to find alternatives to medication. Parents receive more money for children with higher needs but most of these foster families don't have the resources or support to raise these children without medication (Alyssa, Outreach).*

*A lot of foster parents I found are really quick to try to diagnose the kids themselves and say he's acting like this and he is behaving like this. They say what the behaviors are, you know? And the reason they do this is that they think that they will get higher pay; higher money, you know? It's not for the kids, it's for them [...] and the foster parents are saying these kids are acting out of the norm and they have this behavior. They are saying the behaviors are escalating and getting out of control. To me it seems like they're just trying to get paid more [...] Then the foster parents will get more persistent because they're looking for more money. To them our children are a commodity, you know what I mean. It's like they are a commodity and that we will pay more money. But they're not a commodity! They're kids and they deserve better! (Colleen, CFS).*

**Summary of Findings.** When asked to name what institutional/organizational factors are contributing towards the trend to medicate children/youth in care with psychotropics, participants cited two general areas: high caseloads and lack of placements. These situations are constraining and affect what options are available to the social workers when working with the child/youth in care.

Though steps have been taken to improve funding for agencies so they can hire more social workers (AANDC, 2010), caseloads are still high and placements are still low in Manitoba. In fact, in 2010 Acting Children's Advocate, Bonnie Kocsis, wrote in an internal government document that Manitoba's child welfare system is "in a state of chaos" due to high caseloads and a lack of resources (Canadian Press, 2010).

A good example of the "chaos" in Manitoba's child welfare system is what is presently occurring at Sagkeeng CFS which provides services for Sagkeeng First Nation (band registration of approximately 6,640 people). Despite fear of reprisals, case workers at Sagkeeng CFS went to the media in November 2012 to outline their concerns about their working conditions (CBC News, Nov 22, 2012). These workers stated that their

caseloads are unmanageable and the demands placed on them by their supervisors are unreasonable. As one worker explained, “you are being told you need to ignore some of those risks and not be so vigilant about the risks you see in these case files”<sup>16</sup>. They also indicated that between September 2012 and October 2012, five case workers (approximately 35% of their frontline staff) have quit, been dismissed or have gone on stress leave. This has caused the caseloads of others within the agency to balloon to unmanageable levels, with some workers having caseloads higher than 45 (Carreiro, 2012).

As a result of the media attention, Manitoba Family Services Minister Jennifer Howard has called for an investigation by the Southern First Nations Child and Family Services Authority into the allegations of children at risk<sup>17</sup>. Furthermore, Minister Howard has also appointed an administrator to replace the board of directors of the Southern First Nations CFS Authority due to the ongoing legal dispute between the Authority and the Assembly of Manitoba Chiefs over who can be appointed to its board of directors (Kusch, Winnipeg Free Press, November 23, 2012). Allegations of political interference by band chiefs into CFS activities have been levied by child welfare workers<sup>18</sup>. Caseworkers indicate that chiefs are intervening in child apprehensions on behalf of family and friends. When asked whether the chiefs should be interfering in the decisions of professionally trained child welfare workers, Derek Nepinak, the Grand Chief of the Assembly of Manitoba Chiefs, stated that band chiefs have the right to interfere (CBC Radio, 2012). He argued that it is a necessary step in the devolution

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<sup>16</sup> Quote comes from the following CBC video: <http://video.ca.msn.com/watch/video/sagkeeng-cfs-under-investigation/16axzos7w?cpkey=cbcc2012-2111-2216-0045-230808059700%257c%257c%257c%257c>

<sup>17</sup> You can read Minister Howard’s letter calling for an investigation here: <http://www.documentcloud.org/documents/521983-jennifer-howard-sagkeeng-cfs-letter.html#document/p1>

<sup>18</sup> See: <http://www.cbc.ca/player/Radio/Local+Shows/Manitoba/Information+Radio+-+MB/ID/2308460786/>

process whereby First Nations communities take full control of CFS agencies, without outside interference, so as to better protect Aboriginal children and youth.

While devolution has destabilized the child welfare system, residual social welfare is compounding the issue of high caseloads. It may seem counter-intuitive that a residual, hands-off approach to social welfare would lead to more children/youth in care. However, when social safety nets disappear, families struggle and more children and youth suffer. Studies show that fluctuations in child welfare rates are sensitive to shifts in poverty rates (Gelles & Conte, 1990; Trocme & Chamberland, 2003). For example, in an Ontario child welfare sample, 44% of neglect cases were dependant on social assistance (Trocme & Chamberland, 2003). Furthermore, studies of children living in poverty indicate that poor nutrition places children at risk for later learning, behavioural and developmental challenges (Tanner & Finn-Stevenson, 2002). With growing emphasis on risk-profiling in social services, these at-risk groups are able to be identified earlier and steps are taken to reduce the risk these families pose. With retrenchment of social services, often the quickest and easiest intervention is to take the child/youth into care once all other options have been explored; rather than implementing new family enhancement programming.

While there are many wonderful foster placements in Manitoba, participants emphasized that there were not enough for the numbers of children/youth in care. Several participants suggested that some of the foster homes appear to follow the dictum of ‘medication for money’ which may be a reflection of the growing monetary needs of Manitoba families. For instance, in 2012, Manitoba had the second highest child poverty rate in Canada, with over 20% of children (about 54,000) living below the poverty line as defined by Statistics Canada’s Low Income Measure After Taxes (Social Planning Council of Winnipeg, November 2012).

Of the 16 participants who work for CFS, one participant did not respond to caseload size and one was unsure of exact numbers. For the 14 participants who knew their caseload size, half indicated that their caseload is higher than 25 cases (the highest caseload is 42) and 3 participants stated their caseload is 25 cases exactly. In Manitoba, workers are mandated to visit families at least once a month. If you factor in the weekly commitments to intake, court appearances, and administrative responsibilities, only two, perhaps three days a week are available for visitations (see, Carreiro, 2012, ¶28). On top of this, C/YIC are spread across Manitoba. With the switch to a concurrent model where families are able to choose which authority to receive service from, you have social workers who must travel vast distances to provide service. If you add up the driving distances between cases, it leaves very little time to spend with the child or youth. For example:

*Last night I worked until eight o'clock. I went to see my kids in the afternoon because I had to do some paperwork in the morning. I went first to Portage la Prairie, then I drove to Steinbach and then another coworker wanted me to stop by to see a child but I couldn't find the place. I couldn't find the community and so I decided to keep going and I went to Selkirk (Colleen, CFS).*

The distance from this participant's office in Winnipeg to Portage la Prairie is 86 km or about an hour to drive. From Portage la Prairie to Steinbach, it is 158 km or about 2 hours to drive. From Steinbach to Selkirk, it is 70 km or about one hour. It is no wonder that social workers are only able to spend 20 to 30 minutes with the children/youth in their care, once a month.

### **Manitoba Social Worker Roles in Psychotropic Medication Management**

Institutions and agencies operate through differentiated tasks that are assumed by individuals within the particular context (meso-situation). The subsequent actions that

underlie the tasks are shaped through the structure, context, personality and knowledge-base of individuals. It has been argued that social work has a propensity to borrow knowledge derived from other disciplines including psychology, sociology, and medicine (Chambon, 1994; John, 1994). This allows “medicine and psychiatry to act as the formal authority in mental health treatment, psychology to provide the important research and scientific basis for knowledge”, and leaves social work to be the “foot soldiers and the housekeeping” (Epstein, 1994, p. 6).

When asked what role they play in the medication management and treatment process of C/YIC, 4 of the 34 participants in my study did not respond to the question. Additionally, three of the 30 participants who answered this question responded that they did not play any sort of medication related role. For example:

*I do not have a role in the medication (Cathy, Private Practice)*

*None here at MB CFS [Manitoba CFS]. In ON [Ontario] there was a bi-cultural practice (Mica, CFS)*

However, the majority of participants (n=27; 79.4%) indicated that they do play official and/or unofficial medication-related roles within their various fields of practice, with 20 of the 27 participants indicating they play more than one role<sup>19</sup>. These roles, which manifest differently depending on the social worker's working environment and individual case features, include acting as approbator, advocate, consultant, physician's assistant, counselor, monitor, and educator (Bentley & Walsh, 2006). Each of these different roles will be discussed below.

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<sup>19</sup> The roles that study participants said they play may not necessarily be the actual roles they play. A social desirability effect may be occurring; i.e., they may have only indicated roles that they feel they should or ought to play. Without being able to observe actual behavior, the study can only rely on self-reported roles.

**The Role of the Consultant.** According to Moses (2003), the role of a consultant/collaborator refers to the ability of social workers to screen potential cases for the need for medication. Social workers who adopt the role of consultant will assess the child/youth and, if needed, refer the child/youth and/or caregivers to the appropriate resources (physician or supports). In this role, the social worker may also evaluate the client's ability to pay for treatment and will help the client secure funding. Finally, the social worker may also consult and collaborate with physicians regarding the treatment plan (see, Bentley & Walsh 2006). For example:

*I will recommend seeing a general physician if I observe symptoms or behaviours consistent with clinical disorders such as anxiety or depression. I will approach the idea of seeing a therapist/counsellor and, if the youth is open to it, I will advocate to the CFS social worker to secure funds for this (Linda, Clinical Social Work).*

*Typically, I meet with a foster parent or other care provider who tells me how a child or youth is acting out, getting into trouble, having trouble at school, can't sit still, seems to be depressed or anxious etc. At this point the foster parent may ask to have the child or youth assessed by a doctor in order to get medication, but I would tend to try other avenues first such as counselling, therapy, extra support, or a reward system. If those other interventions don't work, then it would be myself as the child's worker who would make a referral to the doctor for an assessment. I would also typically attend the appointment with the foster parent. (Greg, CFS).*

*The role is to assess the child to best of one's ability to work with families in understanding the child's behavior in the home. To fully discuss with the medical profession if there are other options than medication. To gain a better understanding of the usage of medication vs other treatments (Keri, CFS).*

*[I] consult with psychiatrist and staff regarding each youth when meds being considered (Dara, Clinical Social Work).*

Sixteen of the 27 participants who described playing roles mentioned that they act as consultants. All (100%) of the participants working in the mental health field said they



act as consultants, compared to only 42.9% of participants in CFS and 66.7 % of participants in child welfare and other fields.

**The Role of the Advocate.** Gerhart and Brooks define social work advocacy as representing and presenting “the client’s expressed desires to those in the mental health system who have the power” (1983, p. 456). The role of advocate conforms to the underlying values of social work wherein it is the duty of the social worker to protect the client’s interests and rights. The social worker, acting as advocate, “participates in all phases of decision making regarding the choices made for medication” (Bentley & Walsh, 2006, p. 17). For example:

*I serve as an advocate and support for families that have children on medications. I help and support families with the implementation of whatever plan is put in place (Brittany, Outreach).*

*I try to advocate for the child... I talk to teachers, I talk to the foster parents, you know it takes a lot of time. I get everyone on board (Colleen, CFS).*

Twelve of the 34 participants mentioned that they play the role of advocate for children/youth in care in terms of medication and protecting the vulnerable child/youth’s interests and rights. Only 35.7% of participants who work in CFS play the role of advocate compared to half of the participants working in mental health. Sixty-seven percent of participants in child welfare who discussed playing medication management roles stated they act in an advocacy role.

**The Role of Approbator.** The role of the approbator is one that has not been described in the literature on social worker roles in medication management. Most likely this absence is due to the generalized scope of the literature and the paucity of information on CFS and child welfare social worker roles in medication management with children/youth in care. Furthermore, there could be liability risks in indicating

approval for medication when social workers are not licensed to do so unless they are acting *in loco parentis*.

Over half of the social work participants (57.1%) in my study who discussed medication management roles and who work within CFS indicated that their role is to approve whether or not the child/youth should go for treatment or receive medications. Since these workers act *in loco parentis* (in the place of the parent) they are the ones who must determine if foster parents or caregivers can place the child/youth on medication. Additionally, they are the ones who approve the funding for the medications.

*As legal guardian I sign approval (Connie, CFS).*

*As the guardian of children in care, it would be my responsibility to sign and authorize a child to be given medications. A thorough assessment by a qualified medical practitioner will first need to occur (Joy, CFS).*

*If the child is a Permanent Ward then the CFS worker is responsible for deciding to allow treatment/medication to be used and administered (Terry, CFS).*

*I just sort of remind all foster parents, particularly with psychotropic meds, if there are changes needed or if your foster child has an upset stomach or you have a question, by all means go to a pharmacist and ask a few questions. And if something needs to be done by all means do it. Just be extra diligent in terms of making changes, particularly abrupt changes. [...] 24 hour caregivers are right there and if it was their own kids, they could do usually what they want. But when it comes to prescriptions and some medical services, they are supposed to go through us. That makes things more complicated (William, CFS).*

**The Role of Physician's Assistant.** According to Moses (2003), the social worker's role as physician's assistant entails accepting the physician's medication decision and helping clients follow doctor's prescriptions and recommendations. This means that the social worker does not offer advice about a physician's decision to prescribe medication. Instead they unquestioningly defer to the doctor's wisdom (Bentley & Walsh, 2006).

*[...] we are lucky enough to work directly with a psychiatrist right here in this building and see them every day. They are right in charge directly with the medications and then we have nurses who are in charge of the provision of it. So I never have anything to do with that (Amanda, Adolescent Mental Health).*

*At times I will make recommendations for children to be assessed by psychiatry as opposed to a general practitioner when many different medications have been prescribed by the GP. I want a specialist to review the medication combination (Joshua, CFS)*

*Here we have a consulting psychiatrist who will engage in dialogue about alternative treatment for youth and will listen to concerns about use of meds. He will provide medication for our young people and follow up to ensure it is effective, but he does not exclusively encourage med use (Sylvia, CFS)*

*The social worker trusts the advice and professional decision made by the medical doctor if medication is advised (Terry, CFS)*

Half (50.0%) of the participants who described playing roles and who work in mental health and in CFS stated they act as physician's assistant. None of the participants in child welfare or other fields mentioned that they play this role.

**The Role of Counselor.** Several of the participants discussed playing the role of a counselor in the medication assessment and treatment process. In other words, they provide clients with advice, act as a coach, and teach clients how to problem solve. As Bentley and Walsh explain, "In the role of counselor, then, the social worker helps the client solve problems and make decisions about practical matters related to medication use" (2006, p. 15). This role, therefore, overlaps with the role of educator and advocate; however its emphasis is on advice and problem solving.

*In my conversations with foster parents I might encourage or discourage discussion with doctors about psychotropic medication (Maggie, Child Welfare).*

*As a clinician, I work with the parents and youth to develop a treatment plan. [...] Following a consultation, we determine what recommendations*

*the family wishes to pursue. We develop the treatment plan based on their needs and wishes (Rachell, Adolescent Mental Health).*

*In my role I look at the whole system, not just the medication but the whole environment. I put the person into the whole picture what is causing this. I look at all aspects of that person's life their home environment, social and economic things. I will advise the [client] to use other therapies like talk therapy or other models of narrative therapy and not just to go to physicians who prescribe drugs (Tonda, Outreach)*

A total of 17.6% of 34 participants in the study said that they play the role of counselor.

**The Role of Monitor.** The role of monitor entails observing and tracking compliance, symptoms, and effects of the medication. As well, the social worker may then report back to the physician or the caregivers about what has been noticed. For instance, participants stated:

*[My role is] assisting in monitoring progress (Ellen, Child Welfare)*

*I work with foster families, etc. to ensure children take medication if required, and [I] monitor effectiveness of medication (side effects, etc.) (Sally, CFS)*

*Unofficially [my role involves] seeing how the child is day to day on meds (Rosalind, CFS)*

*Occasionally I will be asked to observe students in the classroom and that assessment can be used to look at any changes in behaviour. That information can be sent to psychiatrists or family doctors to look at dosage or whether or not the right medication has been prescribed. (Kelly, School Social Work)*

A total of 14.7% of the 34 participants (18.5% of those who described playing a role in medication management) said that they track the effectiveness of the medication, scrutinize the continuation of the symptoms, and watch for medication compliance.

**The Role of Educator.** Social workers can also play the role of educator when they take on the job of explaining to the client the reason they were prescribed psychotropic medication and the potential side effects of medications (Moses, 2003).

*The families are often asking questions about medications or seeking further clarification. So I have such a general knowledge that I am willing to share kind of generally with them if that is helpful. I would provide a, a fair bit of psycho-education but then direct them to the doctor or the nurses for any of the real specifics (Amanda, Adolescent Mental Health).*

*At times we talk about the medication. You know who, what, when, where and why. And try to influence in terms of when they are not taking their medication to try to impress upon them why they are taking it. And how that will lead, enhance where they want to be. [...] But still [to provide them] a clear idea of why they are using it (William, CFS).*

A total of 8.9% of the 34 participants said that they play the role of educator and impart to clients the effects of the medication and what to attend to.

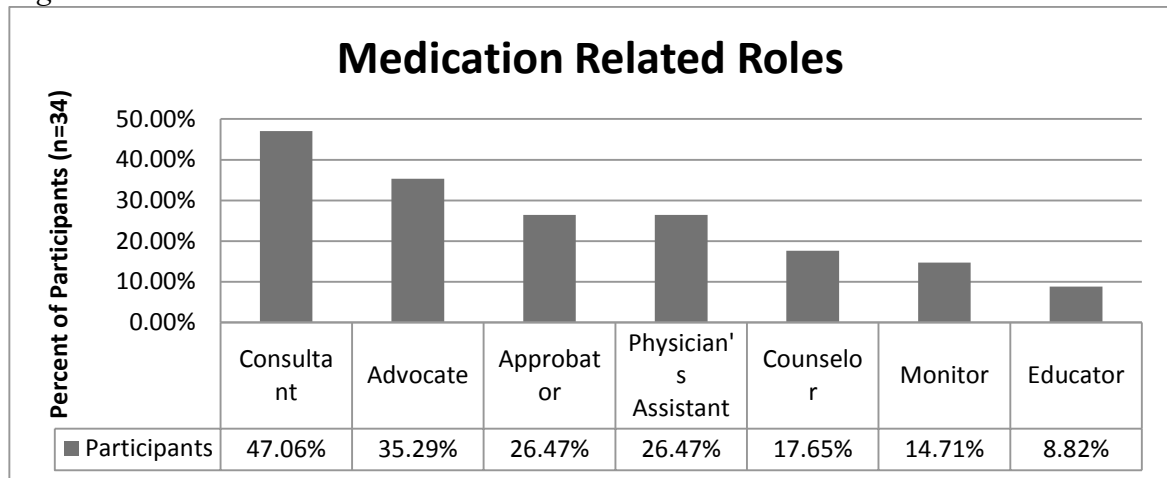
While there are a number of roles that social workers may play in medication management, it is important to understand that the medication-related roles they play may overlap, such as a counselor educating their client and an educator counseling their client.

For example Michael (Adolescent Mental Health) describes playing multiple roles:

*I ensure that parents/care-providers/clients know what medication is being taken, have proper access to information about these medications [Role of Educator]. I advocate that clients/caregivers have opportunities to voice their questions/concerns/feedback to the Physician who is prescribing these medications [Role of Advocate]. I ensure that clients and caregivers understand their role in terms of informed consent and authorization as it pertains to the administration of medications. I help clients and caregivers find funding resources for medications [Role of Consultant] (Michael, Adolescent Mental Health).*

To summarize the roles by numbers, the most commonly mentioned roles among participants is that of the consultant (n=16; 47.1%); followed by advocate (n=12; 35.3%); approbator and physician's assistant (each, n=9; 26.5%); counselor (n=6; 17.6%); monitor (n=5; 14.7%); and educator (n=3; 8.8%) (see Figure 3).

Figure 3: Medication Related Roles



\*Note that participants often mentioned playing more than one role

**Summary of Findings.** A role is more than just a list of duties; it is also the construction of action appropriate to the situation and one’s perspective within it. Social workers have many potential roles that they can play in the medication assessment and treatment process for children/youth in care, including acting as physicians’ assistants, monitors, consultants, counselors, approbators, advocates, and educators. The roles available depend and are determined by varying situational contexts such as age, place of work, levels of experience and so on.

All of the male participants stated that they play the role of consultant compared to 52.2% of the female participants. Half of the participants with lower caseloads (<25) described playing the role of approbator compared to 18.2% of participants with caseloads greater than 25. As well, over a third (36.4%) of participants with high caseloads said they play the role of physician’s assistant (compared to 28.6% of participants with low caseloads). Age differences were also noted. Forty-one percent of younger participants (aged 25 to 44 years old) said they play the role of approbator compared with 20% of older participants (aged 45+). Furthermore, 40.0% of older

participants said they play the role of counselor compared with 11.8% of younger participants.

The role of consultant appears to be the most favored role among participants, regardless of individual and structural features of the situation. Since the consultant role is one of greater collaboration between social work and medicine, this suggests professional regression of medicine. According to the regression hypothesis, the profession of medicine may be withdrawing into themselves and away from tasks they claim professional jurisdiction over (such as evaluating the need for medication), thereby weakening their jurisdictional claims and allowing invasion by other professions (such as social work) (Abbott, 1988). The ability of a profession to sustain its jurisdiction or its claim to particular work lies in the power and prestige of its knowledge (Abbott, 1988). In this case, social workers demonstrate their professional power and knowledge by acting out different medication management roles.

The roles that social workers enact fall under a pastoral modality of power, a positional or situational power (Smith, 2010). Due to the position they occupy (as the benevolent shepherd watching their flock), social workers are charged with the task of integrating the child or youth in their care into the wider social system through corrective training. One aspect of this may be monitoring, assessing, examining and calculating the need for medical intervention and thus, the social worker may play different roles singularly or simultaneously. The role a social worker may play in medication management, however, may depend on whether their experiences with C/YIC medicated with psychotropics has been predominantly good or bad.

## **Participant Experiences with Medicated C/YIC**

A number of different researchers have expressed their concern about over-prescribing or using psychotropic medication without justification on children/youth in institutional settings such as C/YIC (e.g., Connor et al. 1998; Ontario Expert Panel, 2009; Zima et al., 1999). However there is very little empirical research in this area. In a 2008 study, social workers observed that, in their experience, systems cases (including children/youth in care) were less likely than non-systems children/youth to benefit from symptom reduction through medication (Moses, 2008). A recent qualitative study on the experiences of Canadian children/youth in care on psychotropic medication supports this finding. In this Canadian study, the researchers found that the children and youth had a number of negative experiences with being medicated, including weight gain, dependency, development of mood swings, drowsiness, fatigue and lowered self-esteem (Lambe & McLennan 2009). My study, however, focused on social workers' positive and negative experiences working with C/YIC medicated with psychotropics.

An experience is a situation embedded in a particular social time and space, often located within the walls of organizations or in the boundaries of groups. Experiences can be defined which means that individuals can describe what went on, who did what, why it was done, where it was done, and how they feel about it. Experiences anchor conduct and the meanings of experiences are of an emergent nature. Thus, what is experienced in the here and now is always understood in relation to what has occurred in the past and what may occur later; ethnomethodologists have referred to this as a retrospective-prospective sense of a present occurrence (c.f. Cicourel 1972; Garfinkel 1967). It is important to



acknowledge at the outset that individual experiences are plastic, changeable and can be tied to time and place. Therefore, they must be examined and understood in context.

In terms of sheer volume, participants described 53 negative experiences to 75 positive experiences, or 1.4 times more positive than negative experiences. It is important to emphasize though that numbers of experiences do not and cannot reflect the impact the experiences have had on the participant and/or child/youth in their care. In other words, one participant may have had only one negative experience with a medicated child/youth. However, that single experience may have been so devastating and horrific that the impression it left was overwhelming for the participant. So while I do describe numbers and totals of experiences, I am acutely aware that we can lose sight of the individual impact and feeling behind those numbers. Hopefully, the quotes included in this section will impart the level of intensity of the participant experiences.

**Negative Experiences With Medication.** Eight of the 34 participants (23.5%) said they had not had any negative experiences with children/youth in care on psychotropic medications and an additional 3 participants did not respond to the question. The remaining 23 participants described a number of different negative experiences they encountered with children/youth in care on psychotropic medication. These included (of the 23 participants):

- Non-compliance with medication regimens (either not taking their medication or taking their medication inappropriately) (43.5%);
- Cognitive dulling where children/youth become “zombies” and are overly fatigued (39.1%);
- Over-reliance on psychotropic medication and no focus on alternative therapies (34.8%);
- Increased trauma and lower self-esteem due to stigma and labelling (30.4%);
- Medications not working which leads to medication jumping (switching from medications to medications) (26.1%);
- Negative physical side effects such as facial tics and weight gain (21.7%);

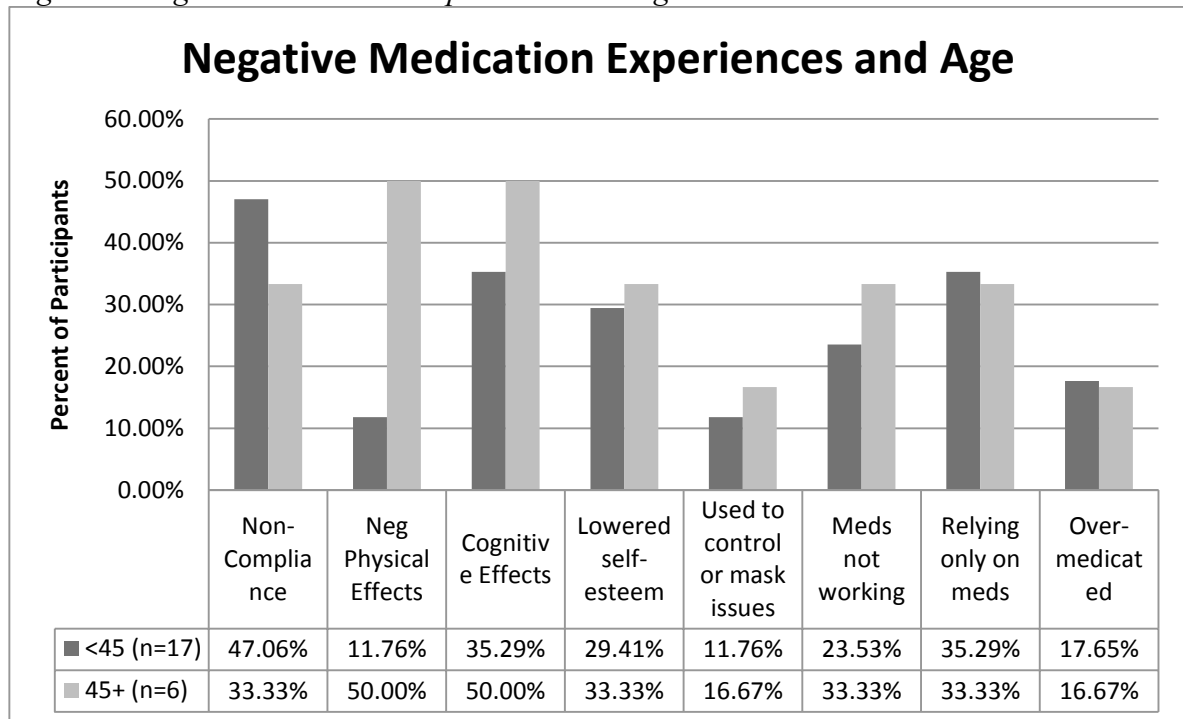
- Over-medication and improper diagnosis (17.4%); and
- Medication being used to control the children/youth and mask trauma (13.0%).

Each of these experiences will be explored in turn; however certain patterns of negative experiences were discovered among participants according to their roles in medication management, age, caseload size, and field of work.

Participants who said they play the role of approbator, counselor, and/or monitor described experiencing compliance issues more than participants playing other roles. This may be due to the focus of these roles; an approbator approves medication use; a counselor advises the children/youth on their medication decisions; and a monitor observes and tracks compliance, symptoms, and effects of the medication.

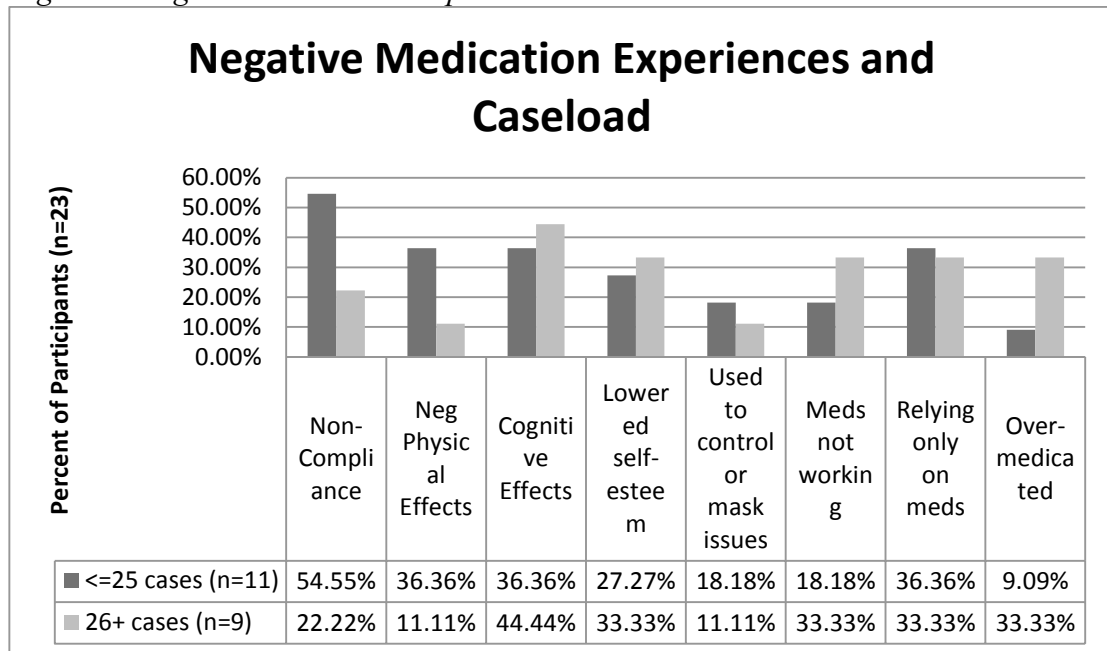
Medication compliance was more of a concern for the younger participants (less than 45 years old) than the older participants (age 45+). This may, in part, be due to experience levels associated with age. One can speculate that the younger participants have less experience with children/youth on medication and less experience in getting the child/youth to comply. The older participants, on the other hand, described more negative physical and cognitive effects on the children/youth than the younger cohort. Again, this may be due to the amount of experience older participants have with medication side-effects compared to the younger participants (See Figure 4).

Figure 4: Negative Medication Experiences and Age



Differences were also noted by caseload size. The ratio of negative experiences with lower caseloads to negative experiences with higher caseloads is 1.3:1.0. Participants with higher caseloads were concerned with the medications not working, while participants with lower caseloads were more concerned about compliance and the negative physical effects of the medication on the children and youth (See Figure 5). Those with higher caseloads may have much less time to spend with the youth, counseling them on medications and advocating for them, hence the greater concern with medications not working. Those with lower caseloads may have more time to notice the negative physical effects of the medication and lack of compliance.

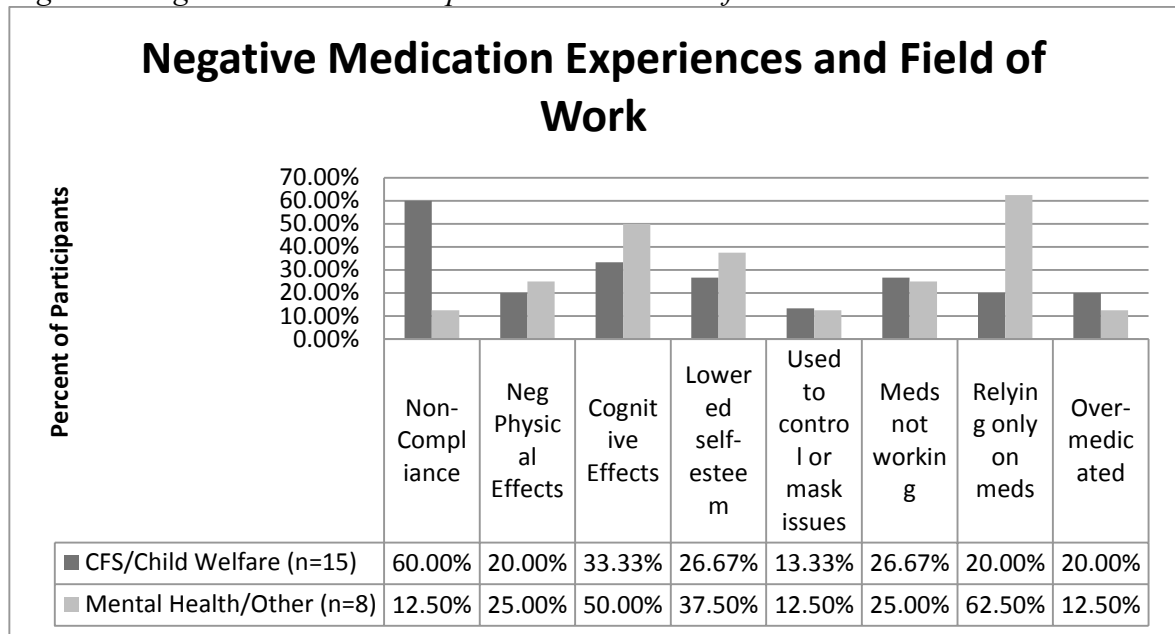
Figure 5: Negative Medication Experiences and Caseload



Note: 3 participants did not know their total caseload size

Furthermore, differences were also noted by field of work. Participants who work for CFS or in child welfare were more concerned about compliance (See Figure 6). This may be due to the caseload size and lack of time CFS and child welfare participants have to work with the children/youth in their care. Additionally, non-compliance with medication regimens might be a greater issue for CFS and child welfare workers due to outside complaints they receive from educators and foster parents (see section on non-compliance below).

Figure 6: Negative Medication Experiences and Field of Work



**Non-Compliance.** When asked to describe some of their negative experiences with children/youth in care on psychotropic medications, 43.5% of the 23 participants answered that compliance with medication regimens is an issue.

*It's really hard when you have a youth who you know should be taking his meds because he can function so much better, and stays out of trouble, but when they don't want to take it, you can't force them to. Obviously we respect client determination and that includes the taking of medication (Greg, CFS).*

*Even when we have people motivated to get help, they might start a medication but that can change over time where they don't feel that they like it anymore. It has changed them or they feel sick so they'd rather not do it [...] and it is very difficult to explain, "well, you might need this medication," "well, you have bipolar disorder and you might need this medication for the rest of your life." You know, lithiums are a pain in the ass (William, CFS).*

Non-compliance often causes foster parents and educators to complain to the social workers about the child/youth's behavior.

*[When they go off their medication] then this worker will start to receive more phone calls from the foster parents, school or work place. There may be an increase in involvement with the law or with substance abuse. The*

*foster parent is frustrated and the placement starts to break down. That is when this worker is needed more to support the foster home and youth as well as more meetings with the school (Terry, CFS).*

*It can be seen as a challenge to keep youth's medication intake stable, when they are transient, AWOL etc. This can be seen as a compounding factor, as both their medication and placements are instable co-currently and can negatively influence one another (Sally, CFS).*

*The youth will refuse and it will become a power struggle (Rosalind, CFS).*

The underlying connotation of these comments is that social workers are under pressure to keep the child/youth medicated. Therefore, non-compliance results in greater work for the social worker.

***Cognitive Dulling and Zombification.*** Several of the participants (39.1% of the 23 participants) said that the children/youth become more fatigued and drowsy when on the medications.

*Medications can help with sleep but some youth report that their medication can also increase sleep and make them feel sluggish with low energy (Michael, Adolescent Mental Health).*

Participants also explained that the medications can result in “zombie-like behavior” and lead to less participation, recreationally and in school.

*One sixteen year old youth was on Seroquel and Risperidone. She would take the medication at bedtime and it was extremely difficult to wake her up in the morning; she was like a zombie (Mica, CFS).*

*Some of these children on psychotropic medication have become docile to the point of zombie-like behavior. There is a change that happens in the some youth/children in care on these medications that transforms the child to the point where their personality changes (Alyssa, Outreach).*

*At times children become too groggy from medications. It can hurt school performance if they're groggy (William, CFS).*

***Over-Reliance on Psychotropic Medication.*** 34.8% of the 23 participants suggested that there is an over-reliance on psychotropic medications that leads to less

emphasis on alternative and simultaneous therapies. Furthermore, they are concerned that using psychotropic medications without therapy can leave basic problems unchanged.

*Medications, when used as a front of the line therapy, sometimes prevent other forms of therapies from being used [...] Also, pills do not build skills - that is medications are at times used without dual focus on helping a youth naturally develop their own coping skills and problem-solving. (Michael, Adolescent Mental Health).*

*[...] medication is only part of the picture. It is not the whole picture (William, CFS).*

### ***Increased Trauma and Lower Self-Esteem Due to Stigma and Labelling.***

Several participants (30.4% of the 23 participants) explained that for some of the children/youth in their care, the medication has increased the child or youth's distress. For example:

*Meds have increased trauma symptoms (replaying the use of intoxicants prior to past assault). Meds have interfered with a youth's hyper vigilant state (used to keep the youth protected in the past and currently not required but the youths system is still wired from chronic trauma). Youth is responding to environmental stress (possibly related to anniversary dates of abuse or loss or actual family upheaval or crisis) and medication is prescribed rather than addressing the contextual issues (Sylvia, CFS).*

Additionally, participants mentioned that children/youth often feel stigmatized and labeled as "defective" once they are put on medication which then lowers their self-esteem.

*[They have a] fear of being "different"; don't see the benefit (Ellen, Child Welfare).*

*Some clients don't have [the] opportunity to try behavior change without the medication. Some feel labeled. And some present as being "high" and "distant" (Cathy, Private Social Work).*

***Medication Not Working and Medication Jumping.*** 26.1% of the 23 participants said that it is problematic when the medication does not work and/or when

the child/youth has to jump from medication to medication in order to find an effective treatment. For example:

*One young man is heavily medicated and has a med review every two months. He is constantly having his medications adjusted (Connie, CFS).*

*Some of the negative effects have been when the medication does not work when different doses are prescribed, or when the medication stops working. Behaviors quickly come back (Keri, CFS).*

**Physical Side Effects Such as Facial Tics and Weight Gain.** Participants (21.7% of the 23 participants) also mentioned that they encountered negative physical side effects due to the medications. They said that the medication caused facial tics, sun reactions, jerky movements and weight gain:

*Tired; not hungry; youth described feeling zoned out; increase in facial tics; weight gain; embarrassing (Terry, CFS).*

*One young man is heavily medicated and has a med review every two months. He is constantly having his medications adjusted as he quickly develops an intolerance and has also been known to have negative side effects such as tongue thrusting and jerky movements. And a severe reaction to sun which can limit activities in community (Connie, CFS).*

*He gained weight, mainly due to the medication (Tonda, Outreach).*

*The side effects from medications (specifically weight gain) can be really damaging (Michael, Adolescent Mental Health).*

**Over-Medication and Improper Diagnosis.** Only 17.4% of the 23 participants stated that children/youth in their care were improperly diagnosed and/or over-medicated.

For example:

*Over-medication. Children are medicated at an early age and are often prescribed too strong of a dosage and the results can be described as “zombified”. Children’s natural artistic abilities and imaginations are curbed (Joshua, CFS).*

*For some students on anti-depressants (particularly with students in high school it is a difficult task to get the right medication, right dosage, etc. (Kelly, School Social Work).*



***Medication to Mask And Control.*** Three of the 23 participants (13.0%) suggested that medication is being used to mask trauma and control behavioral issues.

*Medications sometimes are too easy of an answer to effectively address a youth population with a complex level of need; especially youth who are behaving erratically or in an oppositional fashion. Medicating bad behavior does not appear to help youth long-term as the memories and emotions behind these “bad behaviors” do not go away (Michael, Adolescent Mental Health).*

Although it is clear that participants have had a number of negative experiences working with children/youth in care on psychotropic medication, they also described many positive experiences with C/YIC on psychotropic medication.

**Positive Experiences With Medication.** Twenty six of the 34 study participants described positive experiences with children/youth in care on psychotropic medication.

They said that psychotropic medications:

- Stabilized mental status; the child/youth is calmer and sleeps more easily (69.2% of the 26 participants mentioned this)
- Helped with concentration and focus, particularly in school; improved school outcomes (65.4%)
- Controlled negative behaviors and imparts structure (65.4%)
- Improved relationships and participation (53.8%)
- Improved the child/youth’s self-esteem and quality of life (19.2%)
- Helped prepare the child/youth for other therapy (15.4%)

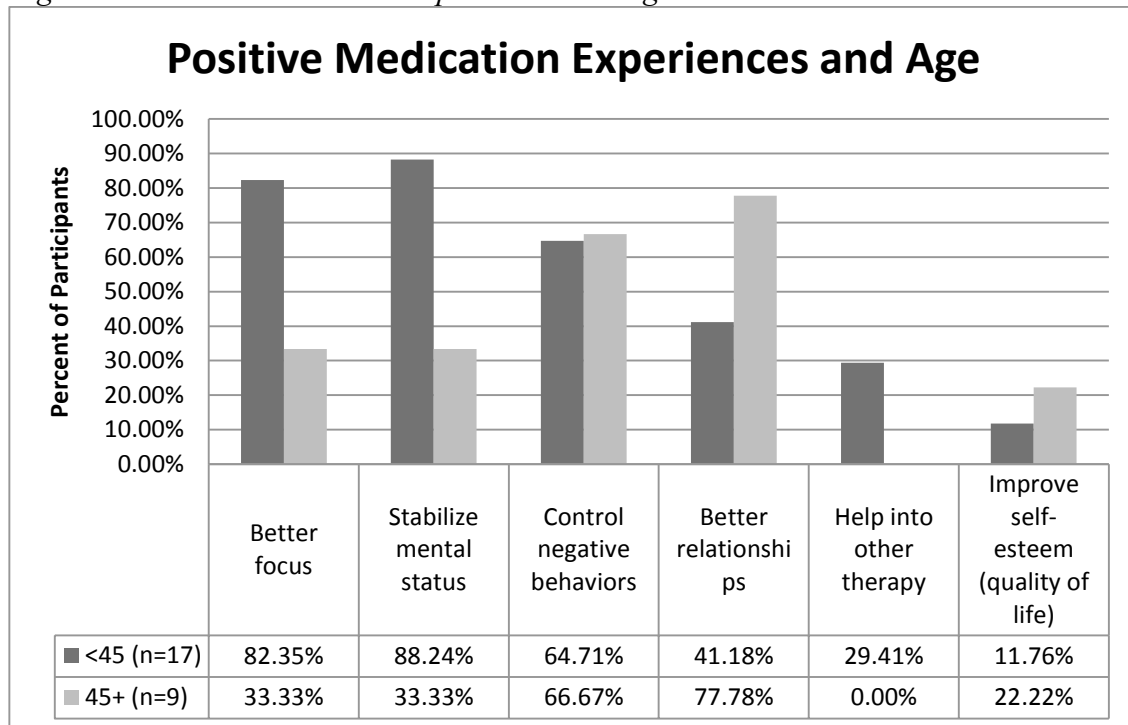
Each of these experiences will be explored in turn; however, like the negative experiences participants encountered, certain patterns of positive experiences were discovered.

Participants who play the roles of physician’s assistants, monitors and/or educators in the medication management of C/YIC appeared to have more positive experiences working with C/YIC on psychotropic medication than participants who play other roles. Additionally, age differences were also discovered. Younger participants (<45 years old) tended to describe the individual benefits of medication while the older

participants (45+) tended to describe the more social benefits of psychotropic medication on the child/youth. For instance, younger participants described experiences where the child/youth can concentrate and focus better and emphasized experiences where the mental health status of the child/youth becomes stabilized making them calmer and easier to deal with. Older participants (45+), however, tended to describe experiences where medicated children/youths are better able to participate in social activities and thus improve their relationships with others (See Figure 7).

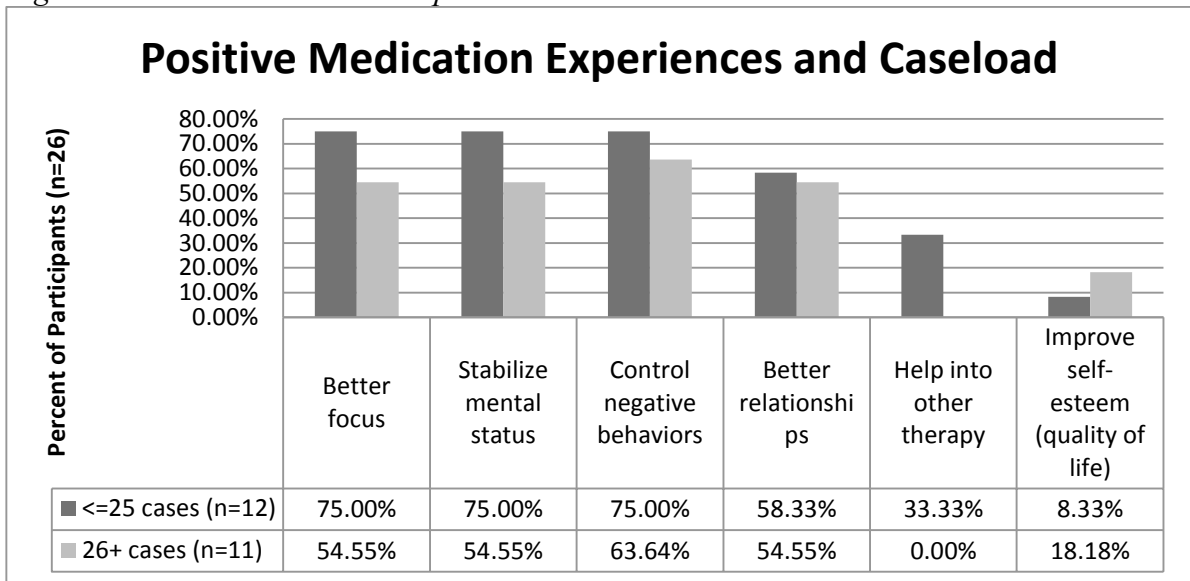
The age effect may be due to the direction that social work practice has been moving towards. The younger cohort has entered a field which has been aligning itself to the dominant discourse of scientific practice in order to gain legitimacy and enhance its status. This leads to an emphasis on the individual rather than on society, thus contributing to the construction of social work practice as dyadic – primarily between client and worker (Chambon, 1994; Mullaly, 2007; Weinberg, 2010). Additionally, the rise of residual social welfare also places emphasis on individual solutions to issues rather than the social system. In contrast, the older cohort may be clinging to a deep rooted vision of social work practice as predominantly social.

Figure 7: Positive Medication Experiences and Age



Differences were also noted by caseload size. Participants with lower caseloads (less than or equal to 25) tended to have more positive experiences with C/YIC on psychotropic medication overall. Thus, the ratio of positive experiences for participants with lower caseloads to positive experiences with higher caseloads (26+) is 1.4:1.0 (See Figure 8). To account for these differences, it is possible that participants with higher caseloads do not have the time to witness or take account of some of the positive effects of medication on the child/youth. However, further research into this is necessary.

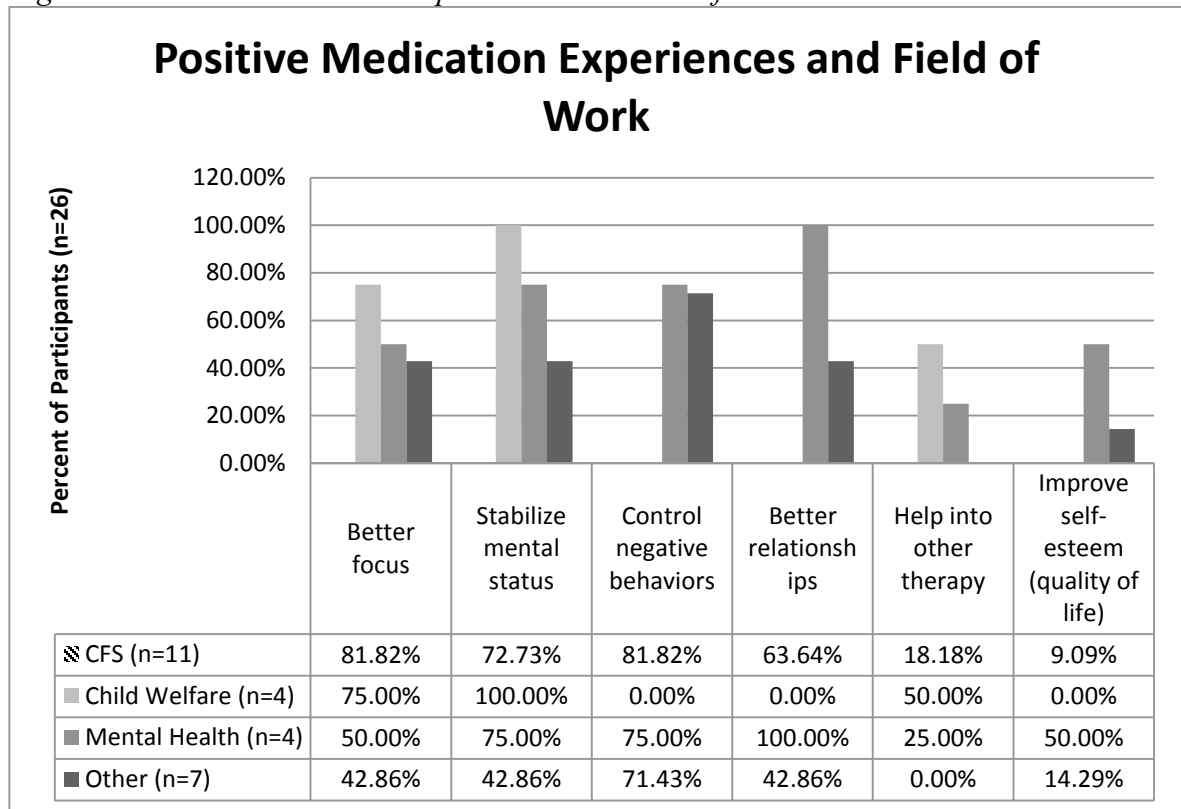
Figure 8: Positive Medication Experiences and Caseload



Note: 3 participants did not know their exact caseload

Differences were also noted by field of work. The main positive experiences mentioned by participants who work for CFS and child welfare agencies include better focus, stabilization of mental status and control of negative behaviors. This, once again may relate to comments made by educators and foster parents to CFS and child welfare workers regarding the benefits of medicating children/youth in care.

Figure 9: Positive Medication Experiences and Field of Work



**Stabilizes Mental Status.** Eighteen of the 26 participants, including all of the participants in the field of mental health, described experiences where medication stabilized the youth/child’s emotions and improved their mental health.

*When one is having symptoms of psychosis, the thoughts and hallucinations that one may endure can be debilitating and very scary. Medications help to reduce these symptoms and alleviate the anxiety and emotions that come along with them. [...] I have seen medications have a positive role with sleep hygiene which of course leads to better functioning during the day (Michael, Adolescent Mental Health).*

*Medications have helped to stabilize the clients and allowed them opportunities for more success (Rachell, Adolescent Mental Health).*

*So in terms of positive experiences, often we found it is quite imperative to be on different medications so that they can think clearly and regain a stable mental status (Amanda, Adolescent Mental Health).*

According to the participants, as mental health stabilizes, the child/youth becomes calmer.

*Generally they seem calmer in home and in school or daycare (Maggie, Child Welfare).*

*There can be a more calming effect (Karen, CFS).*

*Positive: it has enabled youth to be calm, relax (Rosalind, CFS).*

Participants suggest that once the child/youth is calm, their sleep often improves.

*Meds have also helped some traumatized youth settle at night which has helped them sleep and feel more capable in the morning (Sylvia, CFS).*

*Many children have an easier time to fall asleep thanks to the side-effects (Joshua, CFS).*

**Improves Concentration and Focus.** 65.4 % of the 26 participants stated that medication helps the children/youth improve their concentration and focus which leads to improved school outcomes. For example:

*Meds have helped with focus thus supporting youth to feel more competent as students (Sylvia, CFS).*

*Has given the children the ability to remain in school and function at a manageable level (Brittany, Outreach).*

*In the children it has made it more manageable for them to focus for longer period of time in general and also in school (Keri, CFS).*

*Medications help them to concentrate more and increases their ability to learn and hold on to new information. This of course leads to better academic success (Michael, Adolescent Mental Health).*

**Controls Negative Behaviors.** 65.4% of the 26 participants also mentioned that medications have helped to control negative behaviors.

*Well I guess it has helped the youth settle down. More specifically, the kids with ADHD, where they weren't able to sit still or do much of anything, are able to sit still and get work done, focus, and not be bouncing off the walls (William, CFS).*

*Certain impulsive behaviours have been curbed (Joshua, CFS).*

*Appropriate doses of medication can be a real asset, to allow for focusing, calming, reduced violent/aggressive behavior (Cathy, Private Social Work).*

*Youth/children using psychotropic medications become much more manageable in their behavior, and are more agreeable, pleasant, and easier to work with (Alyssa, Outreach).*

*Some youth are less hyper [...] Decrease in outbursts (Terry, CFS).*

**Improved Relationships and Participation.** Fourteen of the 26 (53.8%) participants described how psychotropic medications have helped children/youth in their caseloads have better relationships with people in their lives, as well as increase social activity. In other words, the medications improve relationships. For example, the child/youth may start to participate more in outdoor activities or they may finally be able to overcome their anxiety issues and join a recreational league or club.

*Meds have provided relief to some youth which results in them feeling less distress and out of control so they can speak and relate with others thus feeling less isolated. As one boy said to me, "I feel less whacko". The connection he was able to make with staff and other youth helped him feel better about himself and his daily life (Sylvia, CFS).*

*It has [enabled the children] to interact more positively with their peers (Keri, CFS).*

*Better home/school relationships (Brittany, Outreach).*

*They are able to make friends and work on their social skills [...] Can decrease anxiety allowing the youth to attend school or social outings (Terry, CFS).*

**Improved Self-Esteem and Quality of Life.** Several participants (19.2%) described individual children/youth and the positive impact that psychotropic medication has had on their lives, including helping the child/youth improve their self-esteem.

*One of my youths (age 18) has a prescription for Sertraline. Over the summer she stopped taking it and she was like an entirely different person. She was withdrawn and quiet. Simple tasks such as making a phone call or asking for assistance at the library caused her anxiety. Since being back on the medication she has a much more outgoing personality and a more positive outlook on life. She talks about her future and her goals (Linda, Clinical Social Work).*

*I have seen the use of psychotropic medications have a positive impact in the life of youth—specifically those that have experienced symptoms of psychosis or distorted perceptions (Michael, Adolescent Mental Health).*

*One individual has multiple disabilities and it has improved his quality of life (Connie, CFS).*

**Helps Prepare for Other Therapy.** Several participants (15.4%) also mentioned that medication helps the youth become more receptive to other therapies.

*The prescription might get them to the front door whereas without medication they couldn't even get to the front door for that extra help; whether that is school a counselor, whether that is a resource person, or psychologist, what have you (William, CFS).*

*Medications can help to increase coping capacity and opens up an individual to be able to participate in other more intensive forms of talk therapies (Michael, Adolescent Mental Health).*

**Summary of Findings.** In summary participants described 8 different types of negative experiences they have had working with children or youth in care on psychotropic medication. These include issues with compliance; cognitive dulling; over-reliance on psychotropic medication; reduced self-esteem; medications failing to work; physical side effects; overmedication; and medication being used to control the child/youth. The commentary on negative experiences working with children/youth in care on psychotropic medication varied by age, field of work, and caseload size, and in particular for comments about non-compliance. Participants who were younger, with lower caseloads, and participants who work in CFS or child welfare also talked more about experiences of non-compliance as a negative aspect of medicating children/youth in care.

Most studies on medication adherence tend to focus on patient characteristics (Moses 2003). To the best of my knowledge, there are no studies on the characteristics of



social workers from different fields who report experiences with patient non-compliance. This leads to a number of questions for future exploration. For instance, why do younger social workers describe more experiences with non-compliance? Is this due to their own lack of experience in the field? Or perhaps it is because they are more concerned with being compliant. In a study of clinical social workers in the US (1994), Wilk found that 57% of participants in her study were opposed to allowing the patient the ability to refuse treatment with psychotropic medications and that those who were supportive of client refusal were older (age 40+).

Another question that arises from my findings is why do social workers with lower caseloads describe more experiences with non-adherence to medication protocols? Is it because they have more time to invest in their clients' treatment and are therefore able to notice adherence? Or is it because these clients are getting more help from their social workers and thus do not feel they 'need' the medications as much? Furthermore, why do social workers in CFS and child welfare describe issues with non-compliance more than social workers working in the field of child and adolescent mental health? Unfortunately these questions cannot be answered by my study and require future exploration.

Participants also described 6 different types of positive experiences they have had working with children or youth on psychotropic medication. These include more stable mental status of the child/youth; better concentration and focus; negative behaviors coming under control; improved relationships and greater participation in social activities; improved self-esteem and quality of life; and finally, the medication helps prepare the child/youth for other therapy. The comments on positive experiences also varied among participants by age, field of work, and caseload size. The younger participants (social

workers less than 45 years old) focused on the individual benefits of medication while the older participants (45+) focused on the more social benefits of medication on the child/youth. All of the participants working in mental health described experiences where the child/youth has improved their relationships with others and became more socially active. Furthermore, participants with lower caseloads (less than or equal to 25) tended to have more positive experiences with C/YIC on psychotropic medication than participants with higher caseloads.

This also leads to a number of questions for future exploration. For example, why do younger participants focus more on individual benefits than older participants? Is it due to social work shifting towards a more scientific medical model of practice that focuses on one to one relationships (Warner, 2008; Weinberg, 2010) — and in this case, one to one relationships between social workers and the child/youth in care? Also, why do participants with lower caseloads have more positive experiences with medicated C/YIC? Is it because they have more time to counsel the youth in conjunction with medications? Again, these questions cannot be answered by my study; however, they do present potential avenues of exploration in future research.

## **Conclusion**

Individuals subjectively form their definitions of a situation, interpret the situation and construct their actions to fit in with this definition. However, they are limited in what definitions and interpretations they can consider by organizational constraints, confines of their knowledge, the power of others over them, the obligations of their roles and by others' responses to their actions. For instance, a CFS social worker may have an extremely high caseload. At the same time, educators and foster parents may be

struggling with the behavior of a particular child and may be making phone calls to the social worker demanding action. Wanting to advocate for the child, but also being an approbator with pastoral authority over the youth places the CFS worker into intra-role competition (everyone has multiple identities which vie for time and energy).

Additionally, the dual obligation of the worker to advocate for the child but also to protect society from that child also has an impact on what the focal role will be for the social worker. Past experiences with medicated children and future need to keep the foster parents happy will likewise affect how the social worker defines the present situation. Knowing that there are few community resources available for the child within a system of residual social welfare, the social worker may decide that the best response is to seek medical treatment.

Social work is a profession of multiple specialties and roles; however, in relation to medicine, psychiatry and psychology, social work may seem subordinated or even subsumed into a larger field. According to results from my study, this appears to be changing. The most commonly mentioned role that social workers said they play in the medication treatment and assessment process for children and youth in care is that of the consultant. This indicates that (as far as participants in my study are concerned) a more egalitarian division of labor may be developing between the prescribing physician and social worker wherein each “professional communicates and defers to the other in terms of the other’s area of expertise” (Moses 2008, p. 61)<sup>20</sup>. Client advocacy and physician’s

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<sup>20</sup> This finding differs from much of the social work literature on “deprofessionalization” which suggests that social work practice is being taken over by other professions such as nurses and by generic, non-professions such as “care workers” (cf. Clarke, 2004; Harlow, 2003; Harlow, Berg, Barry & Chandler, 2012; Munro, 2011; Postle, 2008). According to this literature, rather than expansion into new terrains and treatment areas, social work is undergoing “fragmentation; deprofessionalization; increased technicism and managerialization of the role; and the loss of professional autonomy” (Harlow et al. 2012, p. 7).

assistants were the second and third most common roles mentioned by participants in that order.

Despite the roles that social workers may play in the medication assessment and treatment process for children/youth in their care, social work participants felt that part of the reason why there is such widespread use of psychotropic medications in the child welfare system is due to unmanageable caseloads and lack of appropriate placements. In my study, 50.0% of the CFS social workers who work with C/YIC (who know their caseload size) stated that their caseloads are higher than the provincially recommended 25 cases used in child welfare funding formulas for hiring (See, for instance the Southern First Nations 2011–2012 Annual Report).

While a couple of participants said that foster parents are doing the best they can with minimal resources, the majority of participants felt that Manitoba foster homes are severely lacking in numbers and skill. Additionally, a couple of participants argued that some foster parents are only fostering children and youth for the money. They suggested that if the children and youth are medicated, the foster parents are able to receive more money from the province for their care. Therefore, the foster parents are quick to note behavioral issues and abnormalities with the children/youth which in turn may lead to seeking medical advice.

Finally, participants also described a number of positive and negative experiences they have had while working with C/YIC on psychotropic medications. Non-compliance was a frequently mentioned negative experience while stabilization of mental status and the calming effects of medication on the child/youth were the most frequently mentioned positive experiences mentioned by participants. In terms of sheer volume of negative to positive experiences, participants described 53 negative experiences to 75 positive

experiences working with medicated children and youth in care; that is, participants described 1.4 times as many positive experiences with C/YIC medicated with psychotropics than negative.

In the next chapter I will turn to the micro-attitudinal mechanisms through which meso-situational structures and processes affect participant thoughts, feelings, and behaviors towards the use of psychotropic medication on C/YIC. In other words, it is not enough to understand how macro-structures shape the meso-situations and actions (roles) of the participants; we also must understand how these environments become integrated into individual attitudes towards medicating children/youth in care with psychotropics.

## Chapter 6 – Micro-Attitudes Towards Medicating C/YIC

By the time I finish the last interview question, I'm starting to feel bad for taking up so much of Colleen's time. We have been talking for over two hours already and I know that she has a lot of work to do in the CFS office. Just as I am wrapping up, she says to me:

*You know, I can only speak for myself. I know my kids. Though I am not a doctor, I don't think that many of these kids should be on meds. You know what I mean?*

From everything she had been telling me in the interview, I could easily understand how she felt.

During my next interview, I notice that Amanda (Adolescent Mental Health) feels quite different from Colleen about the use of psychotropic medication on children and youth in care.

*The level of peace that [the children] can be at when they're not so disadvantaged from having the chemicals in their brains so badly imbalanced, it is a bit of relief. It's very hard to see children in so much distress.*

At the end of the day, while reviewing my interview notes, I start to wonder whether Colleen's and Amanda's attitudes towards medication are a reflection of their diverse experiences in different fields of work or whether these attitudes are due to the roles they play in those fields. Then again, I wonder if perhaps their attitudes are influencing the types of roles they play and the experiences they have.

Subsequently, in this chapter I provide analysis for data related to Manitoba social worker attitudes towards medicating children/youth in care with psychotropic medication. More specifically I examine: 1) general participant attitudes towards medicating C/YIC with psychotropics (Micro); 2) how participant attitudes are tied to their experiences with

medicated C/YIC and the roles that they play in medication management (Micro and Meso); and 3) how participant attitudes govern their perspectives of a situation which can either change or reinforce the social structure (Micro, Meso and Macro).

### **Micro: Participant Attitudes Towards Medicating**

As described previously, attitudes are fairly enduring beliefs and evaluations that direct an individual's actions (Allport, 1935; Eaton & Visser, 2008; Scherer, 2005). They are evaluative in the sense that they can either be positive or negative and they are enduring in that they remain quite stable over time (Eaton & Visser, 2008). That is not to say that they resist change. Instead, attitudes can be modified incrementally as new information and experiences are encountered. In other words, attitudes may change as individuals learn to associate the attitude with positive or negative situations or consequences (Bohner & Dickel, 2011) – such as through a process of social learning (Bandura, 1977).

According to ethnomethodology, in order to understand and make sense of our reality we are continually interpreting it both prospectively and retrospectively. In a prospective sense, we use knowledge of things in the past to interpret what is happening in the present. In a retrospective sense, when something novel occurs in the present, we may use it to reinterpret the past in terms of new information. This is similar to the underlying proposition of Gestalt psychology which argues that individuals actively process sensations and perceptions to create coherent wholes (see, for example Wertheimer, 1924/1938; Köhler, 1960). Consequently, social workers may be constantly revising their attitudes in terms of new information that is presented to them.

Attitudes are shaped by three dimensions: a cognitive dimension, an affective dimension and a behavioral dimension (Breckler, 1984; Scherer, 2005). First, attitudes can be based on stocks of knowledge (cognitive schemata). For example, in the introduction to the chapter, Colleen believes that her kids should not be on medication because she “knows her kids”. This indicates that Colleen has particular knowledge which makes her more negatively predisposed towards medications. This knowledge can come from personal experience or from an external source such as a valued friend.

Second, attitudes can be shaped by emotion or affective reactions to situations. For example, Amanda feels “relief” when children are “balanced” by medication. This feeling of relief that she associates with children being on medication reinforces her favorable attitude towards medication.

Finally, attitudes can also be formed or changed by reflecting on past behaviors or habits. This occurs when an individual is unsure of their feelings about an object, person or situation and so they reflect on their past behaviors towards the object/person/situation so as to better understand how they feel about it. This may occur prospectively or retrospectively.

Presently, there is very little information in the literature about social workers’ attitudes towards medicating children/youth in care with psychotropics and none on Manitoba social workers’ opinions. It is important to explore their attitudes because these attitudes can influence conduct; that is, they may affect the way social workers respond to the needs of the children/youth in their care and how they provide or recommend resources (such as whether they will collaborate with or refer to physicians) (see, Bentley, Farmer & Phillips, 1991; Moses & Kirk, 2006). Social worker attitudes may, therefore, help to explain the pharmaceuticalization of C/YIC. For instance, Bradley has found that



social workers' "beliefs and theoretical framework impact why, when, and how" they decide to refer for medical treatment (2003, p. 36). Furthermore, a survey by Bentley, Walsh, & Farmer (2005) found that 16 percent of their US social work participants said that holding positive attitudes about medication is important to achieve positive medication outcomes for clients.

In order to understand the underlying attitudes of the participants regarding the use of psychotropic medication on C/YIC, I used a textual data analysis technique which quantifies participant responses as demonstrating either a favourable, unfavourable or neutral attitude towards the use of psychotropic medication on children/youth in care. Variations of this method have been used effectively in other social psychological studies on emotions (e.g., Mossholder et al.; 1995; Sutton & Raphael, 1988), mood states (e.g., Williams et al., 1991) and values (e.g., Namenwirth & Weber, 1987). While a closed-ended Likert scale could have been inserted into the survey to discover participant attitudes towards medication, some studies have found that fixed choice scales produce a stable attitude towards the subject under study (see, for example, Ester & Vinken, 2011).

Instead I examined the survey responses of each participant in their entirety and counted the number of comments which demonstrated a favourable view of psychotropic medication and the number of comments that indicated an unfavorable view of psychotropic medication. Each attitudinal dimension was explored. For instance, I examined the affective dimension by locating comments or words that described feelings about psychotropic medications such as "I feel," "I was upset," and "I was happy". I examined the cognitive dimension by locating comments that expressed thoughts, opinions and beliefs such as "I think," "I know" and "I believe". I examined the

behavioral dimension by locating comments that suggested remembered actions or behaviors in terms of medication use such as “I remember” and “there was this one time”.

In the end, phrases were coded as favourable if they described the positive effects of medication, positive feelings about medications, the belief in the importance of medication, the need for better medications, and so forth. Phrases were coded as unfavourable if they described the negative effects of medication, feelings that medication is being used in inappropriate ways, opinions that medication is detrimental to the child/youth, and so on. Once all of these phrases were coded, I subtracted the number of unfavourable phrases by the number of favourable phrases for each participant to produce a score representing general attitude towards psychotropic medication use on C/YIC. Numbers ranging from +1 to -1 were considered neutral which was interpreted to mean that the participant did not demonstrate either a strongly favourable or unfavourable opinion about psychotropic medication<sup>21</sup>. Numbers that were 2 or greater indicated mainly favourable views towards psychotropic medication and numbers that were -2 and below indicated unfavourable views. The scores ranged from -11 to +18. The higher or lower the score, the stronger the favorable/unfavorable attitude towards psychotropic medication use on C/YIC.

In my study, 12 of the 34 (35.3%) participants revealed mainly neutral attitudes about psychotropic medication. Often these participants expressed that psychotropic medication use on C/YIC can be equally good and bad.

*I have seen both sides of the spectrum when it comes to prescribing medication (Keri, CFS).*

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<sup>21</sup> I want to emphasize here that there is no means of knowing whether the attitudes and opinions participants expressed through the survey questions actually reflect their views and values in everyday life.

Of the 22 participants who expressed favorable and unfavorable attitudes towards using medication, 77.3% had favourable attitudes towards psychotropic medication use, with several stating they had never had a negative experience.

*I have not had any negative experiences (Debra, Developmental Disabilities).*

In contrast, only 22.7% of the 22 participants (n=5)<sup>22</sup> revealed unfavourable attitudes towards using psychotropic medication on C/YIC.

*I have never heard anything positive [about medicating children/youth]. No. You know the foster parents who have children on medication I hear from them that they're not better. The foster parents never said that they get better. I never heard anything positive. I have heard from some foster parents that they took them [the child/youth] off because they didn't need it and now they are doing much better. That's all I hear. So nothing really positive about medication (Colleen, CFS).*

In looking more closely at these attitudes, differences can be noted by sex, field of practice, and work experience. Participants who are female, who work in the field of mental health and who have more years of experience as social workers reflect more positive attitudes towards medicating children/youth in care with psychotropics. Very little difference was noted by age group (Over 75% of both older and younger participants have favorable attitudes towards medicating C/YIC with psychotropics). Furthermore, contrary to the study by Moses and Kirk (2006) which found that those more likely to perceive benefits of psychotropic medication had a larger caseload, very little difference in attitudes between participants with low and high caseloads were found in my study

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<sup>22</sup> Though this number is relatively small, it is still beneficial in a qualitative study to look at differences between participants due to sex, age, work field, caseload size and so forth. All findings are relevant for this sample only and cannot be generalized. Furthermore, while the small sample size may cause concerns about over-reaching the data, I present the small amount of data so as to develop a theoretical framework that will give that data meaning and value and thereby avoid, what Mills (1959) called “abstracted empiricism”.

(over 70% of participants with either high or low caseloads have favorable attitudes towards medicating C/YIC with psychotropics) (see Table 3)

*Table 3: Attitudes towards Medication by Traits of Participants<sup>23</sup>*

Attitude towards medicating C/YIC (n=22)	Sex		Work Field			Caseload size*		Age		Work Experience	
	Male	Female	CFS/Child Welfare	Mental Health	Other	<25	25+	44 years old or younger	45+	Started in 1990s or earlier	Started in 2000s or later
Favorable	50.0	83.3	76.9	100	60.0	71.4	76.9	76.9	77.8	100	64.3
Unfavorable	50.0	16.7	23.1	0.0	40.0	28.6	23.1	23.1	22.2	0.0	35.7
Total	100 (n=4)	100 (n=18)	100 (n=13)	100 (n=4)	100 (n=5)	100 (n=7)	100 (n=13)	100 (n=13)	100 (n=9)	100 (n=8)	100 (n=14)

*n=22, all numbers in percentages*

*\*2 participants did not know their exact caseload size and were excluded*

**Sex.** Moses and Kirk (2006) found in their study that those more likely to perceive benefits of psychotropic medication were male. In contrast, in my study 50.0% of the male participants had favorable attitudes towards medicating C/YIC with psychotropics compared to 83.3% of the females. The difference between the findings of my study and other studies, however, may be due to the limited size of my sample. Of the 5 male participants, one male had a neutral attitude towards medicating C/YIC with psychotropics while two males exhibited positive attitudes.

**Field of Work.** The difference in participants' attitudes by field of work replicates findings from other studies (see Johnson et al., 1998; Moses, 2008; Moses & Kirk, 2006). These studies show that social workers who have more positive attitudes towards treating children/youth with psychotropics were more likely to be working in child/adolescent mental health settings than in other settings. All of the participants in my

<sup>23</sup> Even though differences can be noted by examining the contingency table, it is important to point out that this was a small sample size and future studies must be undertaken with much larger samples if generalizations are to be made.

study who work in the field of child and adolescent mental health had favorable attitudes towards medicating C/YIC with psychotropics. For example:

*Medications have helped to stabilize the clients and allowed them opportunities for more success (Rachell, Adolescent Mental Health).*

*I have seen the use of psychotropic medications have a positive impact in the life of youth-specifically those that have experienced symptoms of psychosis or distorted perceptions (Michael, Adolescent Mental Health).*

As participants within the child and adolescent mental health field explained, they have better access to and relationships with physicians. This suggests that they may have greater knowledge of medication effects and so they may consider these effects as normal. Additionally, they may be better able to address any negative effects more quickly than social workers in other settings. Moreover, those in the mental health field often deal with the most complex of cases. The children/youth that those working in the mental health field see may be more likely to have biological factors that require the use of medication. Further, medication may be seen as a necessary first step in stabilizing a child/youth prior to trying other interventions.

**Length of Work Experience.** To the best of my knowledge, few previous studies have addressed differences in social worker attitudes towards medicating children/youth in care with psychotropics by amount of work experience. In terms of experience, Moses and Kirk (2006) suggest that more experienced social workers, trained at a time when psychopharmacology was less common, may hold different opinions compared to less experienced, newer social workers. Pentecost & Wood (2002), while focusing exclusively on attention deficit/hyperactivity disorder, found that more years of experience was related to more knowledge about ADHD and openness to interventions.

In my study, all (100%) of the participants who started working with children/youth in care in the 1990s or earlier (n=8) had favorable attitudes towards medicating C/YIC with psychotropics compared to only 64.3% of the 14 participants who began working in the 2000s or later. For example:

*My experience with psychotropic medications has been positive (Debra, Development Disabilities Social Work, started working with C/YIC between 1980 – 1989).*

*I had some negative experiences. One sixteen year old youth was on Seroquel and Risperidone. She would take the medication at bedtime and it was extremely difficult to wake her up in the morning; she was like a zombie (Linda, Clinical Social Work, started working with C/YIC between 2000 – 2011).*

The differences in attitudes towards medicating C/YIC with psychotropics by length of work experience may potentially be explained by two models:

- *A deficit-contextualist model* – where newer social workers may lack certain knowledge and experience which leads to a climate of skepticism toward medication (Sturgis & Allum, 2004; Ziman, 1991); and/or the more experienced social worker has greater knowledge which contextualizes the circumstances under consideration leading to more favorable views of medication (Peters, 2000; Sturgis & Allum, 2004).
- *Deprofessionalization of medicine model* – Deprofessionalization according to Healy & Meagher (2004) and Freidson (1984) is the loss of a profession's position of prestige and trust, with rival professionals and/or non-professionals taking over jurisdictional areas. Deprofessionalization can also mean that a profession's monopoly over knowledge is eroding. Keeping this in mind, the more experienced social worker has practiced in a period in which medicine held the ultimate authority over health and illness. The newer social worker, on the other hand, has entered a

field where there is regression of medicine's professional boundaries and at the same time, expansion of their own professional boundaries into the treatment arena and clinical based practice. Therefore, the newer social worker may not have the same amount of deference to the medical model as the older cohort<sup>24</sup>.

While both of these models provide potential explanations, future studies are required in order to explore this topic further.

**Summary.** Similar to other studies, participants expressed more favorable than unfavorable attitudes towards using psychotropic medication on children/youth in care. Attitudes, however, vary by length of work experience, sex, and field of work which is indicative of the participants' varying life experiences and personal stocks of knowledge. Participants who have worked with C/YIC longer, who are female and who work in the field of mental health generally had more favorable attitudes towards using medications.

### **Micro and Meso: Linking Attitudes to Experiences and Roles**

According to a Social Structure and Personality perspective, situational factors like experience and positional roles intervene between the macro social structure and attitude (personality) of individuals; therefore, "every encounter with the intervening structures exerts a socializing feed-back effect on personality" (Turner, 1988, p.2). In other words, situations and experiences influence whether attitudes will be positive or negative. At the same time, attitudes govern interpretations of situations and experiences.

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<sup>24</sup> It is important to note that the neoliberal focus on cost reduction and performance means that many professions have become more technicist and managerialist. In social work, emphasis is being placed on bureaucratic and process-driven tasks (Postle, 2008). The shift from being personally engaged with clients to the assessing of needs and organizing of services delivered by others has been described in the literature as the "management technicist perspective" (Harlow, 2003, p. 34). This Taylorist approach to social work practice indicates that the social worker's role is being reduced to specific tasks that are centrally directed and micromanaged (Harlow et al. 2012). Therefore, despite its possible professional expansion into treatment-based realms, social work is also undergoing deprofessionalization and fragmentation of practice in most other areas (Clarke, 2004).

As a result, behavior depends on the creation and maintenance of meaning where meaning is constituted and revised by interpretations and definitions of situations.

To better understand the development of participant attitudes towards the use of psychotropic medication on C/YIC, I examined: (1) the relationship between their attitudes and their experiences with C/YIC medicated with psychotropics, and (2) the relationship between their attitudes and their roles in medication management of C/YIC.

**(1) Medication Experiences and Attitudes.** Individuals characterize their experiences in terms of their thoughts, feelings and behavioral intentions (cf. Clarke & Payne, 1997). However, experience is also embedded within a complex social systems, i.e., experiences exist within an individual, can be conveyed to others, and occur within a setting. Therefore, experiences are both personal and social.

Participants were asked to describe both positive and negative experiences they have had while working with C/YIC on psychotropic medication. This required participants to reflect on past emotions and thoughts, as well as evaluate past situations and actions with medicated C/YIC. In total, participants described 75 positive experiences and 53 negative experiences.

*Negative Experiences and Their Relationship to Attitudes.* Focusing only on participants with favorable (n=17) and unfavorable (n=5) attitudes towards medicating C/YIC with psychotropics, 41 negative experiences were described by these 22 participants.

- Negative experiences and favorable attitudes<sup>25</sup>: The major issues for participants who demonstrated favorable attitudes are compliance or non-adherence to

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<sup>25</sup> From here forward, “favorable attitudes” indicate participants who have favorable attitudes towards medicating C/YIC with psychotropic medication.



medication routines (35.3% of the participants with favorable attitudes outlined concerns about compliance), cognitive dulling (29.4%) and lowered self-esteem (29.4%). For example:

*If the youth is on medication and chooses to go off, sometimes their behaviour changes and they cannot focus on school (Terry, CFS).*

– Illustrates negative experiences with compliance by a participant with a favorable attitude.

*Some of the doses given to younger children are too strong and has put them in an unresponsive mode (Keri, CFS)*

– Illustrates negative experiences with cognitive dulling by a participant with a favorable attitude.

*One young man I support has an awareness of stigma of diagnosis (Connie, CFS).*

– Illustrates negative experiences with self-esteem by a participant with a favorable attitude.

- Negative experiences and unfavorable attitudes: The major issues for the five participants who have unfavorable attitudes<sup>26</sup> are compliance (40.0% of the 5 participants outlined concerns about compliance) and cognitive dulling (40.0%).

For instance:

*It's really hard when you have a youth who you know should be taking his meds because he can function so much better, and stays out of trouble, but when they don't want to take it, you can't force them to (Greg, CFS).*

– Illustrates negative experiences with compliance by a participant with an unfavorable attitude.

*A 10 year old was on medication for ADHD and she would fall asleep in the car in the middle of the afternoon on our way to do an activity (Mica, CFS).*

– Illustrates negative experiences with cognitive dulling by a participant with an unfavorable attitude.

Note the similarity between the experiences of the two groups; that is, those who have favorable attitudes have had similar negative experiences with C/YIC on

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<sup>26</sup> From here forward, “unfavorable attitudes” indicate participants who have unfavorable attitudes towards medicating C/YIC with psychotropic medication.

psychotropic medication to those who have unfavorable attitudes. Therefore, the number/frequency of the experiences or strength/salience of the experiences may be an important factor in the relationship between attitude and experiences; i.e., those with more unfavorable attitudes towards medicating may describe greater numbers of negative experiences.

The five participants who have unfavorable attitudes mentioned 10 different negative experiences when working with C/YIC on psychotropic medication for an average of 2.0 negative experiences per participant. In contrast, the seventeen participants who have favorable attitudes mentioned 31 negative experiences for an average of 1.8 negative experiences per participant. Thus, participants with unfavorable attitudes described, on average, slightly more negative experiences than participants with favorable attitudes. It is important to keep in mind, however, that these numbers do not indicate the impact of the experiences on the participant and that it is from a very small group of social workers.

Though participants with unfavorable attitudes have had more negative experiences with medicated C/YIC than participants with favorable attitudes, it may also be the case that they have had less positive experiences with C/YIC on psychotropics. It is important to acknowledge that the relationship between attitude and experience may be reciprocal, i.e., experience and attitude may mutually reinforce one another.

***Positive Experiences and Their Relationship to Attitudes.*** The 22 participants with favorable and unfavorable attitudes towards medicating C/YIC with psychotropics described 55 positive experiences.

- Positive experiences and favorable attitudes: The most common positive experiences described by participants who have favorable attitudes are that

psychotropics control negative behaviors (70.6% of the participants with favorable attitudes outlined experiences with behaviors being controlled) and stabilizes mental status (64.7%). For example:

*They are better able to focus, are less impulsive and in many cases their behaviour improves due to their ability to attend to tasks in class, to connect better and in more appropriate way with peers and their academics improve (Kelly, School Social Work).*

– Illustrates positive experiences controlling behavior and stabilizing mental status by a participant with a favorable attitude.

- Positive experiences and unfavorable attitudes: The most common positive experience described by the participants who have unfavorable attitudes is that psychotropics stabilize mental status and calms the C/YIC (40.0%). For example:

*Children have had an easier time to focus in classrooms and are not as disruptive and are able to learn in a more positive environment (Joshua, CFS).*

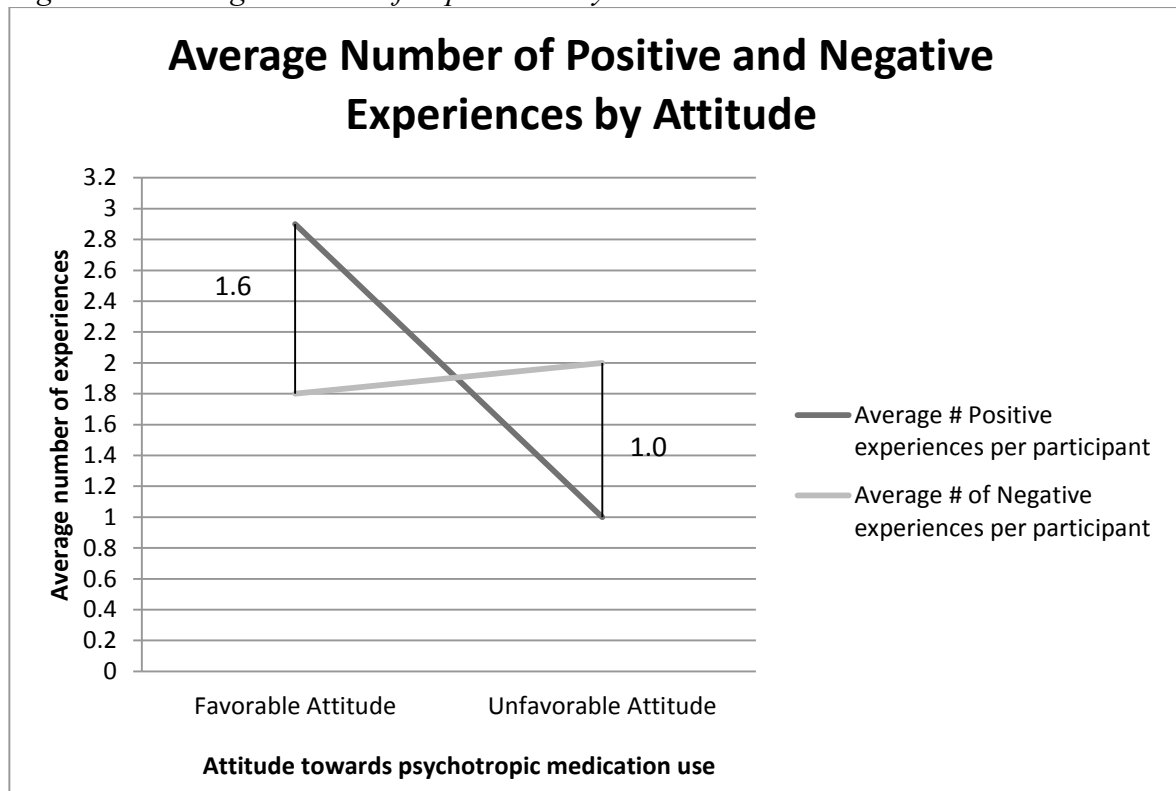
– Illustrates positive experiences stabilizing mental status of a C/YIC by a participant with an unfavorable attitude.

Again similarity between the experiences of the two groups can be noted; that is, those who have favorable attitudes have had similar positive experiences to those who have unfavorable attitudes. However, participants with unfavorable attitudes towards medicating described, on average, one positive experience per participant. In contrast, participants with favorable attitudes towards medicating described on average 2.9 positive experiences per participant. Again, however, we do not know about the impact of the experiences or whether attitude influences interpretation of experience or experience influences attitude.

***Positive and Negative Experiences and Their Relationship to Attitudes.*** Though the number of participants demonstrating unfavorable attitudes towards medicating C/YIC in my study is small (n=5), the ratio of positive experiences (5) to negative

experiences (10) is still compelling. In other words, participants with unfavorable attitudes towards medicating C/YIC with psychotropics described, on average, twice as many negative experiences as positive experiences. Furthermore, participants with favorable attitudes towards medicating C/YIC with psychotropics (n=17) described, on average, 1.6 times as many positive experiences as negative experiences (50:31) (see Figure 10). This suggests the possibility that greater numbers of positive experiences to negative experiences may be related to more favorable attitudes towards medication.

*Figure 10: Average Number of Experiences by Attitude*



It is important to realize, however, that medication management roles in various work settings may also be related to the type and number of experiences participants have had and may also be related to participant attitudes towards medicating C/YIC with psychotropics. Causality, however, cannot be determined due to the uniqueness of the

sample and further research is necessary if causality is to be determined with any accuracy.

**(2) Medication Management Roles and Attitudes.** Individual experiences occur in the context of pre-established meanings (situational definitions) which are subject to individual and social interpretations. The social order exists within the subjective body in the form of meaningful conceptual associations that organize experiences and perceptions. The social order then becomes taken for granted. For example, in the classic sociological study on individuals who smoke marijuana, Becker (1953) found that individuals who continued to smoke marijuana had learned to embrace the role of marijuana user and define the experience as enjoyable. As O'Brien (2006) suggests, smoking marijuana is not a simple physiological response to a psychoactive drug but a socially constructed experience that requires a learned organizational schemata prior to an individual being able to recognize the intended effect. Likewise, social workers who work with medicated C/YIC may learn to define the experiences as favorable or not depending on the situational context and roles they play within their organizations.

By examining role-based self-identification and its link to individual attitudes, we may better understand the components of the social system that are most significant for social workers at this particular point in time in the use of psychotropic medication on C/YIC<sup>27</sup>. Moreover, by examining further the link between the roles that participants play in medication management and attitudes of participants towards medicating C/YIC with

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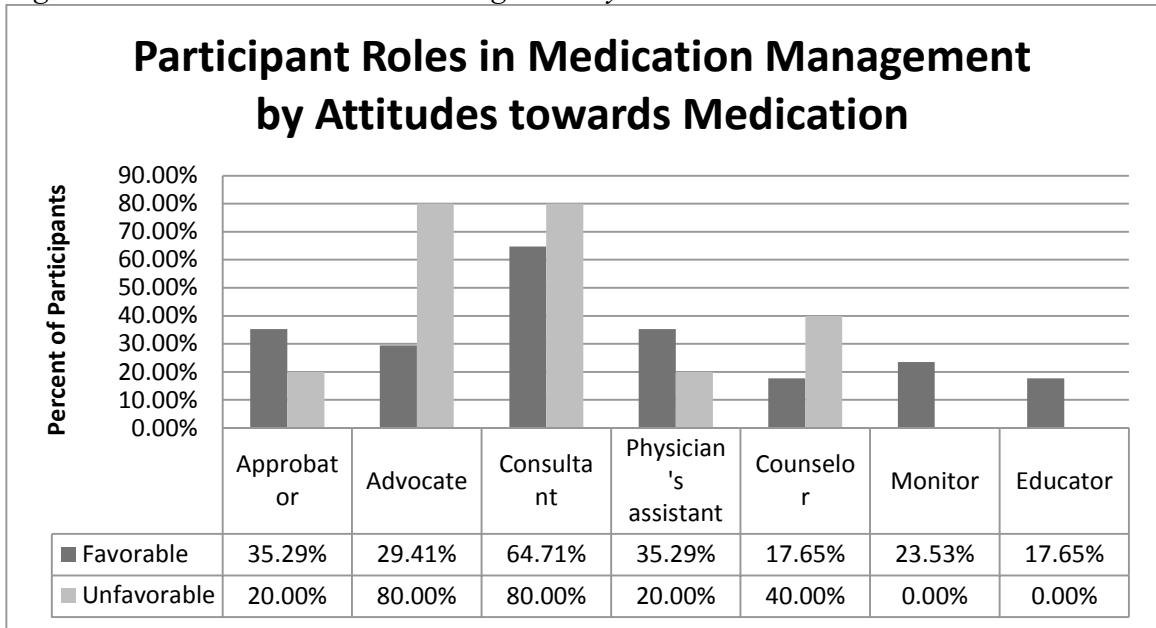
<sup>27</sup> Based on previous literature (cf. Zima et al., 1999; Zito et al., 2003; Zito et al., 2009; Lambe & McLennan, 2009) the underlying assumption of this present study is that there is an increasing trend to medicate C/YIC with psychotropics. Future research should examine medication related roles and attitudes towards medicating at various points in time in order to determine whether these roles and attitudes are changing in conjunction with the trend. Unfortunately, one of the limitations of the present study is that it captures the data only at this particular point in time.

psychotropics, we may better understand the types of experiences participants describe with children/youth in care medicated with psychotropics.

As previously discussed in chapter 4 on the meso-situational context, Manitoba social workers described playing a number of different roles in the medication management of children/youth in their care. The roles they indicated playing vary by structural arrangements such as working environment, individual case features and individual traits. Roles include acting as approbator, advocate, consultant, physician's assistant, counselor, monitor, and educator.

In my sample, participants who hold more favourable attitudes (n=17) are more likely to play the role of consultant, physician's assistant or approbator. In contrast, those participants who hold more unfavourable attitudes (n=5) are more likely to play the role of advocate, consultant and counselor. Consequently, the attitudes towards medicating C/YIC for those who play the role of consultant range from highly favourable to highly unfavourable. Since this role is more directly related to the actual medication process, participants who act as consultants may have had more positive *and* negative experiences with medicated C/YIC which accounts for the more favourable and unfavourable views of this group (see Figure 11). Again, however, causality cannot be determined. Roles may influence experiences and attitudes just as attitudes and experiences may influence roles played.

Figure 11: Roles in Medication Management by Attitudes<sup>28</sup>



Participants who say they play the role of counselor or advocate also had low positive to negative experience ratios with C/YIC on psychotropic medication. Conversely, participants who indicated that they play the role of monitor or physician's assistant had high positive to negative experience ratios. For example, those who say they play the role of counselor mentioned, on average, 1.1 times more positive to negative experiences whereas participants who say they play the role of physician's assistant mentioned, on average, 1.7 times more positive to negative experiences (see Table 4).

<sup>28</sup> This figure is meant to demonstrate correlation between roles and attitudes and does not imply that there is a causal relationship. While the dependent variable appears to be attitude and the independent variable appears to be roles, these can be switched. The figure was presented this way for ease of reading/understanding the correlation.

*Table 4: Ratio of Positive to Negative Experiences with Medicated C/YIC by Roles*

Roles (n=participants often described playing more than one role)	Ratio of Positive to Negative Experiences Mentioned by Participants with Medicated C/YIC (Averaged)	Number of times more positive to negative experiences mentioned
Counselor (n=6)	1.7:1.5	1.1
Advocate (n=12)	2.0:1.6	1.25
Consultant (n=16)	2.7:2.0	1.35
Educator (n=3)	5.0:3.7	1.36
Approbator (n=9)	2.6:1.7	1.53
Monitor (n=5)	3.4:2.2	1.55
Physician's Assistant (n=9)	3.6:2.1	1.7

The above table and graph suggest that roles in medication management, experiences with medicated C/YIC and attitudes towards using psychotropic medication on C/YIC are potentially linked. For instance, participants who said that they play the role of advocate or counselor described less positive experiences with children/youth in care on psychotropic medication (see Table 4) and they also demonstrated a more unfavourable attitude towards medicating C/YIC with psychotropics (see Figure 11). On the other hand, participants who said that they play the role of physician's assistant, monitor or approbator, described more positive experiences with medicated C/YIC (see Table 4), and also revealed more favourable attitudes towards using psychotropic medication on C/YIC (see Figure 11).

It must be noted that the causal direction of the relationship is not very well understood. Favorable attitudes linked with particular roles and/or positive experiences may be interpreted to mean that the roles and/or positive experiences lead to favorable attitudes. However, it may actually be opposite, or it may work in both directions (i.e. favorable attitudes lead to playing particular roles and/or having positive experiences).



Additionally, other situational factors such as funding constraints or attributes of the individuals can also factor in.

Some case examples may help to clarify these points.

- Example 1 : Terry (CFS):

When Terry was asked to describe what role she plays in medication management, she said:

*[I] trust the advice and professional decision made by the medical doctor if medication is advised.*

Accepting the physician's medication decision and helping clients follow doctor's prescriptions and recommendations is the hallmark of a physician's assistant.

When asked to describe the different positive and negative experiences she has had while working with C/YIC on psychotropic medication, she listed seven positive experiences (the medicated C/YIC make better choices, are better focused, less hyper, have better relationships, have fewer outbursts, have less anxiety, and are more calm) and five negative experiences (they have facial tics, are zoned out, feel stigmatized, have weight gain, and have no appetite). Her attitudinal score based on answers to all of the survey questions was +6, a mid to high-strength score indicating a favorable/positive attitude towards medicating children/youth in care with psychotropics. Therefore, Terry said her role was physician's assistant, she described more positive experiences than negative, and her total attitudinal score was favorable. What this does not tell us, however, is the direction of the relationship.

- Example 2: Rachell (Adolescent Mental Health)

When Rachell was asked what role she plays in medication management, she also described playing the role of a physician's assistant.

*I work with the families to deliver the treatment plan. The medications, if recommended by the psychiatric consult – are administered and followed by the family physician.*

When asked to describe the positive and negative experiences she has had when working with C/YIC on psychotropic medication, she listed three positive experiences (medication stabilizes the client, improves their mood and functioning, and allows them to have better relationships) and she listed no negative experiences. She even stated, "There are no negative experiences". Her attitudinal score based on answers to all of the survey questions was +11, a high-strength score indicating a favorable attitude towards medicating children/youth in care. Therefore, Rachell said her role was physician's assistant, she discussed only positive medication experiences, and her total attitudinal score was highly favorable. Again, this only implies correlation.

What the two examples demonstrate is a pattern found in my study sample, a pattern of similar attitudinal scores, numbers of experiences and roles. Theoretically, the *attitude-experience-role relationship* may be understood thusly: individuals have unique backgrounds (such as age; socioeconomic status; family and work history; and past life experiences) which influences their feelings, thoughts and behaviors (attitudes).

Depending on which role an individual occupies, there may be a number of potential experiences they may have. Through a complex interaction of background, roles, and experiences, certain attitudes will develop which govern interpretations of situations. These interpretations ultimately guide individual behavior and, in the case of CFS and

child welfare social workers, the behavior may include final approval for medication use on C/YIC.

**Summary.** My study indicates that there is a relationship between roles, experiences and attitudes of Manitoba social workers towards the medicating of C/YIC with psychotropics; participants who play the roles of physician's assistant or monitor have, on average, more positive experiences working with medicated children/youth in care and have more favorable attitudes towards medicating. On the other hand, participants who play the roles of advocate or counselor have, on average, more negative experiences working with medicated children/youth in care and have more unfavorable attitudes towards medicating.

### **Micro, Meso and Macro: The Pharmaceuticalization Connection**

A situation is composed of a vast number of objects, ideas or tangible things, which one perceives as part of a pattern and tries to assemble into an overall configuration. Situations and roles provide an initial, tentative definition of the situation. However, this definition is prone to evolve and change over time, particularly when individuals construct their acts so as to accommodate their own self, interests and attitudes as well as fit it into the specific acts of others and the situation as a whole. Simply put, behaviors are shaped by attitudes and attitudes are influenced by situations, experiences and roles (Fishbein & Ajzen, 1980). Individual acts, en masse, can either serve to change or maintain the social structure. As Bourdieu has written,

The schemata of perception and appreciation which are at the root of our construction of the social world are produced by a collective historical labor but on the basis of the very structures of that world: as structured

structures, historically constructed, our categories of thought *contribute* to producing the world, but only within the limits of their correspondence with pre-existing structures” (1987, pp. 234-35, emphasis original).

In terms of the present social structure of child welfare, studies indicate that there are between 40-70% of C/YIC in Canada on psychotropic medication (Lambe & McLennan 2009). This suggests that, at the broader level, there is pharmaceuticalization of C/YIC<sup>29</sup>. Consequently, the use of psychotropic medication on C/YIC (pharmaceuticalization of C/YIC) can either be reinforced or changed through actions that are guided by situational perspectives and attitudes.

According to the *attitude-experience-role* findings outlined previously, there appears to be an association between the roles of physician’s assistant and/or monitor, positive medication experiences and favorable attitudes towards medicating. Additionally, there appears to be a connection between the roles of advocate and/or counselor, negative medication experiences and unfavorable attitudes. What remains to be answered is: what behaviors or actions does the attitude-experience-role relationship lead to and how does it affect the pharmaceuticalization trend?

Almost half (48.2%) of the children/youth in care that make up the caseloads of my sample of Manitoba social workers are medicated with psychotropics. In order to better understand the number of C/YIC on psychotropic medication in Manitoba, two overall AERA (attitude-experience-role-action) relationships are explored below.

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<sup>29</sup> This is not to imply that the trend is bad or negative, but only to suggest that it is a trend.

***Overall Sample AERA (Attitude-Experience-Role-Action) Relationships.***

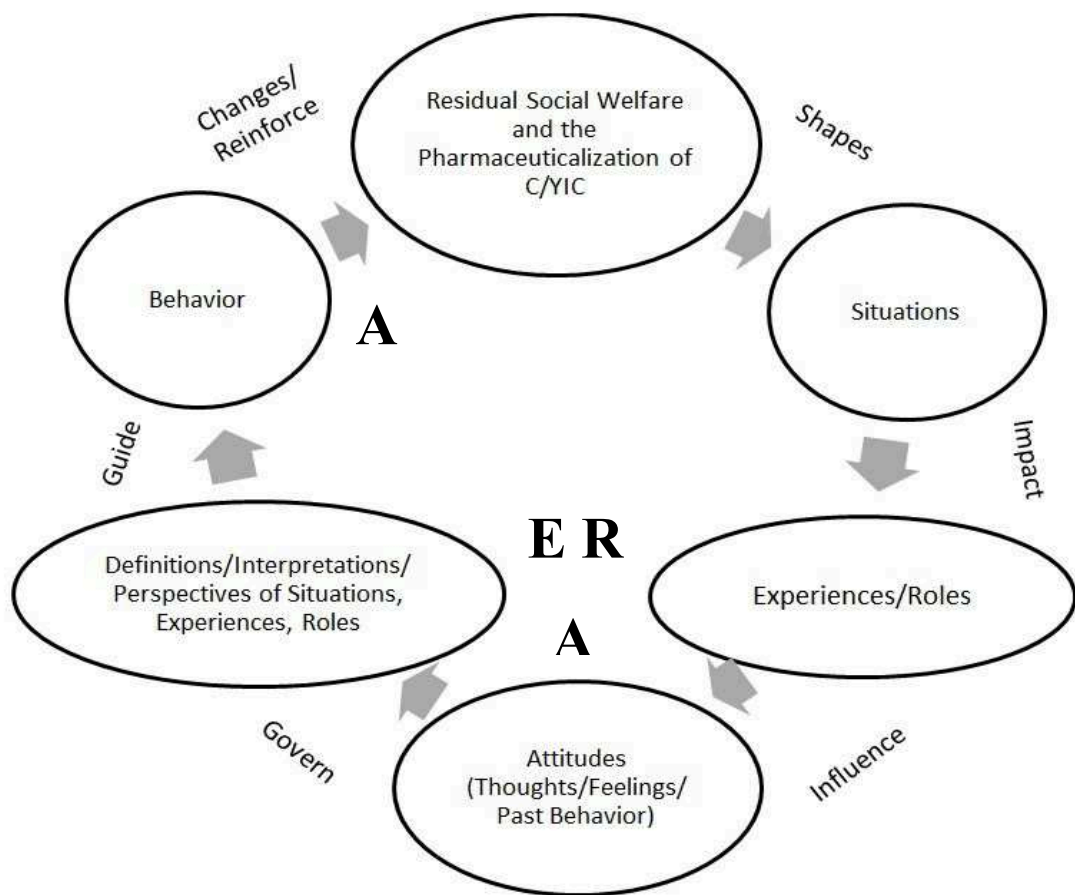
- AERA One Relationship: Five study participants demonstrated unfavorable attitudes toward medication. Of these five, three described more negative experiences than positive experiences and two described an equal number of positive and negative experiences. All of these participants take the role of advocate or counselor. Furthermore, an average of 22.1% of the C/YIC in their caseloads are on psychotropics.
- AERA Two Relationship: Seventeen study participants demonstrated favorable attitudes towards medication. Of these seventeen, eleven described more positive experiences than negative experiences, four described an equal number of positive and negative experiences, and two described one more negative experience than positive experience. Twelve stated they play the role of physician's assistant, approbator or monitor. One said they play no role and the other four said they play the role of advocate or consultant. An average of 55.8% of the C/YIC in their caseload are on psychotropics.

According to the two patterns, those in AERA1 relationships (with unfavorable attitudes, more negative experiences, taking the role of advocates and/or counselors) have fewer C/YIC on psychotropic medication on their caseloads than those in relationship two. Conversely, those in AERA2 relationships (with favorable attitudes, more positive experiences, most taking the role of physician's assistant, approbator and/or monitor) have more C/YIC on medication on their caseload than those in relationship one. In other words, participants who fall into the AERA2 category have as much as 2.5 times as many C/YIC on psychotropic medication on their caseloads (55.8% to 22.1%). This suggests, in

terms of behavior (action), that participants who fall into the first relationship category may not be seeking treatment for the C/YIC on their caseloads as often as those who fall into the other relationship category. It must be understood, however, that the specific details of cases and other situational aspects that may impact on medication decisions are not identified in this relationship.

While statistically the directionality of the AERA relationships is unknown, theoretically it can be outlined thusly:

*Figure 12: Manitoba Social Workers' Theoretical AERA Relationship*



In Manitoba, however, when a child/youth is apprehended by child welfare authorities, i.e. removed from their home and placed into provincial care, the

child/youth's appointed social worker retains parental decision-making rights on behalf of the province/territory (Lambe & McLennan 2009). This includes making all final decisions for medical treatment (Psychiatric Patients Advocate Office, 2007). Therefore, only CFS and child welfare social workers with active caseloads in my study are able to seek treatment or refuse treatment recommendations for the C/YIC on their caseloads. This makes the actions of this group particularly important to explore.

***CFS/Child Welfare AERA (Attitude-Experience-Role-Action) Relationship.***

Though the number of participants are extremely small, it is still important to examine the AERA relationship further to see how it may affect the overall social structure of pharmaceuticalizing C/YIC<sup>30</sup>.

- Relationship AERA One: Two CFS participants demonstrated unfavorable attitudes towards medication. Both of them described more negative than positive experiences and both said they take the role of advocate. For these two participants, 14.2% of the C/YIC on their caseload are on psychotropics.
- Relationship AERA Two: Eight CFS participants demonstrated favorable attitudes towards medication. Seven described more positive experiences than negative. Three said they act as physician's assistants, two said they act as monitors, two said they act as consultants, and one did not provide a role. For these eight participants, 46.4% of the C/YIC on their caseload are on psychotropics.

According to the AERA (attitude-experience-role-action) relationship outlined above, CFS participants in relationship one (with unfavorable attitudes, more negative

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<sup>30</sup> Since all CFS social workers with active caseloads of C/YIC are empowered to act as approbators (whether they name this role or not), the approbator role was removed from analysis. Additionally, only CFS participants that demonstrated favorable/unfavorable attitudes and who knew how many C/YIC on their caseload are medicated with psychotropics were included in the AERA relationship analysis (n=10).

experiences, and taking the role of advocate) have fewer C/YIC on psychotropic medication on their caseloads than those in relationship two. Conversely, CFS participants in relationship two (with favorable attitudes, more positive experiences, and the majority taking the role of physician's assistant and/or monitor) have more C/YIC on medication on their caseload than those in relationship one. In terms of behavior (action), it is possible that CFS participants who fall into the first relationship category may not be seeking as much or may be refusing psychotropic treatment for the C/YIC on their caseload. This would account for the smaller percentage of C/YIC on psychotropic medication in the first group, particularly since these social workers have the final say in medicating C/YIC. It is possible, therefore, that a particular group of social workers that fall into the AERA2 relationship category may potentially be reinforcing the trend to medicate C/YIC with psychotropics. Though the data are suggestive, it is important to keep in mind that the numbers are extremely small. Once again, future studies must include larger samples to test these potential relationships further.

**Summary.** Based on qualitative responses and frequency counts, two distinct AERA (attitude-experience-role-action) relationships were discovered: AERA1 (unfavorable attitudes—more negative experiences with medicated C/YIC—advocate and/or counselor roles—fewer numbers of medicated C/YIC which indicates less active pharmaceuticalization behaviors) and AERA2 (favorable attitudes—more positive experiences with medicated C/YIC—physician's assistant, monitor, and/or approbator roles—greater numbers of medicated C/YIC which indicates more active pharmaceuticalization behaviors). The findings (though based on a very small sample) suggest that the pharmaceuticalization of C/YIC may depend, in part, on a particular group of social workers that fall into an AERA2 relationship category. It also suggests



that transformation or cessation of the pharmaceuticalization trend could potentially occur with social workers that fall into an AERA1 relationship category.

## **Conclusion**

Similar to other studies, Manitoba social work participants expressed more positive (favorable) attitudes towards using psychotropic medication on C/YIC. These attitudes, however, vary by work experience, sex, and field of work. Participants with more work experience, who are female and who work in the field of mental health had higher attitudinal scores which indicate more favorable attitudes towards using medications.

My study indicates that there is a relationship between attitudes, experiences, roles, and behavior of Manitoba social workers towards the medicating of C/YIC with psychotropics. In relationship pattern one (AERA1) participants who have unfavorable attitudes towards medicating C/YIC with psychotropics, have more negative experiences with C/YIC medicated with psychotropics, and who play the role of advocate and/or counselor also have fewer C/YIC on their caseload on psychotropic medication. On the other hand, in relationship pattern two (AERA2) participants who have favorable attitudes towards medicating, have more positive experiences with medicated C/YIC and who play the role of physician's assistant, monitor, and/or approbator roles also have greater numbers of medicated C/YIC on their caseload. This suggests that social worker attitudes, related to situational experiences and occupational roles, may be affecting their behavior in regards to the medicating of C/YIC. In other words, decisions about medical treatment may not only be based on the child's or youth's presentation of symptoms and/or the constraints of the situation; determinations about the need for medication may also

depend on the attitudes of social workers towards medication. However, further research is necessary to test this hypothesis.

In this chapter I have outlined data that suggests a potentially recursive relationship between the macro, meso and micro levels. In this relationship, context influences attitude which governs interpretations of situations which then leads to certain behaviors. These behaviors may go back to either change or reinforce the social structure. Though a theoretical relationship developed out of the study's findings, it does require further future exploration.

## **Chapter 7 – Discussion, Suggestions and Conclusion**

In this thesis I explored and examined the underlying structures and experiences behind the often fluctuating and changing appearance of reality for Manitoba social workers who work with C/YIC on psychotropics. When I was preparing this exploratory study, I used a multi-strata, theoretical analytic that would examine social workers' experiences and perceptions on a number of different levels: macro-structural, meso-situational, and micro-attitudinal. In sociological social psychology, this is referred to as a Social Structure and Personality approach. In this approach, the social world is conceived as a complex arrangement of relationships between macro-social systems and feelings, attitudes, experiences and behaviors of individual agents.

The central questions of my study included: 1) What are the structural factors that social workers say may affect the trend towards the use of psychotropic medications on children/youth in care?; 2) What roles do social workers say they play in the psychotropic medication treatment and assessment process for children/youth in care?; 3) What are social workers' experiences working with children/youth in care on these medications?; and 4) based on these experiences and roles, what are their attitudes towards the use of psychotropic medications on children/youth in care? The point of these questions was to discern, delineate and describe the patterns illuminated by social workers that may be affecting the trend towards medicating children/youth in care with psychotropics.

The layers of description that resulted from the data illustrate how the structural arrangements of society, maintained by the social institutions of medicine, child welfare and education, shape the conceptual processes and situational contexts through which individual Manitoba social workers perceive and understand the reality of medicating

children/youth in care with psychotropics. However, more than that, the descriptive analysis suggests that the reality of medicating children/youth in care may also be a “contingent ongoing accomplishment” of competent social actors who continually construct their social world via “the organized artful practices of everyday life” (Garfinkel, 1967, p.11). In other words, the relationship between the social worker and the world is one of “ontological complicity” (Bourdieu 1989, p. 10; Merleau-Ponty, 1962); that is to say that the inter- and intra-subjective experiences of social workers are grounded in historical, objective structures. The following provides a descriptive summary of the relationship between the social structure; Manitoba social workers working context, roles and experiences with C/YIC on psychotropic medication; and their opinions and attitudes towards medicating C/YIC with psychotropics.

### **Macro Structure**

Whether the use of medication is viewed as appropriate or not, necessary or not, 85% of the social workers in my study described factors which contribute to the increasing trend towards medicating C/YIC with psychotropic medication. For my sample of social workers, almost half (48.2%) of the C/YIC that make up participant caseloads are on psychotropic medication. This lends support for the notion of the pharmaceuticalization of C/YIC (where the use of pharmaceuticals and medical technology are expanding into everyday life). The broad institutional structures that participants suggest are contributing towards the trend to medicate C/YIC with psychotropics include medicine, education and child welfare. Each institution comes into contact with the other through contact with the C/YIC and each are explored further below.

**Child welfare.** Participants describe working in a climate that emphasizes market-based, corporatist methods of child welfare, including operating with minimal funding, resources and training as well as greater bureaucratization and administrative responsibilities, all of which are hallmarks of residual social welfare. Lack of funding, higher caseloads and greater administrative responsibilities leaves less time for social workers to spend caring for and evaluating the children and youth in their care and can lead to greater reliance on psychotropic medications for the emotional and behavioral needs of C/YIC. Furthermore, participants suggest that lack of funding to hire experienced and highly trained workers means that inexperienced workers are dealing with high needs cases. They indicate that it appears to be cheaper and easier to medicate C/YIC than to hire and train experienced workers.

The need for cost efficiency leads to the standardized application of skills within a profession. Ironically, however, participants explain that the bureaucracy of the system makes it more inefficient when trying to work with C/YIC. By delegating greater administrative responsibilities to social workers, less time is available for the social worker to spend with the child or youth in their care. As a result, the worker may not have time to address the needs of the child adequately. This may mean that the child or youth is overmedicated, under-medicated, or not medicated at all when they really should be.

Additionally, participants suggest that the children and youth who are entering the system today are doing so with more complex needs and greater dysfunctions which increase the risk that these children/youth pose to themselves and others. Of particular concern for over a quarter of the participants are the number of children/youth presenting with Fetal Alcohol Spectrum Disorder/Alcohol Related Neurodevelopmental Disorder. Participants feel that medication is often the only option available to social workers to

help them manage the complex neurological issues and behavioral risks of children and youth entering the system. This indicates that medication is needed for containment and control and not only treatment. Constraints in resources and an emphasis on security and risk may increase the likelihood for coercive, excessive or otherwise inappropriate treatment.

**Education.** Similar to what is taking place in child welfare, social work participants describe an education system in Manitoba constrained by a lack of resources and funding. This too is indicative of a residual approach to social welfare (See Appendix C on Approaches to Social Welfare). Due to funding and resource constraints facing educators, participants explained that educators may be quick to refer the child/youth for medication. Educators who refer for medication may be rewarded with extra resources through the provincial funding formula. For instance, the provincial funding formula for education allows educators to receive substantially more money if a child/youth demonstrates a level 2 or 3 emotional or behavioral ‘risk’ (See Appendix C on Manitoba Education Funding Formula). Part of criteria for getting this supportive funding for the classroom is the ability to provide a diagnosis and medication information for the child or youth.

Finally, participants also explain that there is bias against C/YIC in the Manitoba education system. They describe educators automatically referring the child/youth for treatment once they know that the child/youth is a ‘systems’ kid. That is, referral for medical treatment may be made more on the basis of social standing than on potential need.

**Medicine.** The third macro institution that participants indicate is affecting the trend towards prescribing children/youth in care with psychotropics is the health care

system. Participants explain that the health care system is organized around short-term acute care where the focus seems to be on prescribing medication, either on- or off-label. They indicate that once the child/youth is referred for treatment, they tend to receive a prescription. According to participants, as advancements in treatment and medical knowledge occur, newer and better treatments are developed, which also increases the prescribing rates, which exemplifies the notion of pharmaceuticalization.

At the same time as there has been a growth of knowledge and biomedical advancements, participants describe a health care system in Manitoba that has a tremendous lack of skilled medical professionals capable of dealing with the behavioral and mental health issues of C/YIC. Participants suggest that this lack of medical knowledge may be a contributing factor towards the trend to prescribe psychotropics for C/YIC. Put differently, the lack of skilled expertise mean that children/youth in care are being seen by general practitioners. Study participants suggest that these general practitioners, due to their lack of expertise with mental health issues, may be prescribing inappropriately and often.

### **Meso Situation**

The institutions of medicine, education and child welfare penetrate into the organizational structure and situational context of social work practice; this includes shaping the roles, positions, experiences and resources that affect the trend towards medicating children/youth in care with psychotropics. Increased pressure by educators to medicate children/youth in care and a medical system that lacks skilled personnel to put biomedical advancements into practice all influence the situational context that social

workers operate within. The situational constraints, roles and experiences mentioned by participants who work with C/YIC on psychotropics are explored below.

**Situational Constraints.** According to participants, child welfare agencies and organizations are overtaxed and lack the necessary resources for children and youth in care including appropriate placements. High caseloads and increased administrative burden, due, in part, to emphasis on child/youth/family risk assessments, means that social workers have limited time to spend with the children/youth in their care. Furthermore, due to the strain that Manitoba social workers are experiencing within the child welfare system, a number of social workers have been quitting their jobs (see, Carreiro, 2012). This is increasing the burden and caseloads of those who remain. Half of the study participants who work for child and family services in Manitoba have caseloads over 25 cases. This, participants explain, may lead to a greater propensity to find quick, cheap and efficient ways to address the problematic behaviors and/or emotional issues of the children/youth in their care. Often in the cost-benefit calculation, psychotropic medication is seen as the most effective response.

Another important contextual factor that may be affecting the trend towards medicating C/YIC with psychotropics is geography. Manitoba is a province with a number of isolated rural and remote communities. With the switch to a service model that allows families to choose which agency they want to receive services from, social workers may have children/youth in their care spread over vast regions. Traveling to and from these communities hinders the amount of time available for the worker to assess the needs of the child/youth. Once again, due to a lack of time, medication may be viewed as the most effective method of ameliorating problems with the child/youth's mood and/or conduct



Participants also described how a lack of ‘good’ placements may be a factor in the trend to medicate C/YIC with psychotropics. Without enough placements, children/youth in Manitoba are often ‘warehoused’ in hotels with emergency workers. Temporary workers do not have the same level of investment in the child/youth and because of this lack of investment, if the child/youth displays any type of emotional or behavioral issue, the worker may seek medical intervention. As well, since there are so few placements, social workers will do whatever they can to keep a child/youth in a foster home. This may include agreeing to let the foster parents medicate the child/youth. According to several participants, some foster parents may be insisting on medicating the child/youth regardless of need so as to receive extra funding from the province. While the amount is unclear and the Manitoba Child Protection Branch did not respond to my inquiries, one participant suggested that it could be as high as \$50 extra per child per day.

**Situational Roles.** Social workers who come into contact with children/youth in care medicated with psychotropics may engage in different medication management related roles based on their situational context. The majority of participants (79.4%) indicate that they do play one or several official and/or unofficial medication-related roles within their various fields of practice. The roles manifest differently depending on the participant’s field of work, age, and level of social work experience. Almost half of the participants (47.1%) said they play the role of a consultant or collaborator in the medication assessment and treatment process for C/YIC. Social workers who adopt this role evaluate clients and collaborate with physicians rather than automatically deferring to physician expertise and, as such, this role places social work knowledge on a more equal footing with physicians and medical professionals (Bentley & Walsh, 2006).

All of the social workers who work closely with physicians (in child and adolescent mental health) stated they play the role of consultant. This indicates that social work's professional boundaries, particularly within this field, are expanding and moving into areas that were formally the domains of medicine, psychiatry and psychology, thus supporting the idea of professional regression (Abbott, 1988).

The second most commonly mentioned medication management related role in my study was that of the advocate; over a third of participants (35.3%) mentioned playing this role. The advocacy role is often viewed as a critical aspect of social work. As an advocate, the social worker supports the child or youth in their treatment.

The third most common role that participants described playing is the role of physician's assistant. Here the social worker defers to the expert opinion of the physician and helps the child/youth comply with the physician's treatment plans. One of the roles that has not been described in the literature, but was discussed by participants in this study is that of approbator. In this role, the social worker approves all medical treatment for the child/youth. Half of the participants who work in CFS talked about playing this role.

Each of the medication management roles that participants' described are roles which put them in the middle – either between the client and physician, between the client and foster parents or between the client and educators. Hidden beneath these roles, therefore, is what Foucault has referred to as pastoral modality of power (Foucault, 2007). This is not the same as the disciplinary power of medicine or the sovereign power of the state which regulates the behaviour of individuals in the social body and requires obedience to a central authority. Instead, pastoral power is a power that runs between the authority of the state and/or of medicine and the individual. Thus, the social worker acts

as a mediator and is fully responsible for the child/youth in their care and responsible at the same time for their entire caseload.

**Situational Experiences.** Overall, study participants described 1.4 times more positive experiences than negative experiences with C/YIC on psychotropics. Though I examined the volume of experiences for comparative purposes, it is important to stress that the number of experiences cannot possibly reflect the impact of the experiences on the participants.

Participants described eight different types of negative experiences they have encountered with C/YIC on psychotropic medication. However, only half of these negative experiences were ones which described the negative side-effects of the medication on the child/youth. These negative experiences included mental/emotional side-effects, physical side-effects, self-esteem problems, and medication masking the child/youth's trauma. The other negative experiences concentrated on participants' concerns with prescribing and treatment; that is, they describe negative issues about compliance, reliance on medications, ineffective medications and improper diagnoses. Non-adherence/non-compliance<sup>31</sup> was the most frequently described negative experience by the participants, followed by cognitive dulling, medication causing a lack of self-esteem for the child/youth and fear about the over-reliance on medications for treatment.

Participants also described six kinds of positive experiences they have encountered with children/youth in care who are taking psychotropic medications. These experiences include the child/youth becoming calmer, the child/youth becoming more focused, bad behaviors being controlled, improving relationships, improving self-esteem,

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<sup>31</sup> While it is possible that non-compliance might have been viewed as a positive effect for participants who are more negatively predisposed to medication use, participants in the study never described it as such.

and the child/youth becoming ready for other forms of therapy. Younger participants (<45 years old) tended to describe the individual benefits of medication while older participants (45+) tended to describe the more social benefits of medication on the child/youth. This may suggest that the younger cohort has entered a social work field which has been aligning itself with the dominant discourses of scientific practice that places emphasis on the individual. Thus it provides another indication of how the social structure may penetrate through the situation to the individual.

The situational constraints that social workers operate within may affect the types of roles available to them for medication management and the types of experiences they encounter with C/YIC medicated with psychotropics. For instance, when there is a lack of time, limited placements, and high caseloads, social workers may not be able to advocate, counsel, monitor or educate their clients effectively. In their consultation role, they may be inclined to rely on reports from foster parents. As a physician's assistant, they defer to others' expertise. Additionally, the situational constraints may limit their ability to notice medication effects, both positive/negative on the child/youth in care. The fact that non-compliance with medication regimens was a major negative experience for social workers working with C/YIC may indicate that there is pressure from foster parents and the education system to medicate these youth.

Furthermore, roles and experiences may be mutually constitutive and reinforcing. The role that participants play may affect the experiences they encounter and the experiences they have with medicated C/YIC may affect the roles they play. For example, findings demonstrate that participants playing the roles of physician's assistant, monitor and/or educator in the medication management of C/YIC appeared to have more positive experiences working C/YIC on psychotropic medication than participants who play other

roles. Part of the responsibility for all three of these roles is to defer to the wisdom of the doctor, help the child/youth follow the doctor's recommendations and report back to the doctor. This indicates that participants engaging in these roles may view the doctor as expert and they may believe that the doctor would not place the child/youth on medication if he/she expected any negative effects. Therefore, the participants playing these roles may be inclined to see more positive effects of the medication than a participant playing the role of a consultant, for instance. Additionally, as for negative experiences, those participants who enact the role of monitor or educator are most concerned about non-compliance with medication regimens. This makes sense since the underlying task of a monitor is to track compliance and the underlying task of an educator is to educate clients on the reasons why they were prescribed medication and why it is important for them to take the medication.

Therefore, individuals assume roles in a context that they define and this definition is what guides their actions. As William and Dorothy Thomas (1928) wrote: "If [people] define situations as real, they are real in their consequences" (p. 572). For example, a social worker may see a situation with a C/YIC as threatening and will act accordingly (such as recommending treatment), even if the child or youth did not mean to appear threatening. Reality for the social worker is how they define the situation in the here and now. However, these definitions depend on internalization of social norms as well as past actions and experiences.

### **Micro Attitudes**

Micro-level attitudes are inherently social and context-dependent. In Social Structure and Personality research, collective attitudes are often viewed as culture where

culture refers to “a set of cognitive and evaluative beliefs— beliefs about what is or what ought to be—that are shared by the members of a social system and transmitted to new members” (House, 1981, p. 542). This is quite similar to the process of socialization outlined by Berger and Luckmann (1966) where individuals internalize the social order and develop interpretive frameworks that influence how they understand and respond to situational contexts. By examining individual attitudes we can discover how macro-social structures and meso-situational environments are processed and incorporated by individuals into cognitive frameworks which lead to action.

Similar to other studies, Manitoba social work participants expressed more favorable than unfavorable attitudes towards using psychotropic medication on C/YIC. Of the 22 participants who expressed either a favorable or unfavorable attitude towards using psychotropic medication, 77.3% had favourable attitudes towards, with several stating they had never had a negative experience. Participants with more work experience, who are female and who work in the field of mental health had higher attitudinal scores which indicates more favorable attitudes towards using medications.

Participants with unfavorable attitudes towards medicating C/YIC with psychotropics described, on average, two times as many negative experiences as positive experiences. Furthermore, participants with favorable attitudes towards medicating C/YIC with psychotropics described, on average, 1.6 times as many positive experiences as negative. Additionally, participants who hold more favourable attitudes are more likely to play the role of physician’s assistant, monitor and/or approbator. In contrast, participants who hold more unfavourable attitudes are more likely to play the role of advocate and/or counselor.

Findings demonstrate that there is a relationship between attitudes, experiences, roles, and actions/behaviors (AERA) of Manitoba social workers towards the medicating of C/YIC with psychotropics. Two major patterns were established. In pattern one (AERA1), participants with unfavorable attitudes towards medicating C/YIC with psychotropics, also tended to have more negative experiences with C/YIC medicated with psychotropics, tended to play the role of advocate and/or counselor and also tended to have fewer C/YIC on psychotropic medication on their caseloads. In relationship pattern two (AERA2), participants with favorable attitudes towards medicating, tended to have more positive experiences with medicated C/YIC, tended to play the role of physician's assistant, monitor, and/or approbator roles and also tended to have greater numbers of medicated C/YIC on their caseloads. Participants who fit the AERA2 pattern in my sample have as many as 2.5 to 3 times as many C/YIC on psychotropic medication on their caseloads. What this suggests is the pharmaceuticalization trend and decisions regarding medical treatment of C/YIC may not only be based on the outward presentation of a child's or youth's symptoms/behaviors, but may also be conditional on the individual attitudes of social workers towards medication.

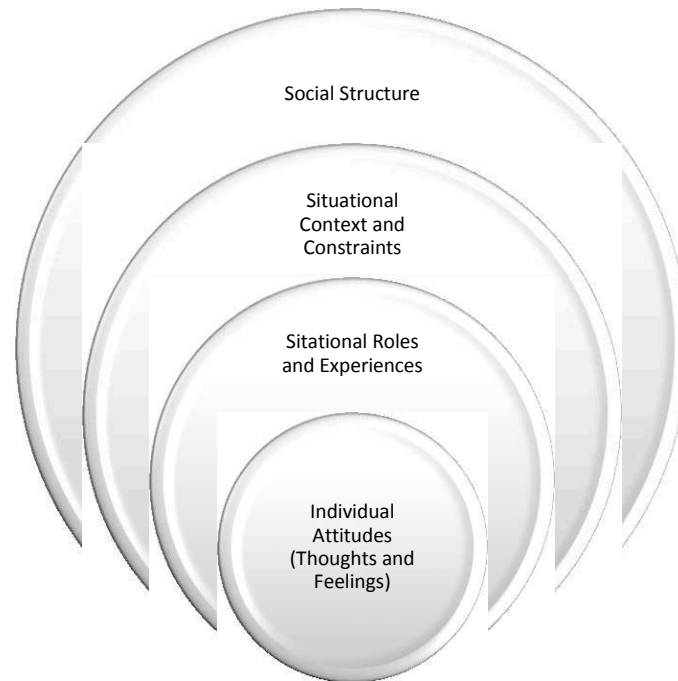
The data, therefore, outlines a potentially recursive relationship between the macro, meso and micro levels. Experiences with medicated children/youth in care and roles in medication management intervene between the macro social structure and attitude of participants. On the one hand, they influence individual attitudes and on the other, individual attitudes govern interpretations of the experiences and roles.

## **Putting It All Together**

Mills explained long ago that, “No social study that does not come back to the problems of biography, of history and of their intersections within a society has completed its intellectual journey” (Mills, 1959, p.6). Every social system has a set of people, a set of positions or roles (social structure) and culture (the domain of the symbolic – attitudes, beliefs, values and norms). The social structure consists of patterned relations or actions that are shaped by the macro system and which penetrate micro social worlds. This leads to the adoption of particular practices and a congruent set of beliefs. In this study I utilized a Social Structure and Personality analytical approach (see, for instance, House, 1981; Kohn, 1989;) to explore and describe the effects of macro social structures and processes (e.g., the increasing trend to prescribe psychotropic medication to children/youth in care) on personality (e.g., attitudes of Manitoba social workers towards medicating children/youth) and behavior (e.g., roles of social workers in the medication process) as found in society (e.g., residual social welfare system). The social world of my participants can be conceived as a complex arrangement of embedded circles with the individual at the core (see Figure 13).

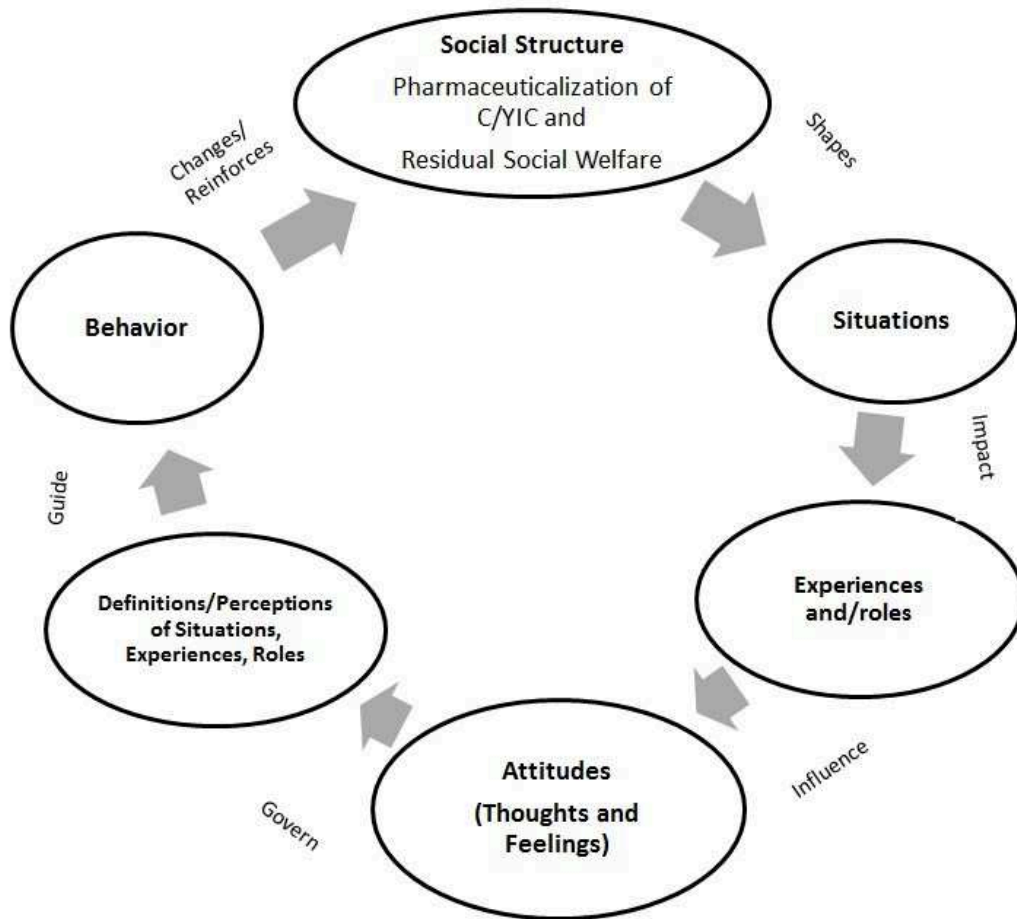


*Figure 13: Social World of Manitoba Social Workers*



What this diagram highlights is that the individual is surrounded by progressively larger and more complex social groupings, including dyads (e.g., experiences of the social worker with the child/youth in their care), small groups (e.g., agency roles), communities (e.g., situational contexts such as CFS social work), organizations (e.g., agencies) and institutions (e.g., child welfare system; mental health system), and finally the larger social system (residual social welfare and pharmaceuticalization) (For another example, see McLeod & Lively, 2003). However, what happens is more than just social workers existing at the core of a social system. There is also a historically embedded, recursive process of influence (see Figure 14).

Figure 14: Process of Influence



In this diagram we see that situational conditions are an important intervening link between society and the individual (Turner, 1988). The social structure (e.g., residual approach to social welfare) shapes situational conditions (e.g., limited funding, high caseloads, less time with children/youth in care) which then, in turn, impacts on experiences and roles and goes on to influence individual social worker attitudes (e.g., more favorable opinion of medicating C/YIC with psychotropics). Additionally, social worker attitudes (e.g., unfavorable opinion of medicating children/youth) govern perspectives of situational conditions (e.g., noting many negative effects of psychotropic medication on C/YIC; being an advocate for children/youth in their care), which then

guides behavior (e.g., determining that the child/youth does not need to see a doctor and be put on medication). This behavior then changes or reinforces the social structure (e.g., pharmaceuticalization).

By using a social structure and personality approach to my study, I was able to examine the relationships between macro-social systems and feelings, attitudes, experiences and behaviors of Manitoba social workers who work with C/YIC on psychotropic medication. My study suggests that there is an increasing trend towards the use of psychotropic medications on children/youth in care in Manitoba. This is symptomatic of pharmaceuticalization, or the growing use of medications in society. Furthermore, the trend illustrates a socio-political turn to residual social welfare that is focused on funding cuts, minimal intervention and greater administrative responsibility.

As professional overseers and care providers for children/youth in care in Manitoba, social work practice, experiences and attitudes reflect institutional constraints, the growing dependence on pharmaceuticals in society, and the actuarial calculations of risk. Medication-related roles of social workers in Manitoba are more collaborative than advocacy-based; experiences with medicated children/youth in care are 1.4 times more likely to be good than bad; and attitudes towards medicating children/youth in care are more favorable than negative.

It is salient that cumulative exposure to social and structural conditions within a particular historical frame will instil attitudes reflective of the external reality within the individual (Berger & Luckmann, 1966). These objective structures, having been inscribed in the individual, signifies that “the analysis of objective structures logically carries over into the analysis of subjective dispositions, thereby destroying the false antinomy

ordinarily established between sociology and social psychology” (Bourdieu & de Saint Martin 1982, p. 47, in Bourdieu Wacquant, 1992).

Though the system of influence is recursive, it does not mean that the social system remains static and unchangeable. Political authority may meet resistance and the social structure may change when new knowledge is created, adopted and defined as legitimate, and internalized into individual attitudes. It is knowledge that acts as a transformative tool and which can structure action and, in this vein, I provide some recommendations for Manitoba’s child welfare system that emerged from the findings.

### **Suggestions and Recommendations: Improving Child Welfare in Manitoba**

My analysis of the survey/interview responses and review of child welfare programs and legislation in Manitoba indicates that Manitoba is in need of and is well positioned to expand services in the area of child welfare and protective services regardless of whether one believes that medicating children/youth in care with psychotropic medication is good or bad. Important groundwork has already been laid through legislation by establishing the four Child and Family Services Authorities, developing differential response programs, focusing on prevention and enhancement, and increasing funding for service delivery through a new federal/provincial formula. However, given the increasing numbers of children and youth coming into care, particularly of Aboriginal background, it is time for services to expand.

Principally, we need a greater capacity to provide child and adolescent mental health services and family enhancement programs and services to communities outside of Winnipeg. This does not imply exporting a ‘city’ service to a rural community. It challenges policy makers to consider how specialized responses can be made available in

smaller communities. Presently there is no province-wide Child and Adolescent Mental Health (CAMH) Strategy in Manitoba; rather it is a patchwork of programs and services offered through the different regional health authorities, private, for profit clinics and non-profit organizations. For instance, the Winnipeg Regional Health Authority has its own CAMH Program that is responsible for child and adolescent mental health services, in both hospital and community settings. However, medical professionals skilled in CAMH are rare in rural and northern locations.

Other realistic and affordable programming must also be made available within and outside of Winnipeg. There are many preventative and enhancement components of service a child/youth or family at risk may need such as better housing, lessons in budgeting, family counseling, health care, etc. However, as one participant in my study described:

*Decisions are being made about allocating funds, supports, training and services by people that are not directly working with the population accessing services. Unfortunately the untrained, unsupported and ill-equipped people working the front lines are the ones that have to work with at risk families and children.*

One of the most effective ways to provide comprehensive services is through intensive case management. Manitoba already has an excellent example of intensive case management to draw from in community corrections called the Criminal Organization High Risk Offender Unit (COHROU).

Intensive case management involves smaller caseloads and greater involvement of the workers. For instance, in COHROU caseloads are on average 15 clients per probation officer. As a result, probation officers can spend more time on preparing comprehensive assessments, developing and implementing prescriptive intervention plans, and working intensively with each offender and multi-systems teams (which may include counselors,

physicians, and educators). COHROU probation officers are highly trained in and skilled at counseling and cognitive behavioural skill building (Jackson, 2009).

We know that every child/youth that enters the child welfare system is in trauma and is at a high risk of developing mental health issues if they do not already have mental health issues. It only seems natural that the province would provide the same level of care, service, and resources to these children/youth that it provides to serious criminal offenders in the province. The question that must be asked, however, is whether the province believes the successful integration of children/youth into society is equivalent to the successful integration of criminal offenders. If so, then why are child and family protection services (which includes children in care and family protection cases) only funded at a rate of one social worker per 25 cases instead of one social worker per 15 cases?

Apart from providing more funding, providing more services and implementing an intensive case management strategy, other key suggestions that developed out of my study include:

- **Support for enhanced work place training on social worker roles in medication assessment and treatment process for C/YIC**– Many social workers reported having received very little training with psychotropic medications and mental health needs of children/youth in care. For example one participant stated:

*Some of the CFS workers that we work with do not appear well-educated.*

- **Bring the Social Work Professions Act into force** – The *Social Work Profession Act*, which was passed by the Manitoba Legislature in 2009, has not yet been brought into force by the provincial government. This means that anyone can call themselves a Social Worker in Manitoba since only the title of *Registered Social Worker* is protected by the current 1966 legislation *the Manitoba Institute of Registered Social Workers Incorporation Act*. By enacting this legislation and

grandfathering in those with relevant experience, children and youth in care will receive more uniform care and standards of service. For example, as one study participant stated:

*They have been working on it for years and years and years, but they're also just figuring out who they'll grandfather into that designation and how it will work in the future. It is surprising, someone with a totally unrelated degree can be working and calling themselves a social worker. So we're looking forward to it being a profession where you have to be registered hopefully.*

- **Provide better support and resources for children and youth in care with FASD** – More programs and resources need to be made available specifically to address the high rates of FASD among children and youth in care in Manitoba. Approximately 17 percent of children in care are affected by Fetal Alcohol Spectrum Disorder (FASD) (Fuchs, Burnside, Marchenski, & Mudry, 2009). Diagnosis of FASD can be complex. Many social workers in my study suggested that FASD was of particular concern to them and several indicated difficulty in getting quick diagnoses and treatment. Greater education and training is needed, not only within the education system, but within the different regional health authorities.

*With the high rates of FASD FAE that is prevalent, especially among children in care, our work is that much harder. Their behaviors, the impulsivity and there aren't enough resources.*

- **Provide better support and training for foster parents** – Foster departments in CFS agencies need to ensure that foster parents understand the stages of child development so that they do not equate normal child behavior with the need for behavior modifying medication.

*I would say a lot of our foster parents are not educated. If they don't know the development stages of a child from infant to a 12-year-old then maybe they will look to medicate them. But if you sit down with them and say that at this age, this is how they act and this is how they behave and this is a normal two-year-old behavior. He could be hyper sometimes, so you know what, you take him outside.*

- **Develop a province-wide promotional campaign to actively seek out individuals to become foster parents** – One of the most prominent issues mentioned by social workers in my study was the lack of adequate foster placements. Study participants stated emphatically that group homes are not homes.

*The system is overwhelmed by the number of youth/children in care and there are not adequate placements available for the youth/children.*

- **The Manitoba Family Services and Labour Ministry should collaborate with colleagues in Health to develop a framework for a provincial child and adolescent mental health strategy** – As a policy unit the Child Protection Branch should develop a central repository of provincial data on child and youth in care diagnoses and prescription patterns. A lack of data on children and youth in care medical records resulting from case transfers is a serious impediment to service and policy development. While the Manitoba Centre for Health Policy has this information in its administrative health database, all available data should be compiled for program and policy analysts in the Child Protection Branch.
- **To undertake a two year pilot study implementing the COHROU case management model at three sites in Manitoba: one urban agency, one rural agency and one northern agency. Fifteen children/youth in care at each agency would be involved in the intensive and multi-team case-management.** – A two year pilot project, to be evaluated in the first and second year, would provide the information policy makers need to determine the impact of such specialization. Outcomes for children/youth in the program can be compared with outcomes for children/youth not in the program. Evaluative measures can include physical, mental, and emotional effects; academic gains; costs of implementation versus not implementing; social/relationship effects; to name but a few. It would be advisable to have the initiative implemented in three different population settings to provide sufficient variation in service terrains and experiences upon which to evaluate the impact of the program.

### **Study Significance**

In the introduction I suggested that this study has potential conceptual, practical and policy significance. Findings from this study have led to the development of a *process of influence* theoretical model that can be used to understand the complicated



experiences and perceptions of the participants. This model, though supported by the data, requires further testing with larger samples.

Perhaps most beneficial to the development of the model and the overall study was the Social Structure and Personality lens that I adopted to make sense of the differing perceptions of social workers. One of the advantages of using this framework is that it provides a set of orienting principles that can be applied across diverse substantive and theoretical areas in sociology, psychology and other disciplines. Thus it allowed me to test a number of theoretical tools to see if they explain the processes through which macro structures become internalized in individuals and how individuals are able to understand social systems.

The practical significance of this study was to fill a gap in research on the context, roles, attitudes and experiences of Manitoba social workers in dealing with C/YIC who are taking psychotropic medications. While this study does provide a basis for understanding social workers' perceptions of the trend to medicate children and youth in care, I must caution that a major limitation of this study is generalizability. The data set comes from a relatively isolated group of individuals – a snowball sample of Manitoba social workers who work with C/YIC on psychotropic medication. Regardless, this project does have potential to provide information to policy makers within the Manitoba child welfare system (as above); particularly in relation to the use of psychopharmacological medication on children and youth in care.

### **Limitations and Concluding Remarks**

As an exploratory survey, this study has obvious limitations. My sample of social workers was a convenience sample and may miss important aspects of the experiences of

social workers in Manitoba with psychotropic medication of C/YIC. Those who responded could be qualitatively different (i.e., more or less engaged in medication treatment with their clients) than non-responders. Moreover, the data are based on self-reports and I have no way of knowing how accurately social workers can gauge the medication effects on children/youth in care. Future studies might consider soliciting information from additional sources, from children/youth, families, counselors, frontline workers, and prescribers to allow for a more complete perspective.

Empirically, the study can only suggest potential theoretical structural formations in broader society. Yet despite the limitations, these data provide a useful glimpse of Manitoba social workers' involvement in the psychotropic medication treatment of children/youth in care. The purpose was to present the data in such a way as to develop a theoretical framework that may serve as a potential basis for future studies into the trend to medicate children/youth in care with psychotropics.

Future research on social worker perceptions on the pharmaceuticalization of children/youth in care should carefully examine the linkages between attitudes, experiences, roles and behaviors towards medicating C/YIC with psychotropics. Additionally, future research should engage in more quantitative and longitudinal approaches so as to examine trends and patterns over time. There is still a paucity of information on this topic considering the vast numbers of children/youth in care on psychotropic medication in Manitoba. Whether there is need for the medication or not, it is important to understand the underlying structures, situations and dispositions that guide this practice.

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## **Appendix A: Sample Recruitment Email**

Dear [insert name here],

My name is Sheri Bell, a Master's student in the Department of Sociology and Social Anthropology at Dalhousie University in Halifax, Nova Scotia. I am currently working on a research project that examines the experiences and perceptions of Canadian social workers in the medication treatment and assessment process of youth in government care.

I am interested in social workers' experiences and roles in working with children/youth on psychotropic medication. I hope to learn whether or not this medication has had an impact on their working relationships with these children/youth and what that impact has been. Furthermore, I hope to learn more about the current working context of social workers within the child welfare system that may affect the trend to medicate or resist medicating children/youth in care.

I would like to survey social workers whose current positions involve working with children/youth in care. Social workers who agree to participate can fill out the questionnaire and return it via email or, if they wish to share more information, they can choose to take part in a telephone interview that will use the same questions as on the questionnaire.

I am contacting you in the hopes that you can help me with this research by sharing your experiences and knowledge on the subject and/or by forwarding this information along with my contact information to other registered, licensed, or certified social workers in Canada who work with children/youth in care.

You will find attached to this email the informed consent form as well as the questionnaire. This will provide you with more details on the nature of the project and my purpose in conducting it. Should you agree to take part, you can decide whether or not to have a telephone interview or type out your answers to the questions on the attached form. If you prefer to have a telephone interview, please contact me at [s.bell@dal.ca](mailto:s.bell@dal.ca) with a time and date that is convenient for you. I anticipate that answering these questions will take approximately 45 minutes. Please note that I am required by law to report current and past unreported child abuse or situations dangerous to children or to persons in care. These are the same laws followed by service providers.

Thank you very much for your time and consideration. Thank you also ahead of time for forwarding this email to any of your interested colleagues. I look forward to your reply.

Sincerely,

Sheri Bell  
Dalhousie University  
[s.bell@dal.ca](mailto:s.bell@dal.ca)  
902-422-1995



## Appendix B: Research Instrument

**Title:** Canadian Social Workers and the Pharmaceuticalization of Youth in Care

**Principal Investigator:** Sheri Bell, Department of Sociology and Social Anthropology  
Dalhousie University  
Email: [s.bell@dal.ca](mailto:s.bell@dal.ca)  
Phone: 204-250-9734

**NOTE:** There are three possible ways that you may respond to this questionnaire:

1) You may answer the questions in this document and return this questionnaire via email to [s.bell@dal.ca](mailto:s.bell@dal.ca)

2) You may print this document, respond to the questions and return the completed copy via regular letter post to:

Sheri Bell  
102 Kirlystone Way  
Winnipeg, MB  
R2G 3B5

3) You may request a telephone interview at a time and date of your choosing by phoning 204-250-9734 or by sending an email to [s.bell@dal.ca](mailto:s.bell@dal.ca) . The telephone interview will use the same questions as the questionnaire

**(A) Please answer the following questions about yourself**

1. Are you licensed, certified or registered to practice social work in Canada?  
\_\_\_\_\_
2. Does your current position ever involve working directly with children/youth in care? [If no, then stop here] \_\_\_\_\_
3. Knowing that your current position involves directly working with children/youth in care, have you also worked with children/youth in care during any of these other time periods? [check all that apply] :
  - a.  Prior to the 1980s
  - b.  1980 – 1989
  - c.  1990 – 1999
  - d.  2000 – 2011
4. What is your sex?
  - a.  female
  - b.  male
  - c.  other: \_\_\_\_\_

5. To what age group do you belong?

- a.  under 25
- b.  25 to 34
- c.  35 to 44
- d.  45 to 54
- e.  55 to 64
- f.  65 to 74
- g.  75 +

6. Which province or territory do you practice in? \_\_\_\_\_

7. How experienced would you say you are in working with children/youth in care?

--

8. Which theoretical orientation are you most comfortable with? [For example neuropsychological/medical model or narrative/solution focused]

--

9. How does your theoretical orientation fit into your present work setting?

--

10. What is your primary field of practice? (choose one)

- a.  Geriatrics
- b.  Child welfare (including foster care/adoptions)
- c.  Criminal justice
- d.  Child & family services
- e.  Adult mental health
- f.  Health
- g.  Child mental health
- h.  Occupational social work
- i.  School social work (doing direct practice)
- j.  Other: \_\_\_\_\_

11. How large is your present case load? Number of service users = \_\_\_\_\_ [If you are unsure, please use your best approximation]

12. In your present case load, how many of your service users are children/youth in care? Number of service users = \_\_\_\_\_ [If you are unsure, please use your best approximation]

\*\*\*\*\*

**Please continue to the next section!**

\*\*\*\*\*

**(B) The following questions examine your experience with psychotropic medications**

***NOTE: Psychotropic medications are medications capable of affecting the mind, emotions, and behavior; they act primarily on the central nervous system where they alter brain function resulting in temporary changes in perception, mood, consciousness, and behavior. Common classes of psychotropic medications include antipsychotics, anti-anxiety medications, anti-depressants, stimulants such as ADHD medications, and mood stabilizers.***

13. To the best of your knowledge, in your present caseload, how many children/youth in care in each age category are prescribed psychotropic medication?

- a. Under the age of 8 = \_\_\_\_\_
- b. Age 9 to 12 = \_\_\_\_\_
- c. Age 13 to 16 = \_\_\_\_\_
- d. I don't know = \_\_\_\_\_

14. How has the use of psychotropic medications affected your work with these youth?

- a) Tell me about some of your positive experiences
- b) Tell me about some of your negative experiences

a)

b)

15. What are some of the institutional/organizational factors in your work that may be affecting the trend towards medicating children/youth in care with psychotropics? For example, bureaucratic structure or administrative responsibilities.

16. What are some of the factors in the broader context in which you work that may be affecting the trend towards medicating children/youth in care with psychotropics? For example, provincial/territorial child welfare policies, political or economic issues, or development of new systems of treatment.

17. Explain what official and/or unofficial role(s) you play in the psychotropic medication treatment and assessment process for children/youth in care in your caseload.

**18. The following is an excerpt from a Globe and Mail newspaper article:  
“Nearly Half Of Children In Crown Care Are Medicated”:**

*“...with close to half of Crown wards on psychotropic medication, their numbers are more than triple the rate of drug prescriptions for psychiatric problems among children in general.*

*With histories of abuse, neglect and loss, children in foster care often bear psychological scars unknown to most of their peers. But without a doting parent in their corner, they are open to hasty diagnoses and heavy-handed prescriptions. Oversight for administering the drugs and watching for side effects is left to often low-paid, inexperienced staff working in privately owned, loosely regulated group homes and to overburdened caseworkers legally bound to visit their charges only once every three months” (Philip, 2007).*

Based on your experience, how accurate is this portrayal of the use of psychotropic medications in the system? In other words, where do your experiences converge and/or diverge with this excerpt?

\*\*\*\*\*

**Finished!**

**Thank you so much for your time!**

\*\*\*\*\*

## **Appendix C: Relevant Manitoba Education Funding Formula 2011–2012 for C/YIC**

The information found in this appendix can be located in the following sources:

<http://www.edu.gov.mb.ca/k12/finance/schfund/funding13-14.pdf>

<http://www.edu.gov.mb.ca/k12/specedu/funding/level2-3.html>

[http://www.edu.gov.mb.ca/k12/specedu/funding/ebd\\_II.html](http://www.edu.gov.mb.ca/k12/specedu/funding/ebd_II.html)

Within the Base Supports provided for students in Manitoba, schools who educate children/youth in care are also eligible for a Student Services Grant which consists of a per pupil amount combined with socio-economic and children-in-care components. There is an additional amount of \$500 per pupil reported in eligible enrolment at September 30, 2012 as being under the care of Child and Family Services.

Under Categorical Supports, schools who educate children/youth in care may be eligible for a Special Needs Level 2 or Level 3 support. Level 2 and 3 support is provided, on an application basis, for approved pupils who require and receive exceptional supports within the guidelines for Level 2 and 3 funding support. Applications are completed by school divisions and submitted to the Funding Review Team, Program and Student Services Branch to determine eligibility. The process for application and guidelines for support are available at:

[www.edu.gov.mb.ca/k12/specedu/funding/level2-3.html](http://www.edu.gov.mb.ca/k12/specedu/funding/level2-3.html)

Extra funding for pupils approved for Level 2 support is \$9,220 per eligible pupil

Extra funding for pupils approved for Level 3 support is \$20,515 per eligible pupil

### **Level Two Funding:**

Funding eligibility criteria for Level 2 support are based on the student's profile of need and level of support required for a major portion of the school day, and full time attendance.

One of the criteria for level two funding that is specifically relevant to this study is whether the student falls under the category of **very severely emotionally/behaviourally disordered**:

This is defined by the province as:

“The student exhibits severe emotional/behavioural disorder(s) characterized by significant behavioural excesses or deficits which disrupt the student’s thinking, feeling, mood, ability to relate to others, and daily functioning. Beyond the emotional impact, the student’s physical, social and cognitive skills may be affected. These behaviours continue over a period of time. The student requires student specific programming and supports with ongoing formal interagency involvement.”

In order to attain funding, the school must provide:

- Student Profile

- Provide concrete and concise descriptions of the most recent observations, informal and specialized assessment data (including dates, roles/titles and names) and the impact this may have on student learning related to each of the following:
- Severe incidents of behaviour (most recent types, frequency, intensity, duration)
  - Behaviours that are dangerous to self or others, out-of-control behaviours
  - Less severe behaviours
- Describe pervasiveness (occur across living/learning environments) and/or chronic patterns (when did it start, how long has it been going on).
- Provide information on relevant life experiences that support emotional basis for behaviours (e.g. difficult or damaging life experiences that have occurred).
- Include any formal diagnoses (biochemical/organic and/or psychiatric) and cognitive information.
- Describe any emotional responses that appear consistent with identified life experiences and diagnoses.
- Resource Profile
  - A brief summary of the adaptations the student requires to achieve curricular outcomes or individual goals.
  - Summarize exceptional services provided to the student and/or parents by student-specific planning team members. Include nature of support (e.g. direct therapy, respite) and time spent.
    - school staff or program
    - direct clinical supports
    - mental health
    - outside supports (e.g. Child and Family Services)
  - Summarize specific interventions that has been developed to address:
    - academic needs
    - therapeutic needs (social-emotional learning, personal needs)
    - system needs (optional)

### **Level 3 Funding:**

One of the criteria for receiving level 3 funding which is of most relevance to this study is whether the child/youth is **profoundly emotionally/behaviourally disordered**. This is defined as:

The student exhibits profound emotional/behavioural disorders and associated learning difficulties requiring highly specific programming and intensive support services at school and in the community. This applies to the student:

- who is a danger to self and/or to others and whose actions are marked by impulsive, aggressive, and violent behaviour
- whose behaviour is chronic -- the disorder persists over a lengthy period of time



- whose behaviour is pervasive and consistent -- the disorder negatively affects all environments, including home, school, and community
- who requires or receives a combination of statutory and non-statutory services from Manitoba Education, *Family Services and Consumer Affairs (FSCA)*, Health, and/or Justice as defined within the *Child and Family Services Act*, the *Mental Health Act*, and the *Young Offenders Act*

Note that C/YIC are more likely to be eligible for level 3 funding since they receive services under the *Child and Family Services Act*.