

**THE EXPERIENCE OF ADDICTION COUNSELLORS AND SOCIAL WORKERS
WITHIN THE CONTEXT OF A MULTIDISCIPLINARY TEAM**

by

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Abstract

In British Columbia in 1997, a multidisciplinary model was implemented with the creation of a new “child centred” Ministry, the Ministry for Children and Families. After approximately five years of operating from this model, this study aimed to explore what it has been like for child protection social workers and addiction counsellors to work together. A qualitative semi-structured interview study was undertaken with 16 addiction counsellors and 16 social workers. The overall question guiding this study was: “What has been the experience of addiction counsellors and child protection social workers working within a multidisciplinary team?” Part of the experience described by participants involved ethical situations they faced in their roles, and the resulting effect on the therapeutic alliance. The influence of the multidisciplinary model on each discipline’s knowledge base and future possibilities for the model were other areas explored.

A qualitative content analysis was then used to identify categories from the interview transcripts. The results yielded three major categories and eight subcategories, for the main question, depicting many parallels between the experience of these two disciplines and that of two different cultures coming together for the first time. The main categories comprised:

1. Transition Theme: Initial Contact between Two Cultures
2. Reorientation Theme: How Can We Make This Work
3. Adaptation Theme: Positive Aspects of Inter-Cultural Conflict and Current Status

The findings revealed intense feelings of not being validated by the host culture, some perceived benefits of the amalgamation, predominantly a negative effect on the therapeutic relationship, and doubts about the suitability of integrating a statutory and non-statutory service.

The implications strongly suggest intervention is needed at the administrative level to ensure

the best utilization of financial resources, optimize service to clients and facilitate professional expertise.

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CHAPTER I

Introduction

*The most universal quality is diversity
(Montaigne, 1580 cited in Novinger, 2001).*

Research Problem

A child's death, Matthew, led to an inquiry of the policies and practices of the former Ministry of Social Services. It was revealed that many professionals and service providers involved with Matthew and his family did not share information, resulting in a very fragmented approach. To improve case planning and collaboration, in 1997 over 100 programs were brought together from the Ministry of Attorney General, Ministry of Education, Women's Equality, Health and Social Services (Open Cabinet Meeting, Address by Minister Hogg, November 7th, 2001). As a result of this reconfiguration, parents involved with the child protection system have been receiving substance abuse counselling from addiction counsellors within a multidisciplinary setting for the past five years. The members of the interdisciplinary team comprise child protection social workers, mental health counsellors, addiction counsellors and probation officers, although the mental health counsellors are generally offsite.

There is no dispute in the literature that both child protection and chemical dependency are serious and prevalent concerns in our society. The Canadian Incidence Study of Reported Child Abuse and Neglect (2001) stated that at least 40% of the families involved in the child protection system in Canada have substance abuse concerns as well (Trocme & Wolfe, 2001). In the United States, the statistics range from 60% to 87% of child welfare clients being drug involved (Hamptom, Senatore, & Gullotta, 1998). The effects of these dual concerns on families are devastating. Children in chemically dependent families are more likely to experience attachment problems, behavioural and emotional problems, and be developmentally

delayed (Gruber, Fleetwood, & Herring, 2001). The families, as a whole, experience multiple complex problems with housing, employment, poverty, domestic violence, isolation and criminal activity (Semidei, Feig Radel, & Nolan, 2001; Tracy, 1994).

At least in part due to the stigma attached to being substance dependent, users often seek out help through professionals that are not directly part of the formal addiction treatment system such as doctors (Ogbourne & DeWit, 1999; Tucker, Donovan, & Marlatt, 1999). Within the child protection system, people in the families lives, family, friends, and professionals, recognize a problem and report them. For many families their chemical dependency issues start to be addressed when they come to the attention of child welfare authorities. The major obstacles to seeking addiction treatment or help with parenting issues is the stigma associated with being a substance abuser or with child maltreatment, as well as the fear that serious consequences will result such as the removal of their children from their home (Faver, Crawford, & Combs-Orme, 1999; Hajema, Knibbe, & Drop, 1999; Tucker, Donovan, & Marlatt, 1999).

Child protection social workers have a legislated mandate and a social control function, meaning their clients are largely non-voluntary. Whereas, addiction program's services are voluntary, yet they also serve a court ordered population. The voluntary client defines his/her problem, while the non-voluntary person has their presenting problem defined by others. The counsellor on a multidisciplinary team is compelled to examine their "role as counsellors whose goal is to bring about change versus roles as social controllers whose goal is to maintain stability" (Slonim-Nevo, 1996, p.117). The more effective strategies that child protection workers and addiction counsellors can learn to work with mandated clients, the better equipped they will be to enter into a productive and healing relationship.

It is mostly women with substance abuse issues who come into contact with the child welfare system compared to men, yet the absolute number of services for women has been inadequate (Department of Health and Human Services, 1999; Marsh, D'Aunno, & Smith, 2000; Miller, 2001). There are not enough residential treatment centres that will take women with their children. It is also necessary that programs address trauma and parenting concerns, which is often not the case (Ragaglia, 2000). The special needs of women with child protection and substance abuse issues needs to become part of the program structure. Another over-represented group in the social service systems is the First Nations people (Kirmayer, Brass, & Tait, 2000). More locally, in British Columbia, the Ministry for Children and Families 1998/99 Annual Report indicated that of nearly one million children in the province under 19 years of age slightly under 1% were in care for that year. Specifically, by March 31st, 1999, 9,813 children were in care, which was up 447 (4.8%) from the preceding year (Ministry for Children and Families Statistical Summary of Child Protection Services, 1998/99). Out of this total 9,813 children in care population, 2,961 (30.2%) were of Aboriginal background, even though they make up only 8% of the general population in British Columbia (Ministry for Children and Families Annual Report, 1998/99). Working effectively cross-culturally, involves respecting their cultural traditions, while weaving into the child protection and therapeutic process their vision of healing and understanding, in the context of compassion for their historical traumatization.

The implementation of a multidisciplinary model in British Columbia is congruent with the expressed need for collaboration between addiction and child protection services generally advocated in the literature. The complex nature and subsequent problems associated with addiction and child welfare are too broad and pervasive for any single discipline to manage on their own (Corrigan & Bishop, 1997; Walter & Petr, 2000). Although it is recognized that these

two issues are very challenging to work with and it is recommended that they combine forces, for the most part, child and family services continue to be delivered through the traditional means of individual treatment and categorical services (Meyers, 1993; Powell, Dossier, Handron, McCammon, Evans Temkin, & Kaufman, 1999; Skaff, 1988). Even though interdisciplinary models have been applied to many settings such as rehabilitation, geriatrics, gerontology, health services, juvenile justice, and crisis units, most of the interdisciplinary teams are in the context of community mental health teams (Onyett & Heppleston, 1994).

From a strictly continuity of service perspective, it makes sense to have professionals working in a team setting. However, when professionals trained and oriented in their respective disciplines attempt to work together, there are challenges, as well as benefits. Members of integrated teams report a perceived loss of status when they are combined with other professionals; blurring of roles; conflict with ethical codes, particularly confidentiality; value differences and a lack of common goals (Galvin & McCarthy, 1994; Graham & Barter, 1999; Reese & Sontag, 2001). The positive experiences of multidisciplinary team staff entail reduced burnout levels; improved service delivery; shared risks and resources; and decreased duplication (Huxley & Oliver, 1993; Schofield & Amodeo, 1999).

In terms of effectiveness, the literature contains contradictory perspectives. Some of the researchers attested to the benefits of collaboration such as increased length of time in treatment; reunification of children with their parents; strengthened support network; and lowered risk for substance abuse and child maltreatment (Gruber, Fleetwood, & Herring, 2001; Moore & Finkelstein, 2001). In the other camp, Galvin and McCarthy (1994) and Hall (1999) concluded that multidisciplinary teams result in unfocused, inefficient and low quality service provision with team members becoming confused, demoralized and deskilled. The major concern of these researchers questioning the utility of interdisciplinary teams was that much of

the literature is descriptive, rather than outcome or empirically based resulting in insufficient evidence to definitively state one way or the other. It is difficult to discern the client's experience of a multidisciplinary team with addiction counsellors and child protection social workers because most collaborative teams encompass community mental health settings that do not comprise these professional groups (Akin & Gregoire, 1997; Diorio, 1992; Gregoire & Schultz, 2001; Ligon & Thyer, 2000).

The research that is available does not speak directly to the model that has been adapted in British Columbia. As discussed earlier, this local model has been operating for five years consisting of parents with child protection issues being referred by their child protection social worker for substance abuse counselling to the addiction counsellor on the same team. There are many reasons supporting placing professionals together to work in a coordinated manner with clients. Nonetheless, due to the very different roles of a child protection social worker and addiction counsellor, there were many concerns pre-and post-implementation of this integrated model. At the heart of the dilemma was the threat to the therapeutic alliance, given the counsellor would be working alongside the parent's child protection social worker. How would this multidisciplinary model affect trust and safety issues so necessary for the working relationship between the addiction counsellor and the client? Would substance abuse counsellors feel like their client's therapist or someone who is monitoring them for the social worker? How have the roles and responsibilities of each profession played out in the interdisciplinary setting? How have the different timelines operating within each profession's work affected a collaborative effort? Did each professions' knowledge base increase? How did the addiction counsellor and child protection social worker handle ethical situations that surfaced? Would the Addiction Services mandate and resources be subsumed by the larger child protection system?

The literature, for the most part, management and policy makers within the Ministry of Children and Family Development have voiced their support for integrated team work, while the front line workers have had very little input. Generally, the literature advocates for the formation of a multidisciplinary model comprising child protection and addiction services, but for the most part this has not materialized on a practice level. Also, with no research arm within the Ministry and this time of economic restraint, it is unlikely research will be undertaken, unless it is carried out by an external researcher at no cost.

In the present study, a qualitative content analysis was used to code the transcribed interviews of 32 research participants. The results showed three major themes and eight sub-themes related to Question 1: What has been your experience working within the context of a multidisciplinary Team? and three main themes and seven sub-themes evolved from the data collected for Question 2: What ethical situations have you come up against? These categories shed light on the child protection social worker's and addiction counsellor's experience of working within the context of a multidisciplinary team, which will be thoroughly presented in the results section. A discussion is developed regarding what aspects of the multidisciplinary model were helpful and not helpful, how to balance the needs of children with keeping the therapeutic alliance solid, the limited third culture development and the continued functioning of the disciplines as separate entities, for the most part, despite being co-housed. Implications to future research, practice of addiction counselling and administrative issues are explored.

The next chapter reviews the literature related to the areas in which child protection and addiction issues intersect. These domains include: the history of amalgamation efforts, role differences, help seeking behaviour, scope of the problem, effects of these dual concerns on families, need for collaboration, ethical issues, special populations, experience of clients

involved with both services and multidisciplinary approaches. The literature review ends with exploring specific qualitative research that informed this study.

CHAPTER II

Literature Review

1. History of Amalgamation: Substance Abuse and Child Protection Services in British Columbia

The current multidisciplinary model in British Columbia has been operating since 1997, taking direction from the Gove Inquiry which was commissioned to “inquire, report and make recommendations on the adequacy of services, and the policies and practices, including training and workload, of the Ministry of Social Services as they relate to the apparent neglect and abuse, and death of Matthew Vaudreuil” (Herbert, 1995, p. 1). Prior to the Gove report there had been many attempts at inter-ministerial coordination of child welfare services.

In 1994, the Child and Youth Secretariat compiled a list of 119 cross-ministry services for children and youth with special needs between the Ministry for Social Services, Ministry of Attorney General, Ministry of Health, Ministry of Education and Ministry of Women’s Equality (Hamilton, 1995). Traveling further back in history during the late 70’s, an inter-ministerial study examined the need for coordination of services, which resulted in the development of “Children in Crisis Committees” to oversee case planning and case management for special needs youth (Thorau, 1995). Shortly thereafter, in 1979, these crisis committees were replaced by Inter-Ministry Children’s Committees, which entailed a broader mandate involving all inter-ministry planning and service issues, but with the target population being “hard to serve youths” between 12 and 19 years of age (Hamilton, 1995).

The Ombudsman’s office became involved in 1988 after many complaints were lodged regarding problems with cross-ministry services for special needs children, youth and their families (Hamilton, 1995). This office’s recommendation was to implement a provincially driven, formally mandated and resource equipped mechanism to better define accountability

and ensure service integration (Hamilton, 1995). It appears that nothing concrete came of this process, until 1989 when a 15 year old youth in care was killed in a fire at a juvenile correctional facility (Hamilton, 1995). Prompted by this tragedy, the Ombudsman's office direction to establish a single authority within government to ensure uniform, integrated and client-centred provincial approaches to policy setting, planning and administration of publicly funded services to children, youth and their families was implemented with the creation of the Child and Youth Secretariat in November 1990 (Child and Youth Secretariat, 1994; Hamilton, 1995). Under the Secretariat, the 25 Inter-Ministry Children's Committees were replaced with 12 regional child and youth committees, and approximately 120 local child and youth committees (Hamilton, 1995).

Annual Reports from the Office of the Ombudsman consistently found that the services continued to be fragmented with the major reforms necessary to achieve integrated services not being initiated (Hamilton, 1995). Due to growing concerns that the Secretariat was not meeting its mandate, in late 1993 an Evaluation Steering Committee was established (Carter, 1995). This process ended with retaining the Secretariat model, but a restructuring by Cabinet took place involving a full-time, permanent Director responsible for the supervision of four Child and Youth Committee coordinators seconded from the lead ministries (Hamilton, 1995). The criticism of this framework was that the Secretariat could only report coordination problems to the assistant deputy ministers' committee, which then reported to the Deputy Ministers' Committee on Children, Youth and the Family with the jurisdiction to only make recommendations respecting service integration (Hamilton, 1995). There still did not appear to be any ultimate authority to ensure the delivery of multidisciplinary, coordinated services. The up to nine ministries delivering children and youth services were still operating according to

very divergent policies, priorities, funding mechanisms and service delivery systems (Hamilton, 1995).

The Gove Inquiry appears to have been the latest development in a long line of attempts to coordinate services. Similar to its predecessors, this report was prompted by the death of a child. The inquiry showed that Matthew and his mother needed a range of public services spanning social services, health, mental health and education, which were delivered in a fragmented and uncoordinated way (Gove Report, Volume 2, 1995). The Gove Report recommended a new child welfare system placing the child at the centre with service providers sharing relevant case information, common values, priorities and a management and administrative structure. Concretely, over 100 programs were brought together from the Ministry of Attorney General, Ministry of Education, Women's Equality, Health and Social Services (Open Cabinet Meeting, Address by Minister Hogg, November 7th, 2001).

Since the restructuring of the Ministry, numerous reports have served a watch dog function monitoring the implementation of the Gove Report recommendations. The Office of the Child, Youth and Family Advocate's 2000 Annual Report entitled "Get On With It" reported that despite all of the extensive research, documents being produced and restructuring of services, little progress has been made in ensuring young people's needs are met. Pallan in The Children's Commission 2000 Annual Report indicated a general disappointment by the response to the recommendations that had been posed in the 1999 Annual Report, which identified 18 areas (e.g. need to create a comprehensive strategy for prevention and early support, effectively implementing the recently developed aboriginal strategy, and establishing children's centres for the delivery of multidisciplinary services for children and youth) that needed urgent attention, and yet in the year 2000 solid progress had been made in only one area - more children and youth were involved in the development of their care plans.

After the amalgamation of all of these programs from various Ministries, the new mission statement became “the Ministry for Children and Families serves the people of British Columbia by ensuring a child centered, integrated approach that promotes and protects the healthy development of children and youth while recognizing their lifelong attachment to family and community. Communities and clients must be an integral part of the work of this ministry. Quality assurance, accountability and openness are fundamental to its success” (The Ministry for Children and Families Annual Report, 1998/99, p. 6). Administratively, this resulted in child protection social workers, addiction counsellors, probation officers and mental health counsellors being brought together under one employer, the Ministry for Children and Families in 1997. On a practice level, this meant that parents with child protection and substance abuse issues would be expected to seek counselling from a therapist on the same team as their child welfare worker. Even though there are many reasons to justify these services coming together, counsellors inside and outside the Ministry both pre-and post-implementation have had concerns about how this configuration would affect the therapeutic alliance due to the divergent roles of child protection social workers and therapists.

2. Role of Addictions Counsellor and Child Protection Social Worker

When different disciplines are brought together in an integrated team environment, there will be aspects of their roles that hinder a truly collaborative process. As the Child Welfare League of America (2001) pointed out, tensions between the two systems arise from the seemingly different nature of their objectives. Child protection social workers’ focus is the child whose development cannot be put on hold, and is working to reunify the family as soon as possible. The addiction counsellor, on the other hand, is concentrating on the substance abuser and is aware that treatment is a process that takes considerable time. Young, Gardner and Dennis (1998) referred to the metaphor of the four hourglass clocks to illustrate the different

time frames for child protection and addiction practice: (a) time limited court orders which dictate planning timelines for children in care; (b) pace of recovery from addiction which is a complex process; (c) children's developmental timelines, and (d) time limits for income assistance recipients whose benefits are threatened when their child(ren) reach a certain age.

There are also differences in education and training of staff. The child welfare system lacks chemical dependency training (Alaszewski & Harrison, 1992). It is pointed out that social workers consistently fail to identify alcohol problems, and further that current professional training produces a professional blindness to substance abuse problems and an incapacity to respond. Chico (1999) reported that there are "only two Master of Social Work schools in the United States mandating substance abuse training as part of their core curriculum" (p. 37). Many schools offer substance abuse assessment and treatment courses, but as an elective resulting in many students graduating without any chemical dependency knowledge (Chico, 1999). Once social workers are hired by child welfare agencies there is typically an average of four hours of alcohol and drug training (Chico, 1999). Despite the high overlap of substance abuse and child maltreatment issues, little is known by social workers in the field about the role and impact addictions play in the child abuse and neglect (Gregoire, 1994). Professionals working in the child welfare system need greater expertise in the area of identifying substance abuse issues and how to work effectively with families struggling with the dual concerns of chemical dependency and child maltreatment (Curtis & McCullough, 1993; Thompson, 1990; Tracy & Farkas, 1994). The Child Welfare League of America (1992) supported alcohol and drug core training designed for all child welfare agencies being incorporated into existing pre-service and in-service training for all staff members. Birchall and Hallett (1995) found that interprofessional training was strongly associated with positive attitudes towards aspects of multidisciplinary practice such as sharing of information and joint conferences.

It is interesting to note that most counselling programs have no coursework dealing with child protection issues. Although the basic counselling skills are learned to develop therapeutic relationships, many counsellors are ill prepared to notice the signs of child maltreatment (Chico, 1999; Reiniger, Robison, & McHugh, 1995). Hampton, Senatore and Gullotta (1998) advocated schools teaching multidisciplinary thinking and cooperation, as well as offering practicums in both child welfare and substance abuse settings. "The central role of universities and colleges in the preparation of human service professionals, places them in a key position to devise and sustain preparation programs that will instill the skills, knowledge, and attitudes needed to guide collaborative interprofessional work" (Knapp, Barnard, Brandon, Gehrke, Smith, & Teather, 1993, p. 137). As Stanley, Manthorpe and Talbot (1998) asserted, "the need to communicate effectively with and work jointly with other professionals has become a core skill rather than an optional extra" (p. 34).

Other factors that lead to frustration between the two disciplines are different definitions of the "client", expectations and success (McAlpine, Marshall, & Doran, 2001). These points are echoed by Azzi-Lessing and Olsen (1996) who commented that convergence of these two distinct fields with separate goals, philosophies, legal mandates and practice wisdom leads to significant hurdles when attempting to integrate them. The child welfare system views the client as the child first and foremost, their philosophy is one of enforcing community standards or a social control function, and they have statutory obligation to ensure children's safety. The addictions treatment system perceives their client to be the substance abuser, they approach their work from a therapeutic context, and the service is voluntary (Carten, 1996; Keene & Woolgrove, 1997; Leathard, 1994).

Another discrepancy between the disciplines involves parenting issues, which are of great concern to social workers, but this is rarely addressed during residential treatment. While at the treatment centre, attention is devoted to the user's individual recovery and family issues are often viewed as a distraction. Treatment programs do not view success in terms of family functioning, rather they focus on drug use (Hampton, Senatore & Gullotta, 1998). At the heart of the conflict between child welfare and addiction services, according to Hampton, Senatore & Gullotta (1998), is the different view about the nature of chemical dependency. Generally, from the addiction staff perspective, chemical dependency is viewed as a disease with biopsychosocial-spiritual components, while child protection personnel often consider substance abuse as an irresponsible choice that should be punished (Hampton, Senatore, & Gullotta, 1998).

In Canada, more so than the United States, there are dual approaches in substance abuse treatment depending on which direction the client wants to proceed. Some parents will choose harm reduction versus abstinence, which often conflicts with the expectations of the supervising social worker. Relapse, a frequent occurrence in the addiction process, is seen by the counsellor as an opportunity for the client to learn what happened and how to combat this in the future. For child protection staff, relapse alerts them to a potentially high risk situation for their children, often forcing them to act by possibly removing the children or delaying their return home. A blending of perspectives and appreciation of each disciplines' orientation needs to occur before effective collaborative work can be accomplished. A strong therapeutic alliance, so crucial for movement to take place, needs to be maintained, while balancing the need to safeguard children from abuse and neglect.

3. Help Seeking Behaviour with Substance Abuse and Child Protection Issues

It is very important to ascertain what substance abuse and child protection professionals can do to facilitate clients seeking help when working within the context of an integrated team. Help seeking behaviour in general is associated with lower levels of perceived control over the problem, willingness to expend time and energy resolving the problem, an internal locus of control, acceptance of personal responsibility, belief in the efficacy of their behaviour and internalized causality for the problem (Simoni & Adelman, 1991). It has been well documented in the literature that only a small minority of individuals struggling with substance abuse issues participate in treatment (Tucker, Donovan, & Marlatt, 1999). An analyses of data in Canada's Alcohol and Other Drugs Survey (1994) showed that 2% of lifetime drinkers reported seeking help to deal with their substance use; help seeking increased as the number of life areas affected rose; those aged 40-49 were three times more likely to seek help compared to younger drinkers; and less help seeking occurred for married individuals (MacNeil & Webster, 1994; Ogborne & DeWit, 1999).

When people with addiction issues do solicit help, it is often late in problem development, after many negative consequences, and may involve coercion such as court or child protection referred (Brooke, Fudala, & Johnson, 1992; Bucholz, Homan, & Helzer, 1992). Much of the help seeking literature related to addiction suggests a strong relationship between participating in treatment and the surrounding social contexts, and a much weaker association with demographic variables, level of substance use and structural factors such as treatment cost and accessibility (Tucker, Donovan, & Marlatt, 1999). In essence, psychosocial problems, particularly interpersonal difficulties, are a primary motive for help-seeking (George & Tucker, 1996; Tucker, Donovan, & Marlatt, 1999). People who seek help report less network encouragement to drink or use, and more prompting to get help. This may contribute to

Alcoholics Anonymous' (AA) appeal because it provides an alternative social network that promotes abstinence (George & Tucker, 1996).

Two major obstacles to seeking addiction treatment are the stigma associated with being a "substance abuser" and having to give up the substance (Hajema, Knibbe, & Drop, 1999; Tucker, Donovan, & Marlatt, 1999). At least in part due to the stigma attached to being substance dependent, users often seek out help through professionals that are not directly part of the formal addiction treatment system such as doctors (Ogbourne & DeWit, 1999; Tucker, Donovan, & Marlatt, 1999). Substance abusers are over-represented in the health, mental health, social services and criminal justice systems, and often these agencies do not recognize or address their chemical dependency problems (Ogborne & DeWit, 1999). For women with addiction issues, there can be competing needs and priorities that drive her to seek help such as domestic violence, depression, anxiety, and current health risks (Brown, Melchior, Panter, Slaughter, & Huba, 1999).

With many families, their chemical dependency issues start to be addressed when they come to the attention of child welfare authorities. Faver, Crawford, and Combs-Orme (1999) stated that prior research on help seeking by maltreating and at-risk families was extremely limited. Much of the literature focused on the end stage of the help seeking process, service utilization, as opposed to earlier stages of help seeking (Greenley & Mullen, 1990). These families did not present for help because they did not recognize the development of problems in the parenting relationship, the stigma associated with child maltreatment and/or service providers, and clients often had different views as to what services were needed (Faver, Crawford, & Combs-Orme, 1999). It can be expected that there would be variation between clients and service providers in the area of parenting, especially related to discipline and

standards of care (Faver, Crawford, & Combs-Orme, 1999). This is even more pronounced if the child protection social worker and family are from two different cultures and social class.

Most clients who end up in the child welfare system are mandated clients. They are not voluntary help seekers, rather other people in their lives, family, friends and professionals, have recognized a problem and reported them. For those families who go unreported, very little is known about how these unidentified families recognize or fail to recognize parenting problems (Faver, Crawford, & Combs-Orme, 1999). It is important to recognize that the existing literature has focused on voluntary help-seeking, whereas most services provided for child maltreatment are mandated (Faver, Crawford, & Combs-Orme, 1999; Pelton, 1990). For those families that access support services such as parenting groups, respite and prevention programs, Telleen (1990) concluded that in these cases the need for support exceeded the client's supportive resources. The factors associated with child maltreating families severely hindered the help seeking process: poverty, isolation, inter-generational abuse, low educational levels, unsafe housing, and violent neighbourhoods (Faver, Crawford, & Combs-Orme, 1999). Further, client's negative perceptions of child welfare agencies impeded their participation in services. Often, families were overwhelmed by fear, and felt very vulnerable in light of the caseworkers' profound authority to remove their children (Diorio, 1992).

Keller and McDade (1997) surveyed 494 parents to determine their attitudes about parenting, help seeking behaviour and obstacles to accessing help with parenting. The results showed that the most likely source of help for these parents was print and video material (94%), followed by family members (88%), and parenting classes (84%). The least likely services to be accessed were child protective services (17%) and a telephone helpline (26%). The obstacles to help seeking mentioned by these parents included fears of being judged, fears of intrusion and being misunderstood, believing services would not be useful, worried that

information would not be held confidential by other professionals/program staff, lack of trust, fear of losing their children, and anticipating that they would be lectured to and made to feel stupid (Keller & McDade, 1997).

The above noted factors affecting help seeking behaviours with addiction and child protection issues can inform the interventions these systems undertake. The social network is influential and interventions could be devised to buttress its role in promoting help seeking (George & Tucker, 1996). Further efforts could be directed at providing locally based services, continuity of care, cross-system collaboration, greater cultural competency, and linking services to prevent child maltreatment to other kinds of services that at risk families are likely to seek voluntarily (George & Tucker, 1996). Keller and McDade (2000) promoted respecting cultural values, offering services in conjunction with community institutions, utilizing an empowerment model emphasizing strengths, and giving information about child care and development in less traditional ways through videos, pamphlets, television commercials, billboards and busboards. Infusing the helping relationship with collaborative principles, trust and sharing of power will also assist help seeking, if parents are not so threatened and intimidated by the process (Gutierrez, 1990). Because so many families affected by substance abuse and child protection issues come into contact with other systems not directly related to these concerns, these other services may serve as a gateway to helping them address addiction and child maltreatment (Tucker, Donovan, & Marlatt, 1999).

4. Scope of the Problem: Substance Abuse and Child Abuse

There is much research supporting the link between substance abuse and child abuse, suggesting the need for collaboration. Gregoire (1994) noted that as early as 1917, reference was made to the impact of chemical dependency on the nature of social work practice, when Mary Richmond wrote of the importance of the social worker's role in combating alcoholism in

society. Most of the statistics reflecting the co-occurrence of chemical dependency and child maltreatment are from the United States. The Department of Health and Human Services (1999) concluded after reviewing studies that parental substance abuse was a contributing factor for between one third and two thirds of children involved with the child welfare system. O'Flynn (1999) noted that between 1982 and 1992, the number of children in foster care doubled with the major cause for the increase being drug use. The introduction of highly addictive crack cocaine to low-income urban neighbourhoods has had a severe impact on maternal substance abuse and its negative consequences for children and families (Marcenko, Kemp, & Larson, 2000). The National Household Survey on Drug Abuse (NHSDA) found that 11 percent of all children in the United States live in households in which at least one parent is chemically dependent, equally divided between mothers and fathers (Marcenko, Kemp, & Larson, 2000). The ethnic make-up of these parents were 64% white, 21% non-Hispanic black, and 10% Hispanic (Hamptom, Senatore, Gullotta, 1998).

Substance abuse is one of the main family problems resulting in child removal and placement in foster care today with a range from 60% to 87% of child welfare clients being drug involved (Hamptom et al., 1998). Parents with substance abuse problems are more likely than other parents to maltreat their children, as much as three times as likely (Department of Health and Human Services, 1999; Juades, Ekwo, & Van Voorhis, 1995; Kelleher, Chaffin, Hollenberg, & Fischer, 1994). Blau and Whewell (1994) reviewed five studies, and depending on the study, between 25% and 84% of the abusing parents misused alcohol. The proportion of new protective services cases involving drug use were as high as 80% to 90% (Azzi-Lessing & Olsen, 1996; Child Welfare League of America, 1992; Feig, 1990). This conjecture would fall in line with the National Committee for Prevention of Child Abuse (NCPA) 1988 study which

concluded that substance abuse has become the dominant characteristic in the child abuse caseloads of 22 states and the District of Columbia (Besharov, 1989).

A prospective study of children of substance abusers determined that nearly all suffered some level of neglect, and one third of children had experienced serious neglect (Semidei, Feig Radel, & Nolan, 2001). It is difficult to ascertain specifically how many child welfare clients have substance abuse problems. Child welfare agencies intake information typically includes the type of abuse being reported such as physical, sexual, emotional, and neglect, which does not capture substance abuse involvement (Rittner & Dozier, 2000; Semidei et al., 2001). In Congressional Testimony put forth by the Commissioner for the Connecticut Department of Children and Families, it was indicated that during the past ten years, the number of children needing protection has doubled nationwide, from 1.4 million in 1986 to more than three million in 1997, and that substance abuse was a factor in 70% of these cases (Ragaglia, 2000). The National Center on Addiction and Substance Abuse (1999) noted that parental substance abuse is involved in at least 50% of all child protection cases, and in some parts of the United States, the prevalence may be as high as 90% (cited in McAlpine, Marshall, & Doran, 2001). The National Committee to Prevent Child Abuse (1997) identified chemical dependency and poverty as the two major factors associated with placement of children, and that substance abuse problems were involved in as many as 80% of child maltreatment cases (cited in Akin & Gregoire, 1997; Gregoire & Schultz, 2001). The National Institute of Drug Abuse (NIDA) Household Survey (1991) estimated that 9% of all women in childbearing years (ages 14 - 44) were current drug users (cited in Cook, 1997).

In terms of Canadian statistics, Trocme and Wolfe (2001) shared in the Canadian Incidence Study of Reported Child Abuse & Neglect that an estimated 135,573 child maltreatment investigations were conducted in Canada in 1998. This corresponded to an

estimated incidence rate of 21.52 investigations per 1,000 children. The primary reason for investigation were concerns of neglect, with physical abuse, emotional maltreatment and sexual abuse following in that order. Substance abuse affected 40% of the caregivers involved. More locally, in British Columbia, the Ministry for Children and Families 1998/99 Annual Report indicated that of nearly one million children in the province under 19 years of age slightly under 1% were in care for that year. Specifically, by March 31st, 1999, 9,813 children were in care, which was up 447 (4.8%) from the preceding year (Ministry for Children and Families Statistical Summary of Child Protection Services, 1998/99). During 1998/99 there were 33,036 reports made to the Ministry for Children and Families regarding children in need of protection (Ministry for Children and Families Annual Report, 1998/99). Unfortunately, these reports are categorized solely according to the type of abuse being described (e.g. sexual, physical, neglect, abandonment) with substance abuse not being one of the typologies (Ministry for Children and Families Statistical Summary of Child Protection Services, 1998/99). Subsequently, there is no concrete percentage of child protection cases with chemical dependency issues that can be reported directly from Ministry statistics.

In terms of substance abuse in the Canadian population, the Canadian Centre on Substance Abuse (1999) indicated that nearly one in ten adult Canadians report having a problem with their drinking. Over 60% of Aboriginal people consider alcohol to be a problem in their communities (Smart & Ogborne, 1996). Demographically, people experiencing the most difficulties with substance abuse are younger (15 to 24 years old), single, low socioeconomic status and the more addictive the substance, with the exception of nicotine, the more marginal the user (Canadian Centre on Substance Abuse, 1999). In terms of illicit drugs in 1994, the most commonly reported drugs used on a lifetime and past year basis were cannabis (23.1% and 7.4%, respectively); LSD, speed or heroin (5.9% and 1.1%); and cocaine (3.8% and

0.7%). Cannabis use increased from 4.2% in 1993 to 7.4% in 1994. Use of cocaine and LSD, speed or heroin showed negligible increases. Rates of illicit drug use in 1994 varied significantly by region. In most instances, drug use was highest in British Columbia and lowest in Newfoundland (Canadian Centre on Substance Abuse, 1999). Overall, the literature consistently reports the coexistence of substance abuse and child maltreatment in the same families, but it is important to point out that a causal relationship has not been established (Rittner & Dozier, 2000; Tracy, 1994; Tracy & Farkas, 1994).

5. Effects of Substance Abuse on Families

There are significant differences between child welfare clients with substance abuse problems and other clients of the child welfare system. Chemically dependent families experience multiple, complex problems such as housing issues, lack of employment, poverty, domestic violence, criminal activity, unresolved trauma for parents, limited support network, diversion of resources from necessities to procurement of substances and lack of parenting skills (Azzi-Lessing & Olsen, 1996; Barnard, 1999; Gerstein, Johnson, Larison, Harwood, & Fountain, 1997; Semidei, Feig Radel & Nolan, 2001; Tracy, 1994). Hohman & Butt (2001) stated that mothers with substance abuse issues were often unaware of their children's developmental level, expected too much maturity from their children, and personalized emotional outbursts from their children. Studies of psychosocial functioning have found that children from chemically dependent families were more likely to experience behaviour problems involving conduct disorder, substance abuse, impaired intellectual and academic functioning, hyperactivity, anxiety, depression, low levels of self-esteem, perceived lack of environmental control, impaired ability to solve problems as well as cope with stress, communicate effectively and hold reasonable expectations (Gruber, Fleetwood, & Herring, 2001).

Inconsistent care giving and unavailability of addicted parents can disrupt the attachment between mother and child, which can lead to many behavioural problems, developmental delays and interpersonal difficulties (Hampton, Senatore, & Gullotta, 1998). Using substances during pregnancy can result in obstetrical, as well as neonatal and developmental complications (Bays, 1990; Cook, 1997). Some of these problems include spontaneous abortion, breech presentation, gestational diabetes, intrauterine death, postpartum hemorrhage, premature labour, risk of HIV infection for both mother and baby, fetal alcohol syndrome, neonatal abstinence syndrome, feeding and sleep difficulties, poor weight gain and hypo- or hypersensitivity to stimuli (Cook, 1997; Miller & Hyatt, 1992). These effects can result in child risk factors that place them at greater risk of abuse (Bays, 1990). Babies who are irritable, sleep less than an hour, do not cuddle, do not suck or swallow well, have shrill penetrating cries, avert their gaze from their mother's faces and are difficult to console are frustrating to care for and caregivers can respond abusively (Bays, 1990). Once children from substance abusing families enter foster care, they tend to remain in care (Tracy, 1994). Given the complex, multifaceted problems facing families with child protection and addiction concerns, it is clear that a single community agency cannot be responsible for all aspects of family well-being (Hampton, Senatore, & Gullotta, 1998; Semidei, Feig Radel, & Nolan, 2001).

6. Need for Collaboration: Among Substance Abuse and Child Protection Services

Within the literature, there is much advocacy for collaboration between the chemical dependency and child protection field. Hampton et al. (1998) unequivocally stated "there is an obvious need for collaboration between child welfare and substance abuse treatment services to meet the dual goals of parental recovery from alcohol and other drug abuse and of protection of children from abuse and neglect" (p. 190). According to Corrigan and Bishop (1997), it is imperative to move away from an uncoordinated and ineffective model towards a collaborative

approach among schools, health agencies and other human services organizations that serve the same families. Doherty (1995) called for multilateral collaboration involving professionals on the team, consumers of the service and the community at large. An interdisciplinary team was viewed as most effective because it attends to the mind, body, family and community which matches the complexity of the biopsychosocial problems that clients experience (Doherty, 1995). Keene and Woolgrove (1997) considered mutlidisciplinary coordination as essential to the provision of a range of services for substance users. Integrated delivery systems were viewed as strategies to enhance cost containment, improve quality and increase consumer satisfaction (Rice, 2000).

Predominately, the research suggests that the complex nature and subsequent problems associated with addiction and child welfare are too broad and pervasive for any single discipline to manage on their own (Corrigan & Bishop, 1997; Graham & Barter, 1999; Hampton, et al., 1998; Hannigan, 1999; Moss, 1994; Schofield & Amodeo, 1999; Walter & Petr, 2000). When these issues co-exist within a family, it is not possible to separate them out from each, nor from other dynamics in the family. Family centred practice models are promoted by family/child advocates and professionals noting that health care, education and social services have a common purpose in the health and welfare of children and families (Corrigan & Bishop, 1997; Glennie & Horwath, 2000; Powell, Dosser, Handron, McCammon, Evans Temkin, & Kaufman, 1999; Walter & Petr, 2000).

Due to some unsuccessful collaborative efforts, child welfare agencies have attempted to duplicate substance abuse treatment within their setting, but this has resulted in negative outcomes due to already huge child protection caseloads, delivery of services by untrained staff without experience with chemical dependency issues, not to mention the replication of services already in the community (Hampton et al., 1998). As long as substance abuse and child welfare

services operate in isolation from one another, cases of child abuse and neglect will continue to go undetected by substance abuse professionals, and most of the child protection clients referred for treatment will never attend (Hampton et al., 1998). In British Columbia, many recent reports have strongly advocated for the development of integrated approaches (Addictions Task Group Report, 2001; Community Directions: An Alcohol and Drug Action Plan for the Downtown Eastside/Strathcona, 2001; A Framework for Action - MacPherson, 2001). Generally, incomplete and inadequate services are delivered to multiproblem families most needing well-rounded treatment. The literature is strongly supportive of a multidisciplinary approach as a vehicle to more effectively provide continuity of service to these families.

7. Ethical Issues: Confidentiality and Dual Relationships

Many ethical issues arise when two distinct disciplines attempt to collaborate in an integrated team setting. The Oxford English Dictionary defines confidentiality as “betokening private intimacy; enjoying another’s confidence; entrusted with secrecy.” In the counselling profession, maintaining confidentiality helps to secure the therapeutic frame, which permits the client to experience the sense of safety necessary to share the hidden facets of the self and move forward (Hoag, 1991). The British Association for Counselling (1996) took this further and asserted that any limitation on the degree of confidentiality is likely to diminish the usefulness of counselling. Counsellor training at the graduate level reinforces the high importance of retaining confidentiality, and to contravene this would be breaching ethical codes of conduct outlined by such organizations as the Canadian Psychological Association. The only exceptions to confidentiality are if the person is a risk to themselves or others, the counsellor is court subpoenaed or child abuse may be happening.

On a multidisciplinary team, a counsellor safeguarding client material may be viewed by other team members as secretive and elitist (Kell, 1999). Yet, a child protection social worker may feel they need to know certain information to determine if a child(ren) is at risk. In British Columbia under Section 96 of the Child, Family and Community Services Act, a delegated child protection social worker has the legal right to review any information held by a public body for purposes of determining a child's need for protection (Ministry for Children and Families Protocol Framework and Working Guidelines Between Child Protective and Addiction Services, 1999). They are also able to disclose whatever information they deem necessary to ensure the safety of a child (Child, Family and Community Services Act, Section 79). In essence, when a counsellor joins a multidisciplinary team, there are a variety of attitudes to confidentiality that are not made explicit and yet need to be worked through for the protection of the client, the counsellor and the functioning of the team (Crowther, Dare, & Wilson, 1990; Kell, 1999).

Anciano and Kirkpatrick (1990) expressed ethical concerns when members of a multidisciplinary team, after gaining a little knowledge in another discipline area, believed they are competent to practice. They stressed that skills sharing within teams can lead to incompetent and diluted provision of services, resulting in the client group suffering. According to Galvin and McCarthy (1994), often issues of accountability, competence and responsibility were not meaningfully addressed within integrated teams.

Professional counselling bodies such as the B.C. Association of Clinical Counsellors consider a neutral or arms length relationship as necessary to safeguard the client from manipulation and exploitation. A dual relationship undermines objectivity, professional judgment and client needs and should be avoided. Within a multidisciplinary team comprising addiction counsellors and child protection social workers, there can be pressure for the

counsellor to take on a quasi-monitoring role, as well as a therapeutic one. A concrete example of an attempt to impose a dual relationship occurred when there was discussion by the Ministry for Children and Families management regarding counsellors signing and monitoring “youth agreements”. This would place the counsellor in a regulatory relationship with the client, deciding when to initiate and terminate the agreement depending on the client’s compliance with the conditions of the agreement. Termination of the agreement would result in a loss of financial support for shelter, food and other living expenses. In the end, this did not come to pass, not due to ethical considerations, but insufficient funding for the continuation of the program.

8. Addiction Treatment: Women and Children

It is mostly women with substance abuse issues who come into contact with the child welfare system compared to men, yet the absolute number of services for women has been inadequate (Department of Health and Human Services, 1999; Marsh, D’Aunno, & Smith, 2000; Miller, 2001). Since 1979, there has been a 600% increase of addicted child bearing mothers, which makes this the fastest growing subgroup of addicted people in the United States (Namyniuk, Brems & Clarson, 1997). Gender interacts with treatment in a variety of ways. The literature indicates that the etiology of maternal substance abuse is multidimensional and connected to a web of factors at many ecological levels: poverty, single parenthood, lack of social resources and supports, inadequate or unstable housing, mental health problems, and current and past experiences of violence and abuse (Daro & McCurdy, 1992; Marcenko et al., 2000; Miller, 2001). Interestingly, a growing body of research indicates that parenting capacities of substance abusing women are similar to those of non-using women in parallel life circumstances (Camp & Finkelstein, 1997; Luthar & Walsh, 1995; Marcenko et al., 2000).

This information suggests the need to reframe addiction as interfering with responsible parenting, rather than as rendering women incapable of good parenting (Markenko et al., 2000).

Killeen and Brady (2000) reported that the majority of women who use substances were polysubstance abusers, and many of these women had poor interpersonal skills and few healthy role models. Substance abuse treatment is often geared toward men and does not address parenting and relationship issues that are important to women (Hohman & Butt, 2001; Semidei, Feig Radel, & Nolan, 2001; Tracy & Farkas, 1994). Often, chemically dependent women are in relationships with addicted men, leaving them with a non-supportive spouse or partner (Hohman & Butt, 2001). Many women involved with the child welfare system are minorities who find that decisions are often made without consideration to multicultural differences in child rearing and parenting practices (Linares, 1998). Substance affected mothers present a unique set of challenges for treatment professionals because of their clinical histories and experiences (Tracy & Farkas, 1994). Many women in treatment for substance abuse are victims of sexual and/or physical abuse, leading to a variety of mental health problems (Hampton et al., 1998; Marcenko et al., 2000; Ragaglia, 2000; Tracy & Farkas, 1994). Treatment programs, to be effective, need to address trauma and focus on nurturing relationships (Ragaglia, 2000). Barriers to accessing treatment for women need to be removed such as providing child care, and meeting immediate needs for safe housing and jobs (Ragaglia, 2000). Women need to be able to live with their children during residential treatment (Ragaglia, 2000), but there are few residential drug treatment programs that work with both the drug exposed infant and chemically dependent mother together (McCullough, 1990).

Gregoire and Schultz (2001) reported that males and females experienced the addiction process: onset and progression of, and recovery from, dependency differently based on a sample of 167 child welfare parents, 59.3% female and 40.7% male. Women consumed smaller

quantities of alcohol and drugs, but progress more quickly to advanced stages of addiction than men (Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996). Chemically dependent females used more tranquilizers and sedatives, received more psychiatric treatment, were less involved with the criminal justice system, were more preoccupied with daily survival, had less education and fewer financial resources, experienced more shame associated with drug use and had an increased concern with the impact of addiction on their children (Nelson-Zlupko et al., 1996). It should be pointed out that the type of drugs used by women corresponded to their socioeconomic status, upper income groups abused alcohol and nonprescription drugs, while lower income groups had higher rates of illicit drug use (Andrews & Patterson, 1995). Even though men were less likely than women to engage in help seeking behaviour and treatment for psychosocial problems, women presented less for substance abuse services because they often viewed their substance abuse behaviour as a symptom of depression (Gregoire & Schultz; Miller, 2001; Namyniuk, Brems & Clarson, 1997). Due to presenting later for treatment, women often had symptoms that were far more severe than men (Gregoire & Schultz, 2001; Namyniuk, Brems & Clarson, 1997; Nelson-Zlupko et al., 1996).

Women remain in treatment for shorter periods compared to men (Gregoire & Schultz, 2001). Traditional treatment and the 12 Step programs are based on a male model, which often do not meet the gender specific needs of women (Wilke, 1994). To be effective in treating mother's addictions, a continuum of services and options tailored to the specific needs of women must be available: day treatment programs, residential treatment, ongoing peer support, case management services, medical and practical supports, services for children need to be developmentally appropriate and staffed by qualified child care professionals, assertiveness groups, life planning, legal services, parenting classes, help with educational and job skills and

outreach (Azzi-Lessing & Olsen, 1996; Marsh, D'Aunno, & Smith, 2000; Namyniuk, Brems, & Clarson, 1997; Nelson-Zlupko et al., 1996).

It is not surprising that child welfare clients drop out of treatment, if they are hoping to address family issues which are not given any attention during the program (Semidei et al., 2001). Hampton et al. (1998) pointed out that evaluations of treatment programs generally did not seek information regarding whether a client had children, nor whether there had been improvement in family functioning, child protection, or custody issues. Yet, women were three times more likely compared to men to report that parenting concerns were a strong motivating factor for their entry into treatment (Gerstein, Johnson, Larison, Harwood, & Fountain, 1997). Concrete services such as transportation and child care were very important in helping mothers with substance abuse issues to be successful in treatment (Marsh, D'Aunno, & Smith, 2000). Due to the complex problems that faced these mothers, it was imperative that follow-up and after care services were provided (Namyniuk, Brems, & Clarson, 1997). There is a growing awareness in the literature of the special needs of women with child protection and substance abuse issues, but program development is lagging far behind (McCullough, 1991). Poole (2000) asserted that "interagency collaboration and coordination were critical both to engage and retain women in treatment, and to assist agencies in providing the needed comprehensive scope of care" (p. 40).

9. First Nations: Context and Help Seeking Behaviour

This cultural group deserves special mention because they make up a large percentage of the child protection and addiction services caseload disproportionate to their numbers in the general population in Canada (Ministry for Children and Families Annual Report, 1998/99; Palmer & Cooke, 1996). As noted previously, in 1999 there were 9,813 children in care in the province of British Columbia. Of the total of 9,813 children were in care population, 2,961

(30.2%) of the children in care were of Aboriginal background, even though they made up only 8% of the general population in British Columbia (Ministry for Children and Families Annual Report, 1998/99). If chemical dependency counsellors and child welfare workers are not sensitive to Aboriginal people's unique history, cultures and ways of healing, the likelihood of developing successful working relationships is remote. First Nations, Inuit, and Metis constitute about one million people, or 4% of the Canadian population, with 11 major language groups and more than 58 dialects across 596 bands (Kirmayer, Brass, & Tait, 2000). This diversity within the Aboriginal population informs against lumping together all First Nations under generic terms, but most of these groups share a common social, economic, and political predicament that is the legacy of colonization (Kirmayer, Brass, & Tait, 2000).

Historically, from the first contact with Europeans in the 16th century, there have been overt attempts by the Canadian government to not only oppress, but destroy indigenous cultures through forced sedenterization, creation of reserves, relocation to remote regions, residential schools, and bureaucratic control (Kirmayer, Brass, & Tait, 2000). Efforts directed towards assimilation such as boarding schools were justified through the ideology that viewed Aboriginal people as primitive and uncivilized, in need of the guidance and control of the dominant culture (Kirmayer, Brass, & Tait, 2000; Palmer & Cooke, 1996). Timpson (1995) pointed out that the non-Native child welfare system paralleled earlier efforts to assimilate First Nations people by judging standards of child care by the dominant Canadian norms, and by the persistent use of non-Native foster family and adoption placements. Together, the legacy of internal colonialism and realities of globalization have continued to marginalize this group of people to the present day (Kirmayer, Brass, & Tait, 2000). The average income, in 1991, for Aboriginal people was about 60% of that for non-Aboriginal Canadians (Kirmayer, Brass, & Tait, 2000). They continue to be overrepresented in social service and criminal justice

systems, as well as suffering from a range of health problems at higher rates than the general population with a substantially shorter life expectancy (Kirmayer, Brass, & Tait, 2000). Given this historical context, it is not surprising and totally understandable that First Nations people do not readily engage in treatment within the child protection and addiction services system.

With Aboriginal people's prior and present experience in mind, as well as their cultural traditions and beliefs, the literature has suggestions to facilitate strong helping relationships with First Nations clients. Bruce (1999) advocated understanding First Nations history and world view; to utilize First Nations counselling values to ensure a sense of interconnectedness and spirituality in the counsellor's theoretical approach to healing; to have nonverbal and indirect forms of communication; to use humour appropriately; to honour silence; and to understand the meaning and importance of family, choice, trust, acceptance and social support. A focus group (n = 27) involving participants from eight Manitoba First Nations bands stressed the importance of culture, including language, ceremonies, and teachings, both as a component of child welfare practice and as a method of healing their communities (McKenzie & Seidl, 1995).

In a qualitative study investigating the experiences of five experienced White male counsellors who work with First Nations clients, some of the themes that emerged were encountering difference, establishing relationships, a willingness to learn, evolving professional identities and impact on self-awareness (Smith & Morrissette, 2001). Traditional healing practices are an important component of First Nations peoples' conception of health and well-being (Wyrostok & Paulson, 2000). McCormick (1997) used the Critical Incident Technique to survey 50 First Nations adults to explore what they perceived facilitated healing. Their unique goals of healing included balance, interconnectedness and transcendence/spirituality. Krestan (2000) advocated being aware of First Nations values and how they differ from the dominant

culture's values: cooperation versus competition; group emphasis versus individual emphasis; modesty/humility versus self-importance; patience versus impatience; nonmaterialism versus materialism; work to meet need versus puritan work ethic; pragmatic versus theoretical; listening skills versus verbal skills, respect for age versus respect for youth; respect for tradition versus progress oriented; and indirect criticism versus direct criticism.

Working effectively cross-culturally, involves respecting their cultural traditions, while weaving into the child protection and therapeutic process their vision of healing and understanding, in the context of compassion for their historical traumatization. An additional element would be to encourage First Nations clients to lobby and advocate for equal and fair treatment in all aspects of this society, to help them overcome the effects of assimilationist practices and cultural loss.

10. Mandated Treatment

Most of the clients involved with the child protection system and subsequently referred for chemical dependency counselling are mandated. Prochaska, Norcross, and DiClemente (1994) referred to this client population as being largely in the precontemplative stage of change. Individuals at this stage of readiness for change are unaware that they have a problem and have no desire to change, even though significant others in their life may believe there is an issue and there are major problems in life areas. In contrast, the voluntary client defines his/her problem, while the non-voluntary person has their presenting problem defined by others. This type of client is very challenging for the child protection worker and addictions counsellor because of the difficulty engaging them in a treatment plan. The task at this stage to facilitate the change process to a higher stage of readiness for change encompasses consciousness raising (Prochaska, Norcross and DiClemente, 1994). There is a need to increase information about the self and the problem through observations, feedback, interpretations and bibliotherapy, not

confrontation. It is important to meet clients at their level of change or they will not invest in the child welfare and addiction process.

There are often disputes among professionals as to whether there is any point to intervening when clients are mandated and at the precontemplative stage of readiness for change. The counsellor on a multidisciplinary team is compelled to examine their "role as counsellors whose goal is to bring about change versus roles as social controllers whose goal is to maintain stability" (Slonim-Nevo, 1996, p. 117). Child protection is a mandated service with a legislated duty to ensure the safety of children. Addiction Services is a voluntary program, yet they are also serving a court ordered population. Perhaps counterintuitively, much of the literature has shown that non-voluntary clients do as well or better in treatment than voluntary clients in terms of meeting treatment goals, experiencing higher rates of compliance; completing treatment and expressing satisfaction with the treatment experience (DiCenso & Paull, 1999; Farabee, Prendergast, & Anglin, 1998; Gregoire & Schultz, 2001; Howard & McCaughrin, 1996; Irveste-Montes & Montes, 1988). Landry (1997) pointed out that research shows that clients who were legally pressured to participate in addiction treatment had an increased likelihood of participating in treatment; remaining in treatment longer; and experienced similar treatment outcomes as clients who voluntarily participated.

Nishimoto and Roberts (2001) study of 292 women coerced to enter treatment by the child welfare system lends support in favour of coercion for treatment because they remained in treatment longer when they had their children with them. Miller and Flaherty (2000) looked into how alternative consequences work in child welfare populations. When comparing chemically dependent pregnant and parenting women who entered the California Options for Recovery Program either voluntarily or to avoid incarceration, the mandated women were more likely to complete treatment. Lastly, Rittner and Dozier (2000) examined the effects of court-

ordered substance abuse treatment in child protective services cases. These authors put forth that often child protection social workers determine children are safe to be returned home when the maltreating, addicted parents comply with court ordered substance abuse treatment. Following this logic, it is important to discern if mandated services are effective and the children are really returning to a safer environment. Four hundred and forty-seven child protection files from a large urban county were examined. The results indicated that level of compliance with mandated substance abuse and mental health treatment did not appear to influence rates of reabuse or duration of service. The study concluded that child protection social workers apparent unsupported dependence on mandated treatment compliance may indicate that other indices of safety and well-being were assigned diminished significance.

It appears from most of the literature that a client's mandated status can be helpful in engaging them in addressing their child protection and substance abuse issues, but there is still some question as to whether treatment compliance means ongoing change in the person's life. Although it is optimal that clients present on a voluntary basis, the reality is that many individuals with serious issues are not at that place for a variety of complex reasons. The more effective strategies that child protection workers and addiction counsellors can learn to work with mandated clients, the better equipped they will be to enter into a productive and healing relationship.

11. Experience of Clients Involved with Child Protection and Addiction Services

Akin and Gregoire (1997) through a qualitative approach explored parent's views of child welfare's response to addiction. Eleven women who had been successful in dealing with their addiction and having their children returned participated in in-depth interviews. The services they received were not delivered through a multidisciplinary model, rather the study focused on the child protection social worker's response to the substance problem. The

findings indicated that successful outcomes were facilitated when child protection social workers were open and honest with clients in delineating mutual expectations; used language that clients can understand; demonstrated support and care through behaviours; helped clients get the resources they need such as housing and child care; listened to parents' stories; maintained a hopeful and non-judgmental attitude; shared power and provided clients with choices; helped clients set incremental goals and found ways to understand the nature of addiction and to know the parent as a unique individual.

Another study by Diorio (1992) explored parental perceptions of the authority of public child welfare caseworkers. Hermeneutic inquiry highlighted the following themes: hitting the iceberg - consciousness of the power of the child protective system; vulnerability and fear; feeling at the mercy of the caseworker; and lack of understanding by the parents as to why the children were removed from their care. These are very powerful themes which will have a profound effect on the working relationship between the child protection social worker and the parent. There will always be an imbalance of power in this relationship, making it imperative that every effort is made to forge as much of a collaborative atmosphere as possible.

A focus group with pregnant and parenting women who access a drop in centre in Vancouver, British Columbia was conducted (Poole, 2000). This program has an integrated team consisting of non-delegated social workers, nurses, infant development workers, addiction counsellor, physicians, outreach worker and a dietitian. During the focus group, the informants were asked what important changes they experienced as a result of getting help from this program. Their experiences involved increased self-esteem; more patience; learning to talk things through and work it through; connecting with other parents, being able to talk and be open with others; to stop using drugs, gaining more self-respect; finding their real beliefs; believing in themselves and valuing themselves (Poole, 2000).

Keller and McDade (2000) when surveying low income parents about their attitudes toward seeking help from child protection services, heard an attitude of distrust expressed by many of the participants. For example, some of the statements were as follows: "They (child protection services) are a negative in our community. They instill fears." "You don't go there for help. Somebody else tells them that you're no good, then they come down on you" (p. 9). The child welfare system was not viewed as a reliable source of help, even if they decided to access it.

An exploratory study of the present and past treatment experiences of 24 women in recovery, some of whom had children in foster care, was conducted using semi-structured, in-depth interviews (Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996). The main themes that emerged comprised: the importance of individual counselling in helping women to stay in treatment; sexual harassment is often present in conventional drug treatment programs; child care is central to the recovery of women with children; most co-ed treatment groups failed to provide a forum for open expression of women's needs and experiences and the effectiveness of gender sensitive services is diminished in treatment settings which fail to support and promote women.

Onyskiw, Harrison, Spady, and McConnan (1999) through a qualitative design interviewed 17 clients and ten team members using a semi-structured format. The purpose of the study was to evaluate a collaborative project in Edmonton, Alberta of various agencies in the health, social services and laws enforcement sectors established to prevent child abuse and neglect. Specifically, the professionals on the team comprise community nurses, social workers, child welfare workers, mental health therapist, police officer and child abuse detective. Generally, it was found that the community-based approach; multidisciplinary composition of

the team; the ability to seek services when needed; the immediacy of the response time and the availability of support during stressful times were aspects that were particularly beneficial.

Clients' experience of their involvement with child protection and addiction services are crucial in guiding the professional's practice within the context of a multidisciplinary team. It is very important that the power imbalance be shifted, as much as possible, to one of shared power. The process needs to be very transparent to alleviate confusion for the parents and decrease their fear and mistrust of the system. The front line workers need to be experienced as supportive, caring, non-judgmental and demonstrate a belief in the client's ability to change.

12. Multidisciplinary Approaches and Experiences of Team Members

Historically, Iles and Auluck (1990) noted that much of the focus on team building stems from the early studies of organizational behaviour and management and leadership styles, which viewed work groups as the building blocks of companies. Collaboration in the health care field can be traced back to the Civil War with the birth of two professions: nursing and social work (Veeder, Hawkins, Williams, & Pearce, 1999). Social workers (volunteers) referred to as "sanitary visitors" addressed issues of ventilation, cleanliness, warmth, food and clothing with dispensary patients. This charitable work continued after the Civil War alongside nurses in hospitals, as well as prisons, orphanages and asylums. Social workers and nurses also joined forces with the establishment of settlement houses, which helped new immigrants navigate the health care and social welfare systems (Resnich & Tighe, 1997; Veeder et al., 1999). More recently, the first multidisciplinary teams were established as early as 1958 in Los Angeles, Pittsburg and Denver by clinicians and other welfare professionals in hospital sites (Bell & Feldman, 1999). In some states teams are mandated by state law, other states have law supporting team investigations, and remaining states have no formal legislative direction (Bell & Feldman, 1999).

Currently, the main context for multidisciplinary team work has been the community mental health teams (Onyett & Heppleston, 1994). However, interdisciplinary models have also been applied to many other settings such as rehabilitation, geriatrics, gerontology, health services, developmental disabilities, child abuse and neglect, behavioural and emotional difficulties with children and youth, crisis units, juvenile justice, training and practice, and drug abuse (Anderson, 2000; Iles & Auluck, 1990; Krueger, 1990; Ligon & Thyer, 2000; Marcus, 2000; Ogles & Trout, 1998; Schofield & Amodeo, 1999). Powell, Dosser, Handron, McCammon, Evans Temkin, and Kaufman (1999) reported that “federal child mental health funding was supporting community wide, collaborative practice in twenty-one sites scattered across the United States” (p. 28). In 1987, 31% of British community mental health centres surveyed by a group of researchers had multidisciplinary team work as a major aim (Moss, 1994). Internationally, many countries such as Canada, Australia, Britain and the United States, prompted by the problems and issues of cost containment of and access to their health care systems, are discussing the development and functions of mental health and social services in primary care settings (Rice, 2000). Yet, for the most part, child and family services continue to be delivered through the traditional means of individual treatment and categorical services (Meyers, 1993; Powell et al., 1999; Skaff, 1988).

There are a variety of terms used interchangeably, as well as to denote different meanings, to refer to interdisciplinary teams and collaborative practice such as multidisciplinary, interdisciplinary, multiprofessional, interprofessional, teamwork, integrated, transdisciplinary and transprofessional (Rice, 2000). This becomes a problem when the terms used to describe the “multidisciplinary” concept have different meanings from one article to the next. The terminology is confusing with the labels often not being defined. For instance, in one article multidisciplinary may mean various professionals coordinating a treatment plan

together, while in another article this same term refers to professionals who did not have contact, may have been involved with the client at different times, but there was not necessarily any coordinated planning (Schofield & Amodeo, 1999). Vinokur-Kaplan (1995) provided a definition of team work, "a number of individual staff members, each of whom possesses particular knowledge and skills, who come together to share their expertise with one another for a common purpose" (p. 522). Another definition that highlights the interdependent nature of interdisciplinary work is "two or more individuals who must interact interdependently and adaptively to achieve specified, shared and valued objectives" (p. 522). Several authors conceptualize multidisciplinary work as moving along a continuum from cooperation to coordination to collaboration to integration (Walter & Petr, 2000; Rice, 2000; Powell et al., 1999). As the team of professionals move from cooperation to integration, the decision-making processes and structures are increasingly shared.

As one would expect, bringing together various professionals trained and oriented in their respective disciplines, will promote challenges as well as benefits. Optimally, the actual make-up of teams will depend on the clients being served and their presenting issues. However, Rice (2000) and Marett, Gibbons, Memmott, Bott, and Duke (1998) shared that the literature lacks any type of conceptual approach regarding the actual formation of interdisciplinary teams, and in fact tend to be formed in a haphazard way on the basis of convenience. The professionals in a multidisciplinary team could encompass doctors, nurses, psychologists, social workers, occupational therapists, counsellors, probation officers, pastors, family therapists, youth workers, police officers, infant development workers, mental health therapists, among others, in any combination.

Many of the barriers noted in the literature when various professionals start working together on a team encompass (Abramson & Mizrahi, 1996; Brown, Crawford, &

Darongkamas, 2000; Daka-Mulwanda, Thornburg, Filbert & Klein, 1995; Ducheny & Talen, 1996; Easen, Atkins & Dyson, 2000; Galvin & McCarthy, 1994; Graham & Barter, 1999; Hallett & Birchall, 1992; Harris, 1999; Leutz, 1999; Nicholson, Artz, Armitage & Fagan, 2000; Reese & Sontag, 2001; Schofield & Amodio, 1999; Veeder et al., 1999):

1. Issues related to differing roles

1. Poor definition of roles and responsibilities
2. Professional terminology differences
3. Communication difficulties among the different disciplines
4. Overlapping of roles
5. Lack of awareness and understanding of team members' skills and roles
6. Sense of autonomy developed in professional training

2. Core differences

1. Value differences
2. Lack of common goals
3. Differences in ethical codes
4. Theoretical divergence
5. Dissimilar confidentiality and record keeping practices

3. Status

1. Perceived status differentials on the team
2. Shift in status for some disciplines

4. Ways of protecting discipline

1. Turf issues
2. Adherence to rigid mandates
3. Competition for clients

5. Demands and expectations

1. Heavier time commitment necessary by participants
2. Open examination of contributions which may be threatening
3. Need for various disciplines to expand their knowledge base
4. Different levels of personal commitment to the group

6. Organizational practices

1. Disagreement over leadership and the distribution of authority
2. Lack of administrative support
3. Lack of supervision
4. Lack of appropriate training
5. Loss of efficiency
6. Lack of financial and human resources
7. Problems with decision making
8. Different capacities to handle personal and professional conflicts
9. Fragmentation from other colleagues in the same discipline

Even though some teams will not move beyond these hurdles, many will make the transition to a collaborative relationship albeit not smoothly (Graham & Barter, 1999). The process often involves initially disappointment, anger and the persistence of rigid disciplinary roles (Graham & Barter, 1999). As the team members become aware of each disciplines' unique contribution to achieving shared goals, the stages of realistic appraisal, accommodation, and integration take place (Graham & Barter, 1999).

When multidisciplinary teams begin operating in a more integrated fashion, the strengths of this model become apparent. A group of professionals working together to help clients address problem areas in their lives can lead to these benefits: (a) a better understanding of client needs, (b) improved service delivery, (c) reduced likelihood of burnout, (d) shared risks and resources, (e) increased morale, (f) decreased duplication, inefficiency and poor communication, (g) enhanced range of options, expanded knowledge and expertise through exposure to other professionals, (h) shared responsibility for complicated cases, (i) opportunity for cooperative research ventures among staff, (j) improved access to care for clients, (k) greater objectivity is promoted when not working alone, (l) enhanced problem solving, and (m) increased ability to respond to diverse situations (Abramson & Mizrahi, 1996; Eason, Atkins, & Dyson, 2000; Graham & Barter, 1999; Hallett & Birchall, 1992; Huxley & Oliver, 1993; Marett et al., 1998; Nicolson, Artz, Armitage, & Fagan, 2000; Schofield & Amodeo, 1999).

For multidisciplinary teams to be effective, many elements need to be present. Veeder et al. (1999) asserted the need for open communication, mutual respect, tolerance, flexibility, focus, shared goals, self-confidence about one's knowledge and skills, sensitivity and humour as necessary characteristics to help a team reach successful collaboration. Further characteristics of true integration entail interdependence between roles; mutual goal setting; the ability to compromise; shared responsibility and decision making; extensive practice and

training; constructive criticism; encouragement; equal status among professionals; shared values; sufficient financial resources; leadership support; right timing; persistence; compatibility of organizational design; and strong relationships (Corrigan & Bishop, 1997; Krueger, 1990; Powell et al., 1999; Rice, 2000; Schofield & Amodeo, 1999). Further strategies for successful collaboration, according to Fieg (1998), comprise: joint training, funding, and goal-setting; improving family assessments as they relate to substance abuse; using a parenting focus to engage parents; integrating child development services with substance abuse treatment; providing families with long-term services that vary over time; and involving family members caring for the client's children (cited in Department of Health and Human Services, 2000, p. 89).

West and Poulton (1997) suggested the principles of effective team working as including: team members needing to feel they are important to the success of the team; roles should be meaningful and intrinsically rewarding; there should be intrinsically interesting tasks to perform; individual contributions should be identifiable and subject to evaluation; and team goals need to be clear with built in performance feedback. Braye and Preston-Shoot (1993) promoted developing the skills associated with partnership being developed in training. In circumstances requiring or mandating coordination, rather than voluntarily seeking it, if staff members perceived it would produce desirable outcomes with acceptable costs, then the coordination linkage was likely to be stronger than if the relationship had not been mandated (Hallett & Birchall, 1992). Ovretveit (1993) asserted that team members needed to perceive that team work saves time, was satisfying and enjoyable, more financially advantageous, and provided better service for them in order to invest positively in the integrative building process. Gray (1985) promoted a developmental model of collaboration in helping to realize a well functioning team (cited in O'Looney, 1994). The developmental or stage approach to team

building advocates several conditions being met during appropriate phases of the collaborative process: problem setting phase, the direction setting phase, and the structuring phase (O'Looney, 1994).

Another important facet, according to the literature, that contributes to fostering collaboration is the organizational structure that surrounds the team. Meyers (1993) suggested "it is essential to consider organizational factors when developing strategies for service coordination" (p. 568). These factors include: professional values and organizational norms that support the overall goal of service coordination; internal socializing and management strategies that emphasize cross-agency cooperation; sufficient new resources being provided to induce participation; and mandates being used either to create new service demands that can be solved through coordination and/or to reduce categorical separations of administration and funding (Meyers, 1993). Morrison (1996) echoed that front line staff were powerfully affected by agency cultures; management styles and organizational structures. Also, for successful team work both vertical (different levels of government) and horizontal collaboration (community based service providers) are recommended by Daka-Mulwanda, Thornburg, Filbert, & Klein (1995). Given the complex nature of developing successful collaborative endeavors, O'Looney (1994) suggested the wisdom of several disciplines need to be drawn upon: political theory, leadership, administration, dispute resolution, adult education, program evaluation, and technology assessment, for a start.

In terms of the effectiveness of integrated teams, the literature contains contradictory perspectives. Galvin and McCarthy (1994) concluded that multidisciplinary teams resulted in unfocused, inefficient and low quality service provision with team members becoming confused, demoralized and deskilled. These authors put forth that integrated teams failed largely due to the complexity of the tasks handed over to them, which they were ill equipped to

handle. They noted that empirically little is known about the effectiveness of interdisciplinary teams with the literature consisting mainly of descriptions of team structure and process. Galvin and McCarthy (1994) indicated that rather than multidisciplinary assessment occurring within teams, in practice clients are assigned depending on space and unidisciplinary assessment was more the norm. Multidisciplinary teams were still being promoted, according to Galvin & McCarthy (1994), due to ideology rather than by evidence and because they made an attractive marketing package for senior managers who appeared to be addressing the broad community mental health agenda. Schofield and Amodeo (1999) concurred stating that the literature repeatedly endorsed the team model with little empirical evidence of efficacy, weaknesses in terminology and research content.

Hall (1999) described being skeptical if collaborative efforts resulted in improved outcomes. He questioned the effectiveness of continually organizing and re-organizing welfare services with one of the reconfigurations being inter-agency arrangements. He referred to two Department of Health documents in the United Kingdom promoting inter-agency arrangements for welfare services entitled *Modernizing Health and Social Services* (1998) and *Partnership in Action* (1998). Hall's concern was that much of the discussion of interagency arrangements, as with previous efforts to re-organize, was proceeding without consideration of research findings. He noted there has been research on various aspects of interagency work, although little on children's services in the United Kingdom. Huxley (1993) stated that "there (was) ample evidence that organizations frequently fail(ed) to achieve fully effective working relationships with others, even in cases where a good deal of conscious effort (was) put into the process" (p. 21 as cited in Hall, 1999). Hall's article examined various research findings to determine the outcome of interagency arrangements. It should be noted that the situations described involved different contexts from cooperation to collaboration to integration.

Hall (1999) considered the results of a study by Glisson and Hemmelgarn (1998), which assessed the outcomes of children placed in state care in Tennessee through a coordinated service compared with those of a control sample. The conclusion was that the coordinated services achieved worse outcomes for children than uncoordinated ones because caseworkers relinquished responsibility for activities associated with the quality criteria for the children in their caseloads assuming they would be handled by the service co-ordination team. Kauppi (1997) studied the integration of social work with child health and special education services in northern Ontario (cited in Hall, 1999). The findings indicated that the benefits hoped for were not achieved due to central control being maintained with an overemphasis on rules and measurement, restricting local flexibility; and the role of social worker to develop care plans was inhibited by other professionals maintaining autonomy. Kauppi cited other research such as Nash (1990) in which power in multi-professional teams remained with those considered to have the most expertise (cited in Hall, 1999).

Hall's article mentioned another study which explored an attempt to integrate service for children with mental health problems to test the success of the continuum of care approach. The trial group received a coordinated service, while the control group received a fragmented service. The results showed that the outcome of the trial group was no better than those of the control group (Bickman, 1996 cited in Hall, 1999). Overall, Hall (1999) expressed concern about the effectiveness of inter-agency arrangements as the way to improve services and suggests that they must be seen in relation to other features of services such as decentralization, organizational climate, professional affiliations, managerial control, complexity of task, and interdependence. He suggested that possible inter-agency approaches were not the way forward, instead efforts to improve services should concentrate on intra-organizational issues.

Whetten and Leung pointed out that there are costs as well as benefits in engaging in coordinated efforts, but the costs get considerably less coverage in the literature (cited in Hallett & Birchall, 1992). It is suggested that accounts of demonstration projects and innovative service developments primarily cite their successes, while the failures silently fade away (Hallett & Birchall, 1992). Further, it is posited that the efficacy of multidisciplinary teams is more often asserted than supported by empirical evidence. The authors viewed this as a general pro-coordination bias in the literature (Hallett & Birchall, 1992). Challis (1988) referred to “the manic-depressive cycle of the policy debate about coordination with fits of enthusiasm yielding to bursts of disillusion” (cited in Easen, Atkins, & Dyson, 2000, p. 355). This disillusion with inter-agency and inter-professional coordination stems from “its poor track record in achieving the expectations set for it; often proving difficult in practice, with reports in recent years, pointing to continuing problems” (Easen, Atkins, & Dyson, 2000, pp. 355 - 356).

On the other hand, Rice (2000) stated that “although most research has shown the benefits of collaboration, one study in Great Britain did not show improved health outcomes for heart patients in a collaborative follow-up model” (p. 61). Further in the article, Rice noted that most of the literature indicated that integrated services improved patient care and reduced the overall cost of care. The Child Welfare League of America (2001) reported on several collaborative model programs showing signs of success: a multidisciplinary team working with parents of drug exposed infants in Sacramento County found that the percentage of children living with parents who completed the program increased by 48%; a program called Prototypes involving residential treatment for women and their children resulted in benefits in the areas of substance use, employment, criminal behaviour and homelessness for women who stayed longer; and a program in Florida serving both women and their children resulted in 364 of the

945 children being reunited with their mothers, and when these children were retested a year later, the developmental lags they had been experiencing had disappeared.

Reese and Sontag (2001) explored the barriers and possible solutions to successful interprofessional collaboration on the hospice team. The barriers mentioned in the study include a lack of knowledge, on the part of each team member, of the other professions' expertise, skills, training, values and theory; overlap of roles on the interdisciplinary team, which leads to competition between disciplines and decreased quality of services; contrasts between values and theory underlying the perspectives of professionals on the interdisciplinary team; and negative team norms such as a lack of commitment to the team process, lack of willingness to share equally in the work of the team, scapegoating, and power differentials. Some of the proposed solutions were having each new staff member oriented during training to the role of each profession; developing administrative procedures that call for automatic referrals to specific team members in certain case situations; recognizing areas of convergence, as well as conflicts, and sharing perspectives openly in an atmosphere of mutual respect; and teaching positive group norms to the team through exercises and/or adopting a consensus model of team functioning.

Kearney and Ibbetson (1991) examined a multidisciplinary approach with pregnant opiate users at a busy, inner-city hospital. The team constituted social workers from the Obstetric Department, Pediatric Unit and Drug Dependency Unit, as well as other professionals in the community as necessary such as child protection social workers, health visitors and probation officers. Particular attention was given in this study to the statutory child protection responsibilities. The research reviewed 13 births with a follow period of three years. It was found that every case was referred to the relevant social worker; in all but one case social work contact was firmly established; and the social worker involved was able to identify the existing

and potential future professional network in time to call a series of planning meetings or case conferences. Two of the babies were born prematurely, and one baby subsequently passed away. The remaining babies had normal deliveries at full term and were within normal limits weight wise. At follow-up, all of the families had stable accommodation. In terms of the status of the children, one child died from Sudden Infant Death Syndrome; one child was removed from his parent's care; one baby was living with relatives; one baby was adopted; one baby disappeared in the care of the father; one child the whereabouts were unknown; and six children had remained in the care of their family. Overall, this interdisciplinary approach was viewed as a way of ensuring an appropriate professional and organizational response to child protection concerns for professionals who either encounter it rarely or have a range of other activities more central to their daily work.

Gruber, Fleetwood, and Herring (2001) described the Bridges Program as a program which involved an intervention approach with a blended model of substance abuse recovery work and family preservation targeting four areas: individual actions and cognition, individual recovery actions, family actions and cognitions and family recovery actions. Two case examples are presented that experienced success with reunification with children, strengthened social network, increased recreational time, maintained employment and solid recovery plans. Other studies exploring collaborative efforts between child protection and addiction services purporting successful outcomes comprise a group based parenting program for families affected by substance abuse, which enhanced parents' satisfaction and competence and lessened the risk of both child abuse and substance abuse (Moore & Finkelstein, 2001); Project Link in Connecticut which bridged the child protection system and the adult substance abuse treatment system on a statewide basis enabled timely substance abuse evaluations and screenings and the ability to monitor show rates and retention in treatment (Ragaglia, 2000); and the Center for

Addiction and Pregnancy combining several disciplines to assist pregnant women with substance abuse issues found generally good birth outcomes, and children with good developmental outcomes (Jansson, Svikis, Lee, Paluzzi, Rutigliano, & Hackerman, 1996).

Even though there is a dispute in the literature regarding the effectiveness of multidisciplinary teams, it appears the major concern of researchers questioning its utility is that much of the literature is descriptive, rather than outcome or empirically based. In essence, according to these authors, there is insufficient evidence to definitively state one way or the other. More research is needed for further clarification. As Hallett and Birchall (1992) noted "although there is a bias in the favour of coordination in much of the literature, the data on outcomes are limited and equivocal, in relation to social welfare and to child protection" (p. 2).

There is also some concern cited in the literature that coordination has the potential to achieve a greater degree of social control (Hallett & Birchall, 1992). It is suggested that a threat is posed to civil liberties by too high a degree of coordination, especially in services characterized by a high level of social control such as child welfare. As Dingwall (1983 cited in Hallett & Birchall, 1992, p. 21) notes:

A certain amount of duplication, inefficiency and missed cases, even when these lead to child deaths, might be a necessary condition for some of the freedom that we all take for granted. The more we push agencies together, with shared at risk registers, joint procedures and consultative machinery, the more we create the possibility for a kind of social policing which many people find rather disturbing. We could only hope to eliminate mistreatment in a thoroughly illiberal society.

It is further purported that coordination may destroy the pluralistic character of an agency by suppressing diverse political purposes and values. Conflicting values between agencies may be masked through coordination and dominant paradigms reinforced. Innovation in service delivery may be stifled and client choice limited (Hallett & Birchall, 1992).

In the United States, when integrated, interdisciplinary teams are not occurring between child protection and addiction services, other methods of forging links are being promoted. The National Center on Child Abuse and Neglect advocated for interagency coordinating councils in the absence of an umbrella agency capable of providing the continuum of services needed by chemically dependent families involved with the child welfare system (Department of Health and Human Services, 1994). Interagency service teams were also recommended that involve team members making joint home visits for the purpose of assessment and planning, meeting on a regular basis for sharing of information and ideas, and participating in cross-training (Department of Health and Human Services, 1994). These service teams were facilitated by interagency agreements that described each agencies' role and responsibilities (Department of Health and Human Services, 1994).

The National Conference of State Legislatures (2000) reported on several state strategies directed towards collaborative efforts between the child welfare and chemical dependency fields. In Arizona, a joint substance abuse treatment fund has been implemented to develop community-based programs and provide comprehensive treatment services for parents whose substance abuse is a barrier to preserving or reunifying the family (National Conference of State Legislatures, 2000). In Illinois, there has been an expansion of treatment capacity for families in the child welfare system involving substance abuse screening, assessment and treatment, outreach services, case coordination, aftercare, collaborative administration, joint training and ongoing quality assurance. A multidisciplinary advisory committee meets quarterly to identify service gaps and make recommendations (National Conference of State Legislatures, 2000).

In Maryland, a demonstration project consisting of multidisciplinary teams with chemical addiction counsellors, recovering substance abusers who serve as mentors, parent aides, child welfare workers and treatment providers provide case management services to

mothers whose children are in foster care or are at risk of being placed in foster care (National Conference of State Legislatures, 2000). The Department of Human Resources and the Department of Health and Mental Hygiene, in Maryland, were directed to consult with a wide array of stake holders and to develop by December 1st, 2000, a statewide protocol for integrating child welfare and substance abuse treatment services. The protocol will include such areas as: cross-training; financial incentives for child welfare and addictions personnel who achieve specified levels of expertise; placement of addictions specialists in all child welfare offices, based on caseloads; all parents involved with the child welfare system will be screened for substance abuse; and establishment of a procedure for notifying the local child welfare agency of the results of assessment and progress in treatment (National Conference of State Legislatures, 2000).

In New Hampshire, Title IV-E waiver, involved the placement of licensed substance abuse counsellors/family therapists in selected child welfare field offices to assist with training, consultation, case management, assessments and referrals for treatment (National Conference of State Legislatures, 2000). In Nevada, the Family Drug Court has been implemented which involves collaboration among the court system, local treatment programs, a case management provider, the state department of parole and probation, the county child welfare agency, and a team of court-appointed volunteer mentors (National Conference of State Legislatures, 2000). It is clear that there are many initiatives underway to coordinate services between child welfare and addiction services, but an integrated, interdisciplinary framework still seems to be the goal, rather than the reality.

King (2001), as part of her Masters Thesis, studied two multidisciplinary programs. The Alcohol and Drug Abuse Project Team (ADAPT) program in Ohio was developed to identify the met and unmet maternal needs for child welfare and substance abuse services in

order to keep families together. Substance abuse and child welfare professionals joined together under a common mission of service to their clients. Two ADAPT caseworkers teamed up to manage each case, both staff had specialized addiction training and worked in both substance abuse and child protective services to ensure cross training. The second program, Sobriety Treatment and Recovery Teams (START), was developed to integrate addiction services treatment, child welfare practice, and family preservation practice into a model that will serve the needs of substance abusing families. Social workers, working in concert with advocates and drug treatment staff at outside agencies, helped clients to increase their support network and skills for their recovery process. The advocates had at least two years recovery from substance abuse, as well as completion of a two year chemical dependency certification program. The advocates were responsible for engaging clients, provision of role modeling and educating, and continued assessment of their recovery and potential for relapse. Both of these programs were pilot projects operating from the fall of 1999 to the fall of 2000.

Using a phenomenological approach, the substance abuse aides and social workers were asked to describe their experiences in these programs. The themes that emerged included: (a) interdependent relationships among substance abuse aides and social workers - communication between the aide and social worker regarding case plan development, approaches to clients, case recommendations and the aides blending of roles, (b) disciplines discerning in substance abuse and child welfare - values, perspectives and personal views in the areas of addiction, recovery or abstinence, child welfare and client motivation, (c) strengthened commitment to operate collaboratively - knowledge of the other professional, substance abuse identification, child welfare training, and prior experience related to substance abuse issues, and (d) empowerment and recognition of the professional and paraprofessional - merging of the disciplines over time comprising adaptation and responses, service delivery, client awareness,

and systems knowledge. Over time, it appears these professionals, through an open attitude, learned how to work together in a mutually satisfying way.

A prior attempt at integrating various social service providers in British Columbia was attempted in the 70's (Clague, Dill, Wharf, & Seebaran, 1984). The reasons for initiating this project three decades ago resonate with the motivation behind the current multidisciplinary model; the welfare system was too fragmented to deal effectively with the combination of problems associated with poverty (Clague et al., 1984). The initiative did not end up succeeding; there was not any overall design or guide to implementation and the staff felt excluded with no organized effort to consult them or to inform them about the process. Physical integration occurred, but professionals continued to work separately.

Generally, the literature advocates for the formation of a multidisciplinary model comprising child protection and addiction services, but for the most part this has not materialized on a practice level. The effectiveness of interdisciplinary teams is also questioned in the literature with both negative and positive perspectives stated strongly. Much of the integrated team work research explores the team's possible effects on children being returned home, retention in treatment and developmental progress for children, rather than the experience of the disciplines involved. Brown, Crawford, & Darongkamas (2000) indicated that to date still little is known in a systematic way about the experience of multidisciplinary work for team members despite the large number of initiatives.

13. Specific Qualitative Research Informing this Study

There are particular studies in the literature that have examined multidisciplinary teams, which inform this study. Mouzakitis and Goldstein (1985) looked at the use of an interdisciplinary team in the treatment of two child neglect cases. They commented that interdisciplinary teams in the treatment of child abuse and neglect cases were either

underutilized or non-existent, even though the concept emerged some thirty years previously. Keeping in mind this article is 19 years old, it is still significant that from 1955 to 1985 the development of multidisciplinary teams within the child protection field did not grow. The multidisciplinary team examined in the Mouzakitis and Goldstein (1985) article was comprised of the following professionals: a consultant within the protection field, a child protection social worker, a pediatrician, a lawyer, a school social worker, a psychiatric social worker, a mental health counsellor, a child psychologist, a social worker from an alcohol and drug abuse program, a police officer, a social worker from a public housing unit; and a pediatric social worker. Cases were brought to the team's attention by the social worker or their supervisor when workers were at an impasse, when consensus was needed to remove a child and when there was difficulty managing cases requiring multi-agency interventions. The study found that multidisciplinary team consultation was useful and effective in diagnosing and treating cases that otherwise could have become chronic problems.

Kolbe and Strong (1997) explored multidisciplinary team approaches to the investigation and resolution of child abuse and neglect. A telephone survey design was utilized with 50 respondents, each one from a separate state, who possessed the most knowledge related to multidisciplinary approaches used in the investigation and resolution of child abuse and neglect. The respondents were also asked to mail in material describing their program. All participants completed the phone survey and 80% sent information regarding their service. The results illustrated that initiatives to take a multidisciplinary approach to the investigation and resolution of child abuse and neglect exist in all 50 states, but each with a unique configuration. The composition of the multidisciplinary teams were most likely to include child protection services, law enforcement, and the legal system. The next most commonly represented professionals were from medicine, education, mental health, public health, and juvenile

corrections. The less frequently represented professionals on the team were psychologist, psychiatrists, family support, child care agency workers and court appointed special advocates.

The benefits reported in Kolbe and Strong's (1997) article of the multidisciplinary approaches were an increase in coordination and collaboration between agencies; broader range of view points on problems was considered in the decision making process; more decisions were made jointly; otherwise unknown resources were identified; more cases were actually reviewed; better assessments, treatment plans and services were provided; fewer cases fell through the cracks; more cases reached successful resolution; and greater sense of accomplishment among the professionals was experienced. The challenges noted are collaboration was not always easy; some of the child protection services workers were confused about leadership roles; questioned the ownership of the case; felt additional scrutiny of their work; and interdisciplinary decision making can be more time consuming than traditional approaches.

Brown, Crawford, and Darongkamas (2000) interviewed 29 members of three community mental health teams regarding their experience of roles and boundaries. Each of the staff had until recently been working in a single discipline team, but a new structure had been developed where each team had been reconfigured in an interdisciplinary fashion. The professionals involved in the teams involved clinical psychologists, community mental health nurses, occupational therapists, psychiatrists and mental health support workers. The findings indicated that the lack of managerial direction and the encouragement of generic working seemed to make some respondents all the more insistent on separate professional identities. The author's overall conclusion was that boundaries between professions are actively encouraged by the experience of interdisciplinary modes of working, rather than a relic of the past or a product of ingrained attitudes.

Veeder, Hawkins, Williams, and Pearce (1999) conducted a qualitative study to explore collaboration in the 1990's between social workers and nurses and to suggest a new model based on this data. The sample consisted of 16 nurses, 16 social workers, and one person trained as both who were interviewed through a semi-structured format regarding their views of the challenges to collaboration posited by managed care. From this information emerged the proposed Biopsychosocial Individual and Systems Intervention Model (BISIM). The key characteristics of this model encompass tasks being performed at both the client level and system level interventions; advanced case management by advanced systems practitioners; clinical case management; holistic view of the biopsychosocial person-in-situation; a life model, strengths, and a client competency enhancement conceptual framework; interdisciplinary team case management; strong advocacy component; differentiation between nurse and social worker roles on the team according to those tasks for which each clearly is best trained; and a strong qualitative and quantitative monitoring and outcome evaluation accountability component.

Abramson and Mizrahi (1996) looked at the positive and negative interdisciplinary experiences when social workers and physicians collaborate. They interviewed 53 social workers and 50 physicians in 12 hospital settings about their best and worst experiences collaborating on a case. For the positive cases, both groups stressed the importance of their respect for their colleague, their similar perceptions and the quality of communication between them. Social workers focused more than physicians on the other professionals' understanding of his or her role, acknowledgment of the other's capability, and respectful treatment by the collaborator. The physicians focused primarily on the collaborator's capability and also stressed being kept informed more than social workers.

As far as negative cases, both social workers and physicians focused on interaction and relationships with the other profession to a greater extent than when assessing positive cases; dissimilar perceptions about the case ranked highly for both professions; as well as poor quality and amount of communication. The doctor's negative style was of great concern to social workers, whereas the social worker's negative style was ranked much lower by physicians; the same pattern was repeated regarding lack of respect of the other professionals toward social workers. Social workers stressed lack of understanding of their role, while competence was highlighted much more frequently by physicians. Lack of timely feedback and not being kept informed were more important for doctors. Overall, the patterns in rankings indicated that social workers focused more on the relationship with physicians and on what their collaborator thought of them than did the physicians, who concentrated more on what social workers did.

Of the five studies discussed above, two of them are related to the area of child welfare. In the Mouzakitis and Goldstein (1985) study, the interdisciplinary team operated in a consultative fashion rather than case managing on a day to day basis, which differs from the functioning of the multidisciplinary team this study focused upon. Also, it explored the effectiveness of the team with two child neglect cases versus the experience of team members. Kolbe and Strong's (1997) telephone survey study showed that initiatives are in place for multidisciplinary approaches in all 50 States, but mostly encompassing child protection workers, law enforcement personnel and the legal system. Their study also noted the positive and negative aspects of integrated practice, but did not explore the experiences of the team members. The remaining three studies involved integrated teams within community mental health and the medical field. The dissimilar composition and setting for these teams would result in very different dynamics compared to the model researched in this study. However, the qualitative design and semi-structured interview format utilized in most of these studies was

very helpful in eliciting the experience of the participants or gaining more depth and breadth depending on the focus. This method lent itself well to the purpose of this study, which was to explore the experience of addiction counsellors and child protection social workers within the context of a multidisciplinary team. Furthermore, these studies uncover aspects of the integrated team experience that guided areas explored in this study.

The next chapter delineates the method utilized for this study. The design, role of the researcher, participants, interview settings, data collection, analysis, and verification methods are described. The chapter ends with exploring the ethical issues attached to this research.

CHAPTER III

Method

1. Type of Design

This study comprised a qualitative research design with a semi-structured interview format using content analysis to analyze the interview data. Mertens (1998) suggested three possible reasons for choosing qualitative methods. First, the researcher's view of the world will influence their choice. Given my interpretive/constructivism orientation that "multiple realities exist that are time and context dependent, a qualitative design will facilitate obtaining an understanding of the constructions held by the participants in that context" (p. 161). Second, the nature of the questions in a study can dictate the type of design chosen. This research project required information about the participant's experience within the context of a multidisciplinary team, which a qualitative framework lends itself well to. Third, practical reasons may motivate a researcher to choose a qualitative design. Because my humanistic values are more conducive to the personal contact and data that would emerge from a qualitative study, I chose this design.

Further qualitative paradigm assumptions that influenced the framework for this study include the process of research is inductive, context bound, with emerging categories during the research process (Patton, 1990; Rice & Ezzy, 1999). The researcher also interacts with that being researched and qualitative research is value laden and biased (Babbie, 2001). The language of research is informal with evolving decisions and a personal voice (Mertens, 1998). Patterns and theories are developed for understanding (Berg, 2001). Accuracy and reliability are accomplished through verification and, lastly, qualitative research is descriptive in that the researcher is interested in process, meaning, and understanding gained through words or pictures (Firestone, 1987; Guba & Lincoln, 1988; McCracken, 1988 cited in Creswell, 1994).

2. Role of Researcher

The researcher was the primary instrument in data collection and analysis (Creswell, 1994; Mertens, 1998). “The data (were) mediated through the researcher, rather than through inventories, questionnaires, or machines” (Creswell, 1994, p. 145). Gubrium and Holstein (2002) described the qualitative interview as a face to face encounter between researcher and informant directed toward understanding the informant’s perspectives on their lives, experiences, or situations as expressed in their own words. The qualitative interview was modeled after a conversation between equals, rather than a formal question and answer exchange. Far from being a robotlike data collector, the interviewer, not an interview schedule or protocol, was the research tool. This characteristic of the qualitative researcher necessitated the identification of personal values, assumptions and biases (Creswell, 1994).

My work experience has encompassed both the roles of addiction counsellor and child protection social worker. My familiarity with the topic may have caused me to overlook details about which I assumed I was already informed. I also may have unintentionally given the informants the impression that I knew the answers to the questions being asked (Gubrium & Holstein, 2002). I worked hard to take on the role of curious researcher and remain curious about the participant’s experience, which may or may not reflect mine.

My previous employer has been very generous, paying partially for my tuition fees, being very accommodating adjusting my work hours for classes, as well as arranging some time off from work. These gestures have created feelings of loyalty towards the Ministry which, in part, is why I chose this topic of study because I thought it would help advance our work. I needed to ensure these feelings do not colour the findings. I have also had very negative experiences while working within the Ministry for Children and Families. It can be a very punitive, authoritarian and fear based system. However, this “insider perspective” was valuable

in facilitating more richness of material, but I needed to be cautious to not influence the process away from the participant's experience.

Uncovering my biases may be regarded as an ongoing process. As I engaged in the active process of research, more of my subjectivities were tapped into. I used my field notes as a tool to keep abreast of my reactions and internal processes that could impinge on the research undertaking. Also, I continued to talk with colleagues in an effort to help shed light on aspects of myself that are out of my direct awareness. Additionally, steps were completed to facilitate trustworthiness of the findings, which are discussed under "Methods for Verification."

3. Participants

Recruitment. Any of the many sampling procedures used in other data collection techniques can be used in content analysis. For this study, the participants were sought through purposive sampling, which does not aim for formal representativeness (Palys, 1997). I intentionally sought out sixteen child protection social workers and sixteen addiction counsellors that met the criteria of working within the context of a multidisciplinary team within Ministry for Children and Families. Palys (1997) noted that "sampling is always purposive to some degree, since identifying a target population invariably expresses the researcher's interests and objectives" (p. 137). These purposive choices may have indirectly reaffirmed rather than challenged my understanding because the purposive sample reflects my perception of the phenomenon of interest (Palys, 1997). This aspect of purposive sampling made it very important to remain aware of my potential biases to prevent analyzing the data through a prejudiced filter. The positive attribute of purposive sampling was the participants had the experience and knowledge necessary to shed light on the focus of interest.

They were three potential options for recruitment. First, an email would be sent to all addiction counsellors and child protection social workers within the lower mainland providing a

brief outline of the study and encouraging them to contact me, if interested. As an employee, I have access to the in-house email system, which permitted quick access to the participants; see Appendix A for recruitment notice. Second, if the above strategy did not elicit the targeted sample numbers, then I was prepared to attend staff meetings to describe the study and solicit participants. Third, as each participant was being interviewed, they would be asked if they knew of any front line worker who fits the criteria and might be interested. As it turned out, the first method of recruitment, through email, elicited the sample numbers sought.

A demographic survey with two questions was given to each participant at the start of the interview, after completing the Informed Consent Form; see Appendix B for survey and Appendix M for Informed Consent. The two questions on the survey were: (a) “How satisfied are you with your experience of working within the context of a multidisciplinary team?”, and (b) “Do you think children and families are receiving better services as a result of the multidisciplinary model?” The results indicated that slightly more than half of the participants are somewhat satisfied with their multidisciplinary team experience and believe families are receiving better service; see Table 1.

Age and gender. The average age of the addiction counsellor sample was 47 years ($SD = 5.29$), while for the social workers it was 37 years ($SD = 9.15$). The range in ages for addiction counsellors was from 38 to 55 years and the range for social workers was from 26 to 55 years, which would be the same for the total sample as well. Forty-two years of age was the mean for the total sample with a standard deviation of 7.47. In terms of gender, 20 females (8 addiction counsellors and 12 social workers) and 12 males (8 addiction counsellors, 4 social workers) were interviewed, which reflects the higher number of women employed in these lines of work. Although, among the addiction counsellor sample there was equal representation gender wise.

TABLE 1

Responses to Question: How satisfied are you with your experience within the context of a multidisciplinary team?

	Very	Somewhat	Not
AC	2 (6%)	9 (28%)	5 (16%)
SW	4 (13%)	9 (28%)	3 (9%)
Total	6 (19%)	18 (56%)	8 (25%)

Responses to Question: Do you think children and families are receiving better service as a result of the multidisciplinary model?

	Yes	No
AC	7 (22%)	6 (19%)
SW	11 (34%)	5 (16%)
Total	18 (56%)	11 (35%)

Note: One participant did not answer the question, another participant responded "not sure" and another participant answered "sometimes". These were not included in the above results.

Education and marital status. Educationally, 14 participants had Master's level education in either counselling psychology or social work, and 18 had Bachelor's degrees in the areas of social work, sociology, anthropology, psychology and child and youth care. Dividing the samples, 12 out of the 16 addiction counsellors had a post-bachelor level of education and two out of the 16 social workers had beyond undergraduate education. Regarding marital status, seven of the interviewees were divorced, six living in common-law situations, twelve married, one separated, and six single. Marital status was similar between sub-samples. Sixteen of the participants had children, leaving 16 without children. More addiction counsellors had children compared to social workers, the younger ages of the social workers could account for this difference.

Ethnic background. The ethnic backgrounds reported by the participants included Chinese, Fijian, East Indian, African, Asian, European (Irish, English, Welsh, Dutch, German) Ukrainian, Russian, and French. Nine out of the 32 participants listed their ethnic heritage as other than European.

Length of work experience. The average length of work experience for the addiction counsellors sample was 11 years ($SD = 5.11$) and with social workers was 6.6 years ($SD = 5.70$). For the total sample, the average length of work experience was 8.8 years ($SD = 5.41$)

Representation. Although the intent of this study was not to obtain a truly representative sample, it is interesting to note that 16 addiction counsellors were interviewed out of a possible 24, meaning 67% of the total sample was interviewed. With social workers it is an entirely different picture, 16 social workers were interviewed out of a total of approximately 150 social workers (Communications Department gave the total number of social workers, but did not exclude social workers working solely with youth, adoption or guardianship), which is approximately 11% of the total sample. Overall, for the purposes of

this study, the interviewees were highly qualified to provide first hand information of their experience of working within the context of a multidisciplinary team within the Ministry for Children and Families.

4. Interview settings

The informants were all employees of the Ministry of Children and Family Development (formerly the Ministry for Children and Families), but during the course of this study the addiction counsellors were transferred to the Health Authority Boards. Letters requesting approval to conduct this research were sent to management within the Ministry of Children and Family Development, Vancouver/Coastal Health Authority and the Fraser Health Authority, specifically the Director of Performance Management and Economic Analysis, Director of Alcohol and Drug Programs, and Executive Director of Mental Health and Addictions respectively; see Appendixes C, D and E. The organizational charts of the Ministry of Children and Family Development and the Fraser Health Authority are included in the appendix; see Appendixes F and G. Approval to conduct this study was obtained from the aforementioned management; see Appendixes H, I and J. Subsequently, with this approval, I was able to recruit interested addiction counsellors and child protection social workers in the Vancouver and Surrey area. Each participant was given the option of meeting at my home, their home, a space in the community (e.g., room in a public library or community centre, quiet restaurant); my office or their office. Also, the time for the interview was left open for the participants to choose: daytime through the week, any evening, and weekends. This provided the interviewees with the opportunity to choose a location and time which was most comfortable for them, as well as most convenient. The University of British Columbia Ethics Review Board granted ethical approval to conduct this research; see Appendix K.

5. Data Collection

The means of data collection was through semi-structured interviews. The participants were interviewed once for up to 60 minutes with a follow-up to have informants provide feedback regarding the results. For the follow-up component, the participants were given the choice of having an in-person interview or reviewing the derived categories via an email attachment. An interview guide was used to ensure certain facets of the participant's experience were explored, while allowing the opportunity for exploratory, unstructured responses within each of the questions (Mertens, 1998); see Appendix L for copy of Interview Guide.

The strength of qualitative interviewing is that through it we can come to understand the details of people's experience from their point of view (Seidman, 1991). Other advantages are interviews elicit information directly from people; allows opportunity for probing, finds out why people feel or respond the way they do; explains complex information; clarifies previously collected data; discovers the subjective meanings and interpretations that people give to their experiences; permits new understandings and theories to be developed; creates space for participants to discuss sensitive matters away from their peers; and participants generally find the experience rewarding (Rice & Ezzy, 1999; Sproull, 1995). The disadvantages of interviewing, according to Sproull, involve the heavy time commitment, possibility of inaccurate data because people may omit information or have selective recall, and the researcher's bias may influence the interaction.

I also kept a journal noting emerging ideas, impressions, observations, thoughts, themes; ways to improve interviews and aspects of the interview that the audio-tape cannot capture such as non-verbal behaviour, physical setting, distractions, tone of voice, and dress and demeanor, which can help in highlighting new directions, adding context and corroborating discrepancies

(Mertens, 1998). A pilot was conducted involving interviewing one child protection social worker and one addiction counsellor, this data was included in the analysis. This provided an opportunity to determine if the questions developed needed to be modified, to check out if the time allotted was sufficient and to reveal aspects of my interviewing style that helped and hindered the process (Seidman, 1991). All interviews were audio-taped and transcribed by the researcher.

6. Data Analysis

Once all the data were collected content analysis was utilized to draw meaningful inferences. Babbie (2001) stated that “content analysis is essentially a coding operation with coding being the process of transforming raw data into a standardized form” (p. 309). Weber (1990) noted that social scientists who must make sense of open-ended interviews will find this technique indispensable, which uses a set of procedures to make valid inferences from text. The story of each participant is dissected and sections belonging to a defined category are collected and then contrasted and compared (Mertens, 1998). Content analysis is considered a useful and appropriate method of qualitative data analysis when a problem or a phenomenon is shared by a group of people (Palys, 1997). The categories researchers use in content analysis can be determined inductively, deductively, or by some combination of both (Patton, 1990). An inductive approach was utilized in this study. Manifest content are those elements that are physically present and countable while latent content is extended to an interpretive reading of the symbolism underlying the physical data (Creswell, 1994).

The strengths of content analysis are it is cost effective; can be used with any type of communication; widely applicable in many situations since most circumstances involve communications; can be checked for accuracy, if recorded; able to handle unstructured material; can cope with large volumes of data; and can be used with existing data or with data the

participants generate (Berg, 2001; Rothe, 2000; Sproull, 1995). Some of the limitations are locating unobtrusive messages relevant to the particular research questions, which is remedied through the semi-structured interviewing format; if not done rigorously, content analysis can be overly inferential; and it can be time consuming (Berg, 2001; Rothe, 2000; Sproull, 1995). To address these concerns, I applied the steps of content analysis rigorously and devoted the necessary time commitment.

The specific steps of content analysis this study followed are outlined by Gillham (2000). He views “content analysis as a way to organize the substantive content of the interview: the content that is of substance” (p. 59). He sees two essential strands to the analysis: identifying key, substantive points and putting them into categories. The steps undertaken were:

Step 1. Each audio-taped interview was transcribed with no more than 350 words per page double spaced to permit room for notes or coding references. A different type face was used for my questions and interjections, so that what the interviewee said was clearly demarcated. The questions were put in bold face to mark the headings. Each transcript was clearly identified with a numerical code.

Step 2. The substantive statements (those that make a point and answer questions) in each transcript were highlighted, while ignoring repetitions, digressions and other clearly irrelevant material. The data not used did not answer the research questions. Typically, this meant information that did not relate to the participant’s experience of the multidisciplinary model being studied. It should be noted that the vast majority of material provided by the participants was included for analysis. The reading of the transcripts was paced and the highlighting of transcripts was kept to two a day, preventing my concentration from becoming dulled.

Step 3. After going through all the transcripts, I went back to the first one and read them through again to see if there were any statements that had failed to be highlighted or if some had been highlighted that should not have been.

Step 4. I went through all of the highlighted statements again, trying to derive a set of categories for the responses to each question.

Step 5. The list of categories was studied to see if some of them could be combined or split up, or were inadequate or unnecessary because they did not appropriately reflect the material shared by the participants.

Step 6. With my list of categories beside me, I went through the transcripts and checked each substantive (highlighted) statement against the category list to see if it had somewhere to go. If it was necessary, categories were modified or new ones added to fit the statements.

Step 7. I spent time reflecting on what the categories and statements were telling me. The conceptualization that emerged further modified and collapsed categories.

Step 8. I put statements belonging to each category on poster board and looked at each in turn to ensure that every statement was in its rightful place. A requirement for the derivation of categories is that they should be exhaustive, as well as exclusive. The kind of statements that go into one category clearly belong there and could not really go anywhere else.

Step 9. The coding forced me to look at each detail to see what it added to my understanding. I ensured that the categories made sense in view of the data and that the data had been appropriately arranged in a category system. Once I derived the categories I was able to put them together to build an integrated explanation or conceptualization.

Step 10. I then chose statements from each category to use in the results section that reflected the range of responses.

7. Methods for Verification

To heighten trustworthiness, “the inclusion or exclusion of content is done according to consistently applied criteria of selection; this requirement eliminates analysis in which only material supporting the investigator’s hypotheses are examined” (Holsti, 1968, p.598 as cited in Berg, 2001, p. 241). With latent content analysis, it is important for researchers to incorporate independent corroborative techniques (Berg, 2001). A colleague, as well as participants, provided feedback regarding the derived themes. Specifically, one colleague provided interrater reliability by checking to see if they highlighted the same statements and placed them in the same categories. The second coder was given information about content analysis before they coded and the nature of my research was explained. They were also given several unmarked transcripts picked at random and asked to highlight what they saw as substantive statements. They had an overview of the categories and placed quotes into categories according to where they believed there was the best fit. There was a high level of agreement. The only differences entailed the co-coder not highlighting statements that I had marked as important. Once I explained my reasoning for including them in the analysis the second coder agreed with my logic.

The participants examined the resulting categories to see if they resonated with what they intended to convey and to ensure they felt represented. The feedback from the participants reflected that the categories accurately depicted their experience. None of input provided by the interviewees indicated disagreement with the derived themes. The participants concurred with the results believing the categories reflected what they intended to convey. Also, detailed excerpts from relevant statements which serve to document the researchers’ interpretations

were included in the write up. Berelson (1952) and Weber (1990) noted the need for two types of consistency: (a) different coders producing the same results when applying the same set of categories to the same content, and (b) the same results being produced at different times. Mertens (1998) stated that the member check is the most important criterion in establishing credibility.

Validity is further strengthened through the following means: (a) the trustworthiness of the participant's reports, (b) the quality of the interviewing itself, (c) valid translation from oral to written language, (d) whether the questions put to an interview text are valid, (e) whether the logic of the interpretations is sound, and (f) whether a given report is a valid account of the main findings of a study (Kvale, 1996). Patton (1990) advocated using high quality tape recording equipment; choosing a place that is quiet and free from interruptions; testing the recording system; speaking clearly and not too fast; avoiding use of the voice activation feature as it may fail to record the first few seconds; and corroborating elements of the transcription with field notes. These are all measures I have undertaken in this study to increase validity.

8. Ethical Issues

Kvale (1996) outlined several ethical issues in a qualitative study utilizing an interview design. It is important that beyond the scientific value of the knowledge sought, that the purpose of an interview study look at improving the human situation investigated. By enhancing our understanding of how different disciplines can work together more collaboratively and effectively, the service to a very important client group, parents involved with the child protection and addiction services system, will be positively influenced. The participant's informed consent was obtained, measures to secure confidentiality were outlined, and the possible consequences of the study were discussed with the participants; see Appendix

M for the Informed Consent. Seidman (1991) indicates that “the standard assumption is that participants in interview studies will remain anonymous” (p. 50).

To ensure confidentiality, I avoided listing names or sites of people that could be traced later when the research is completed. All participants were assigned a code number and documents were identified by these code numbers, and kept in a locked filing cabinet, which only the researcher and co-researcher had access. The transcriptions did not have the participant's proper names, instead code numbers were used, and I transcribed all of the interviews. The final report does not contain any identifying information, and if needed, I actively disguised the participant's identity. A brief synopsis of the study will be given to each of the participants. All records pertaining to this research project will be destroyed in five years.

The potential benefits of this study include the front line worker's voice being heard and perhaps future practice being modified to reflect what was most helpful to the work, while barriers to the service could be removed. Recommendations to help guide organizational restructuring that will facilitate collaboration could be elicited. More wisdom being gained about how to balance the needs of children through sharing of information and coordinated case planning, while maintaining a solid therapeutic alliance. It is an opportunity to determine if the suppositions regarding multidisciplinary practice have been reflected in actual practice. With the transfer of Addiction Services to the Health Boards, aspects of the interdisciplinary model that are working well could be retained. The only potential concerns that came to mind were the participants may have worried if they shared that their experience within the multidisciplinary team had been negative, their colleagues may find out, which could affect their working relationship. These concerns were addressed by informing each participant of the

measures being taken to ensure their confidentiality. Also, for the same reasons their standing in the organization would not be affected by this study.

The results of the study are presented in the next chapter. The findings related to the first two questions of the interview guide are set forth, and a summary of the results for the remaining two questions is included. Chapter IV conveys, in the participant's words, what it was like for addiction counsellors and social workers to work within a multidisciplinary team together.

CHAPTER IV

Results

1. Overview of section

The global question which guided this study was: “What has been the experience of addiction counsellors and child protection social workers within the context of a multidisciplinary team?” An interview guide was implemented to help bring forth certain facets of the participant’s experience, while still facilitating exploratory, unstructured responses within each question; see Appendix L. The presentation of the findings will follow the framework of the interview guide. The derived categories and subcategories from the coding of the transcripts will be shared for the first two questions of the interview guide:

Research Question 1. “What has been your experience working within the context of a multidisciplinary team?”

Research Question 2. “What ethical situations have you come up against?”

It was decided that for the remaining two questions a summary of the content including some observations and interpretation will be presented. This decision was based on the overall volume of work involved in coding four separate questions and the limitations given the time constraints. Question 3 and 4 are:

Research Question 3. “How has your knowledge base been influenced as a result of working with the other discipline?”

Research Question 4. “What would you like to see happen with the multidisciplinary model in the future?”

The nature of these questions is described in more detail in the separate sections devoted to each question.

The quotes used to build a valid argument for choosing the themes are presented as close to verbatim as possible. They have been edited minimally by removing words that do not

contribute to the meaning of the statements or that had a bridging function. Words were taken out if they digressed from the substantive issue, were repetitious or confused the meaning the participant was intending to convey. Any editing undertaken is clearly marked through the use of three dots ... which symbolizes that a change or omission has occurred. If a piece of a statement has been taken from its entirety because the remaining portion does not contribute to the issue under discussion, the symbol ... is used again. When parentheses are utilized, it indicates a word or phrase that was not provided by the participant in the text, although the meaning was clear in the body of the speech. Grammatical changes have been undertaken such as punctuation and bridging words to decrease confusion and to help convey the intended meaning with more clarity. If an interviewee's identity could be ascertained by a quote, it was altered to protect their identity without changing the intended meaning. In a few instances, parts of quotes have been capitalized to demarcate where a participant was being particularly emphatic. The quotes have been numbered for easy reference. For instance a quote with the number 3.2.5 would translate to category number, sub-category number and quote number. There is a need to distinguish which question the number refers to because the numbering scheme is repeated for both Question 1 and 2.

2. Research Question 1: Nature of experience of working within the context of a multidisciplinary team?

The conceptualization or overarching theme that evolved from the data for this question was two different cultures, Addiction Services and Child Protection Services, coming together. In this framework culture was a broader concept than nationality, language, or ethnicity; it refers to professional roles which make people see the world differently from others (Berghof Research Center, 2000). There are many concepts of culture. Culture can be seen as the logic by which we give order to the world (Novinger, 2001) and a learned meaning system (Ting-

Toomey & Oetzel, 2001). Culture can refer to knowledge, experience, meanings, beliefs, values, attitudes, religions, concepts of self, the universe and self-universe, relationships, hierarchies of status, role expectations, spatial relations, and time concepts accumulated by a large group of people over generations through individual and group effort (Novinger, 2001; Senghass, 2002; Ting-Toomey & Oetzel, 2001). "Culture manifests itself both in patterns of language and thought, and in forms of activity and behavior and acts as a filter for communication" (Novinger, 2001, p. 14). Korzenny (1991) defines culture as:

The mechanism that allows human beings to make sense of the world, and to deal with it. Culture is a mix of manifest and latent patterns of behaviour and relationships among human beings, patterns that allow humans to function and strive in the pursuit of order and survival. Culture is a social product and is the result of humans originating interaction, that is, communication processes (p. 56).

"Culture is always relevant, if culture is defined broadly, that is, including many types and levels of difference, all conflicts are ultimately intercultural" (Berghof Research Center, 2000, p. 4). Even though these two disciplines shared some common goals, differences in their professional cultures, the lack of familiarity with each other's practices, communication difficulties, and the amalgamation process itself led to poor coordination of effort.

Addiction counsellors are considered to be the newcomers to the host culture, comprising social workers and the organization itself, the Ministry for Children and Families. The ingroup, consisting of social workers and the Ministry organizational culture, perceived a common fate and shared attributes. The outgroup, consisting of addiction counsellors, was perceived as disconnected, unequal, and resistant to change; they carried very different characteristics, and these attributes were in conflict with the ingroups' standards. The experience described by these two disciplines echoed the process observed when two diverse cultures are brought together, and their experience encompassed three thematic dimensions: (a) transition theme, (b) reorientation theme, and (c) adaptation theme; see Table 2.

Table 2. The Experience of Working within the Context of a Multidisciplinary Team

Categories Derived from Coding the Transcripts

Number of Participants with Responses in Category

	AC	SW	TOTAL
1. Transition Theme: Initial Contact between Two Cultures			
1.1 Experiencing culture shock	15/16 (94%)	4/16 (25%)	19/32 (59%)
1.2 Interface between newcomer, host and organizational culture	13/16 (81%)	8/16 (50%)	21/32 (66%)
1.3 Emergence of cross cultural conflict	16/16 (100%)	16/16 (100%)	32/32 (100%)
2. Reorientation Theme: How Can We Make This Work			
2.1 Development of adjustment strategies	12/16 (75%)	10/16 (63%)	22/32 (69%)
2.2 Evolution of intercultural relationship	15/16 (94%)	15/16 (94%)	30/32 (94%)
3. Adaptation Theme: Positive Aspects of Inter-Cultural Conflict and Current Status			
3.1 Perceived benefits of amalgamation	15/16 (94%)	14/16 (88%)	29/32 (91%)
3.2 Current status as separate entities	16/16 (100%)	16/16 (100%)	16/16 (100%)
3.3 Impediments to mutual acculturation	10/16 (63%)	12/16 (75%)	22/32 (69%)

Table 2 lists the major categories and their sub-categories. Next to each sub-category on the right hand side of the table are the number and percentage of addiction counsellors and social workers making responses in that category out of the total number of counsellors or social workers (16). The last column denotes the number of participants that made comments out of the total sample (32). For example, with the sub-category “Experiencing Culture Shock”, 15/16 addiction counsellors and 4/16 social workers made statements. This is understandable given the counsellors are the group that experienced being dislocated and entered a new culture. The next sub-category “Interface between Newcomer, Host and Organizational Culture” includes 13/16 addiction counsellors and 8/16 social workers making responses. The counsellors originating organizational culture was quite different than the authoritarian one they entered when amalgamating into the Ministry. On the other hand, the social workers, for the most part, were already assimilated into the administrative structure. The remaining sub-categories have fairly equal representation among social workers and addiction counsellors in terms of the number of participants making responses. The number and percentage of responses are included in the table simply to reflect how many participants made comments relevant to each sub-category. The participants’ experience related to each sub-category is discussed in detail in the sections devoted to each sub-category.

3. Category 1: Transition Theme: Initial Contact between Two Cultures

Initially, during the amalgamation phase, when addiction counsellors were moved out of the Ministry of Health and in with the Ministry for Children and Families, the experience shared by addiction counsellors reflected a form of culture shock. They recalled the tension and anxiety associated with entering into a new culture combined with the sensations of loss, confusion, and powerlessness. The host culture, during this transition process, expressed moving from excitement and anticipation about having a new service for their clients to

disappointment, when they did not receive what they had hoped for. The second theme that emerged during the transition period was the interaction between the newcomer, host and organizational culture. These three elements created a socio-cultural context within which these two disciplines operated, shaped the formalized processes for collaboration to occur and compelled verbal and behavioural responses from members of the two cultures. The remaining category in the transition dimension captures the cross cultural conflict that emerged as the two cultures experienced each other.

Sub-category 1.1: Experiencing Culture Shock

The newcomer culture experienced culture shock, while the host culture was not displaced, but had expectations of the incoming group that were not met. The experience described by the outgroup involves a level of preparedness, ambiguity, uncertainty, threat to identity, and intense feelings in reaction to the host cultures' behaviour. The ingroup identified feelings of confusion about what the plan was for the two disciplines and disappointment about not having addiction services for their clients in the form they envisioned. Taft (1977) described "cultural relocation as a composite experience of: strain and fatigue, loss and deprivation, feeling of rejection, identity disturbance, shock of cultural differences and feeling of impotence," all of which was reflected in the participants' quotes (cited in Ishiyama, 1995, p. 265).

Fifteen of the 16 counsellors (94% of the addiction counsellor sample and 47% of the total sample) made comments describing facets of culture shock. Four of the 16 social workers (25% of the social work sample and 13% of the total sample) shared responses falling into this subcategory. Six key themes emerged within the sub-category of "Experiencing Culture Shock": (a) proactive measures attempted by the addiction counsellors, (b) unclear expectations regarding the counsellor role, (c) professional invalidation, (d) assimilation versus

culture identity maintenance orientation, (e) emotional struggle over amalgamation, and (f) transition experience from the social worker's perspective. Each theme is described hereunder.

Proactive measures attempted by addiction counsellors. The newcomer culture attempted to prepare themselves for the transition to the Ministry for Children and Families. "The strangers' adaptation potential is directly a function of the degree to which they are prepared for change" (Kim, 2001, p. 166). By anticipating and planning for what might be forthcoming, members of the outgroup were hoping to be more prepared to face the challenges of crossing cultures and of the host culture. An addendum to the above noted quote, to fit this particular transition experience, would be that in addition to preparing for change, adaptation potential was contingent upon the degree to which the addiction counsellors felt their concerns were heard and mattered to the host culture. In this case, the preparation undertaken by the newcomer culture ended up causing some anger and a sense of injustice. Their concerns materialized after the host culture neglected to address problematic areas the newcomer culture anticipated would occur as reflected in the following quotes:

- 1.1.1 (A manager) came in and said, "I'm here to get your feedback in terms of what we're going to do, and how this process is going to come about, and I want to let you know right up front that the decision has already been made, and your feedback will have absolutely no impact on my decision."
- 1.1.2 My mind is going back to before this ever happened. When we as a team learned of it, we actually wrote a letter (saying that) we were really concerned about it (moving into the Ministry) and I think the main concern was the situation of coercion, that it wouldn't likely be effective for the client ..., WE WERE RIGHT, WE WERE RIGHT.
- 1.1.3 We said right off the bat that it didn't have to involve physical dislocation and physical amalgamation with multidisciplinary teams, it didn't have to mean on the same site. We said that from the beginning, we knew that our identity would get worn down, and that we would be supervised by a profession that probably didn't know totally what we were about. We expressed all those things right down to how are we going to answer the phone.

Unclear expectations regarding the counsellor role. There was much confusion, ambiguity and uncertainty expressed about what the expected functions of the addiction counsellor were. This suggests a lack of dialogue between the disciplines about their respective roles, and how they could best work together. Participants noted there was very little communication between management and the front line staff.

- 1.1.4 I was a little confused about what exactly is my role in the whole multidisciplinary thing. I don't know that I am all that really clear on it now, but I am more clear than I used to be It was a little confusing in the beginning as to what exactly are we suppose to do with these social workers. I don't think they knew either what they wanted from us, they thought we were going to do it all.
- 1.1.5 I remember the addiction counsellors just showed up one day, they were just as befuddled as us, like they landed from another planet.
- 1.1.6 For a multidisciplinary team to gel, you need the managers talking to each other and the managers talking to the team leaders and the team leaders talking to their workers. There wasn't a fantastic level of communication or sharing of information on those three levels, it wasn't there.

Professional invalidation. Some counsellors described the integration process as being in a war, like being taken over by a more powerful enemy. There was a strong sense of being invalidated at the time of transition, when there is a heightened need for self-validation (Ishiyama & Westwood, 1992). The host culture, in the mind of all of the counsellors interviewed, intended to use their role for Ministry purposes. The discipline was not viewed as having an identity of its own, rather only in relationship to what function it could serve on behalf of the social worker. The majority group members often did not understand the need for positive identity affirmation that the minority group members felt and at times were annoyed by such efforts to differentiate themselves from the organization (Ting-Toomey & Oetzel, 2001). This perceived threat to the addiction counsellors' distinctiveness laid the groundwork for a negatively discerned transition experience. The struggle for dignity, self-pride and visibility versus invisibility was strongly present in the following passages:

- 1.1.7** In some ways the experience was like being in a war and you were the loser and the victor takes the spoils. I felt like we were the spoils, like we got pillaged and robbed. I thought they really weren't seeing our service for what it is, which is a holistic service that serves all the general public and that they actually took us over and thought we were going to somehow be their little worker bees, where we were their little servants almost, their little helper, almost this visual picture of standing there with a tray like as a servant, "Can I help you mam, sir?" "Would you like more coffee?" I think their attitude sucked as a matter of fact, it really sucked, they had attitude big time. I think they were insulting in terms of what they thought we did, they were totally ignorant of what we do.
- 1.1.8** There were rumors among the front line staff that this was the beginning of the end, that we weren't going to be Addiction Services anymore ... we had that from the beginning, those fears that eventually whether we were going to be child protection social workers or what we didn't know, but it sounded like that's what the plan was. There were frequent discussions about what are they really up to, what is the plan, they probably got a plan, they're not telling us what it is and the plan is to absorb us, assimilate and to lose our identity ... they want FTE's (full time equivalent positions), they want to keep them, they're going to hang on to us, change our names, change our labels, so that when and if anybody ever decides to go back to the other model, they won't remember who the hell we were, that's what we thought was their agenda, we were on our guard, our guard was up all the way through.
- 1.1.9** I happened to say something to my supervisor "Oh, I had this client who I had to ask to leave because he was almost to the point of being violent," now what I'm used to is someone saying, "Wow, that must have been terrifying what can we do about that, what would you do if he did become violent," and "do we have something in place." To me, that's the normal thing to say to your colleague, and this supervisor said to me, "Welcome to our world," and three times over a period of six months that happened, so I went into the supervisor's office and I said, "I don't expect a supervisor to speak to me that way, it is extremely disrespectful, I have a world, I've got my world with me, it's not part of your world, it's different."

Assimilation versus culture identity maintenance orientation. Another counsellor shared that it was made clear to them at a meeting that the expectation was to identify themselves as working for the Ministry, rather than indicate their role. It did not appear to be acceptable to have an identity separate from the Ministry such as professional affiliation:

- 1.1.10** There was an attitude from day one, I mean the first day we got together (addiction counsellors and social workers) ... we were suppose to be together and share about our disciplines and we went around the room and said our names and which discipline we were from and all the social workers they didn't say social

worker, they said we're with the Ministry for Children and Families, all the social workers and the secretaries said that, so you knew they talked about it beforehand where the rest of us were saying our name and that we were with Addiction Services.

"It is important that people be addressed by their preferred titles and identities, this conveys to others recognition of their existence and the validity of their experiences, it confirms self-worth by being sensitive to their self-images" (Ting-Toomey & Oetzel, 2001, p.184). The issue of assimilation versus culture identity maintenance was a powerful theme throughout the interviewees' recollections of their experience. Counsellors became preoccupied with their large group identity when it was threatened or perceived to be threatened. Issues of validation versus rejection, approval versus disapproval, respect versus disrespect and valuing versus disconfirming are created when a group's identity is in peril (Ting-Toomey & Oetzel, 2001).

Emotional struggle over amalgamation. During the interview process, the intensity of feelings incurred by the addiction counsellors as a result of the amalgamation process became very evident. This was significant, indicating the magnitude of the impact of being placed with the child protection culture, particularly given, at the time of the interviews, almost five years had elapsed since the dislocation had occurred. The following excerpts seem to reflect the depth of pain and emotional struggle encountered by many of the counsellors:

- 1.1.11** It's been an abusive experience; I have felt abused as a professional and as a person. I've been on multidisciplinary teams before and I wasn't expecting this kind of experience. ... I just feel battered and I'm sick of being battered I mean enough, enough It's hard going around every day feeling nothing but rage and anger ... I've got a lot of feelings about this (being placed with the Ministry) and a lot of stuff is coming up. When I said I feel abused I mean it, and I'm really, really hurt, ... I mean I'm even crying.
- 1.1.12** We went around the room and we said how we were feeling. When it was my turn, I burst into tears and I said, "I've never been treated so disrespectfully" and I pointed to this person in a management position and I said, "You have been disrespectful, you haven't respected the discipline of addictions and how we work, my morale is as low as it's ever been, I don't want to come to work and it's very dissatisfying for me," and this person called me into their office

with another management staff and they reamed me out, “You are not to ever put the team leader down in front of other people.”

Transition experience from social workers’ perspective. Social workers expressed many hopes and expectations regarding the type of service addiction counsellors would offer once onsite. After eagerly awaiting the arrival of addiction services, it became evident to them over time that the newcomer culture was not going to assimilate and deliver the service exactly as they envisioned. This caused feelings of disappointment and frustration:

- 1.1.13** Initially, I remember thinking finally we have addiction services for our clients, but really we don’t In terms of frustrations, it’s got to the point where we’d rather not have the addiction counsellor in the office ... just using up space. (This level of frustration has built) after years of expecting to get more than we have received.
- 1.1.14** I think what the social workers were hoping to get and what they got were two different things, that we weren’t going to be giving them the information they wanted. What they expected and what we were, were two different things.
- 1.1.15** I think social workers were really disappointed that we couldn’t do what they wanted us to do. We didn’t have the training to do the assessments they wanted, that’s never been our focus.

It appeared that during the amalgamation process, the newcomer culture experienced an assimilation versus ethnic identity maintenance climate as discussed in the cross-cultural psychology literature (e.g., Cushner & Brislin, 1996; Ishiyama, 1995; Kim, 2001; Novinger, 2001; Ting-Toomey, 1999; Ting-Toomey & Oetzel, 2001). Any potential motivation to acculturate by addiction counsellors was sabotaged when their identity was severely threatened. This stance was reinforced and magnified when the counsellor’s proactive measures to address their concerns were ignored, and their identity continued to not be validated. From both the social workers’ and addiction counsellors’ perspective, social workers became frustrated and disappointed when addiction counsellors failed to provide the service in the manner the host culture had planned. The Ministry did not appear to anticipate the newcomer culture’s

reactions and backlash effect by not taking a more collaborative approach during the amalgamation process.

Sub-category 1.2: Interface between Newcomer, Host and Organizational Culture

Both social workers and addiction counsellors made up subcultures within the context of the Ministry organizational culture. These three cultures interacted with one another and in a reciprocal fashion, influenced each other in a tri-directional process. One culture cannot act in isolation from the other. An organization is “a collection, or system, of individuals who commonly, through hierarchy of ranks and division of labour, seek to achieve a predetermined goal” (Tubbs & Moss, 1994, p. 352 cited in Ting-Toomey & Oetzel, 2001, p.137). Van Mannen and Schein (1979) defined organizational culture in these terms:

Any organizational culture consists broadly of long-standing rules of thumb, a somewhat special language, an ideology that helps edit member’s everyday experience, shared standards of relevance as to the critical aspects of the work that is to be accomplished, matter-of-fact prejudices, models of social etiquette and demeanor, certain customs and rituals suggestive of how members are to relate to colleagues, subordinates, superiors and outsiders, and a sort of residual category of some rather plain “horse sense” regarding what is appropriate and smart behaviour within the organization and what is not. All of these cultural modes of thinking, feeling, doing are, of course, fragmented to some degree, giving rise within large organizations to various “subcultures” or “organizational segments” (p. 210 cited in Landis & Brislin, 1983, p. 51).

According to Handy (1976), variations in organizational cultures can include: (a) beliefs about the way work should be organized, (b) how authority should be exercised, (c) how staff should be rewarded and controlled, (d) how much planning is done and within what time perspective, (e) degree of conformity and initiative considered desirable in subordinates, and (f) individual and collective decision-making processes that operate (cited in Landis & Brislin, 1983).

The participant’s expressions in this category speak to the Ministry’s approach to conflict; procedural systems, hierarchical structure, diversity and managerial style. Eight of the 16 social workers (50% of the social work sample and 25% of the total sample) made responses

related to this subcategory. Thirteen of the 16 addiction counsellors (81% of the addiction counsellor sample and 41% of the total sample) related experiences directly influenced by the interaction between the newcomer, host and organizational cultures.

There were six themes that emerged within this subcategory, which are explored further in the next section: (a) a monolithic organizational culture, (b) conflict viewed as destructive, (c) addiction counsellors perceived as an adjunct service, (d) power imbalance leads to feelings of impotence, (e) replacement versus augmentation position, and (f) positive team experiences.

Monolithic organizational culture. Several participants voiced experiencing the organization as monolithic, a bureaucracy that adheres to uniformity, leading to an inattention to diversity issues (Ting-Toomey & Oetzel, 2001). With a monolithic perspective, assimilation into the organizational framework is expected (Ting-Toomey & Oetzel, 2001). “It is predominantly composed of members from the majority group, members of the minority groups are generally restricted to the lower levels of the hierarchy” (Ting-Toomey & Oetzel, 2001, p. 158). There is little tolerance for differences in procedures and behaviours (Ting-Toomey & Oetzel, 2001). The power and control felt by participants is pervasive in the comment: “We went through ... being told you just do what you’re told to do, you go here and just do what we tell you to do.” This quote echoed many of the reflections shared by other members of the sample:

- 1.2.1 What they did when they got us in here is they told us this is the way you are going to do your job, wait a minute what the hell am I chopped liver, I don’t know anything about addictions, I don’t know how to deliver a service.
- 1.2.2 We’re (Ministry) taking you over, so you’re going to do whatever we want you to do and we’re going to design this however we think. It shouldn’t matter what you say about how this doesn’t work for you, too bad.
- 1.2.3 The management of the Ministry for Children and Families posited we’re saving children; therefore, we’re the most important, and the rest of you just have to do whatever we need you to do. I think that’s the Ministry’s downfall

as to why we're still not in the Ministry for Children and Families. It's because they actually took a universal service, really mismanaged it, and really knocked the hell out of it.

- 1.2.4 I remember when addiction counsellors met with upper management for a meeting shortly after we moved into the Ministry for Children and Families. We were told Addiction Services isn't even a blip on the Ministry's radar, talk about feeling dismissed, and totally unimportant as a service.
- 1.2.5 If you screw up you're damned, you'll be disciplined, you'll have your letter lifted, you'll be treated badly because you are a bad social worker.
- 1.2.6 At management meetings which I didn't enjoy at all ... the manager would come in and do all of the talking (with) everybody else sitting there and listening.

Conflict viewed as destructive. In a monolithic culture, conflict is viewed as destructive and bad (Department of Communication Studies, California State University, 2003). Consequently, the Ministry did not put a mechanism in place to deal with dissension. According to the participants, conflict management was approached through an ethnocentric lens with selective seeing, selective hearing, defensive judgment, impositional self-interest, and coercive power (Ting-Toomey & Oetzel, 2001). From this perspective, the conflict itself was viewed as the problem. The system operated from the position that it should not be adjusted to the needs of its staff, rather the staff need to adapt to the established values of the system.

Participants described the mismangement of conflict in these terms:

- 1.2.7 There was a complaint made about me by a social worker, and I heard about it through the grapevine, but I was totally bypassed. When I went to try to resolve it, I was told, "Well, we don't share that information", what kind of a multidisciplinary team is that, if you're not even suppose to share information about working together with someone, that's really sick and that describes the Ministry, extremely sick.
- 1.2.8 When someone would come and complain about a social worker, for instance, and then someone would complain about the addiction counsellor to that supervisor, there wasn't even a good mechanism for those people to deal with things. Quite often they would go above the supervisor and then there would be upset because the one supervisor would kind of hear about things back from the

person above them, so there were not those mechanisms to deal with things and there was a lot of prickle.

Addiction counsellors perceived as adjunct service to social workers. The addiction counsellors reacted to what appeared to be the Ministry's plan for them to be social workers' helpers. The counsellors noted that they were not perceived as a discipline in their own right, but only as an adjunct service to child protection. As one participant shared: "One social worker told us (addiction counsellors) that we were to meet and figure out in what ways we were going to help them" (quote #1.2.9). Another interviewee related: "Social workers told me that when we (addiction counsellors) were coming, they (social workers) were told we were coming to help them" (quote #1.2.10). The Ministry gave the impression, in the minds of the addiction counsellors, that there was an expectation that addiction counsellors would simply become an appendage of child protection, which created friction and a non-collaborative process. The message heard by counsellors, loud and clear, was the needs of the host culture were most important.

Power imbalance leads to feelings of impotence. In the context of a huge power imbalance between the in-group and out-group, the interviewees reported a sense of hopelessness, impotence and overwhelm. There was a recognition that the host culture was not going to compromise and come toward the newcomer culture and meet in the middle, instead any and all movement had to occur by the out-group. The political ties, unequal power distribution and sheer immensity of the undertaking of integrating these two disciplines provoked these feelings of futility, resignation and overwhelm as noted below:

1.2.11 I decided to stop hitting my head against a wall and move on to other things, do what I can, and then go okay for my own well-being, I'd rather put my energy elsewhere than being walked on We are working in a strategic power dynamic, how can I best serve the person here involved being impotent half the time, and I mean impotent and helpless, so no wonder clients are like that. In the end, my experience ... was that we had almost no power influence.

At the end of the day, the social workers had more power to come in, more power than the police is what I understand and experienced, and so then, it really is about supporting an individual to maintain their own personal dignity. ... I saw that it was of no use for me to start engaging in trying to influence the power dynamic, to just work with the individuals in it, so it was so close to what I call apathy and giving up, and yet for my own well being, I had to withdraw. The system as it is currently is insurmountable.

- 1.2.12** You can yell all you want, but nothing is going to change ... I don't think there's a political will to help children in this country, certainly not in this province.
- 1.2.13** (Prior to amalgamation) we were much more arms length, so we didn't know the social workers, we usually only talked with them on the phone ... and getting information from us was really like pulling teeth. I didn't have much energy or much enthusiasm to change that kind of relationship even though I felt we were too much at arms length from other agencies. I was thinking this is a big kettle of fish and this is a lot of work, so I just didn't want to go there.

Replacement versus augmentation position. In essence, the addiction counsellors seemed to have encountered a replacement versus augmentation approach (Mak, Westwood, Ishiyama & Barker, 1999). This reflects a high concern for self (host culture) and a low concern for the newcomer culture. Participants shared that cultural differences were ignored. They recounted that when there was any deviation from what the host and organizational culture thought should be occurring, an accusation of the newcomer culture being resistant to change was leveled:

- 1.2.14** Everything is subsumed by the Ministry even our mandate, everything, and that's what they're doing with the way they deliver their service. They have a pac man mentality that's let's gobble this up.
- 1.2.15** It's ironic to me that what happened was that the system was imposed on us, and we were told how we should change to adapt, but we didn't really have the reverse - well we really think the Ministry system needs to change.
- 1.2.16** Addiction counsellors started hearing at meetings if we complained about being integrated where we voiced a concern of some sort, management would respond, "You're just resistant to change." ... then I started hearing social workers use that, "Oh well, you're just resistant to change," they wanted us to do home visits with them, kind of have us at their beck and call, and if we said,

“No, we don’t do that or I don’t see that as being useful”, then “Oh, you’re just resistant to change.”

- 1.2.17** Right from the beginning management was saying you are now under the Ministry for Children and Families. We had the impression that they were running the show, and I just better listen because they’re telling me what I’m going to be doing from now on.

Positive team experiences. The successful team experiences noted by interviewees in terms of the working relationships between social workers and addiction counsellors had certain organizational aspects in common: (a) a manager who was committed to the integration process, and working in a multidisciplinary fashion, (b) attendance at meetings by both disciplines was strongly encouraged, and followed up, and (c) a supportive supervisor and a skilled manager who were able to create safety for both addiction counsellors and social workers to open up, and invest more in the process.

- 1.2.18** The case conferences that we had were a positive aspect of being part of a team, actually being able to have input by the manager who understood Addiction Services was a big positive for us. This manager was able, quite subtly, to include us in things, so that was a big positive for us.
- 1.2.19** We had a very encouraging supervisor. We had a team manager with experience in several disciplines, so they had a really good overview. In terms of direction ... that was all there, and I think all the structures were in place to encourage openness, to encourage sharing, to encourage the opportunity to work jointly. I think that was all there.
- 1.2.20** You have to focus on what makes the multidisciplinary team work, and so I think that’s where my experience of working in more than one office is actually kind of useful. I learned that if you do not have the commitment of the manager, whoever is in charge of that team, it’s not going to work, it doesn’t matter even if you had tons of clients in common, it’s probably doomed to failure.
- 1.2.21** At one office, their experience was management sat down with the addiction counsellors and said, “Tell us what your needs are, we want to see how we can bring you into our office.”

Culture needs to be used as a bridge, not as a weapon. Unfortunately, the experience described by the participants conveys that the host system used their culture as a weapon.

Culture becomes a weapon when one party perceives the other side's culture as presenting the risk of forcibly changing the shared and enduring meanings, values, and beliefs that characterize the first party's ethnic group (Ting-Toomey & Oetzel, 2001). In response to this force, the minority culture becomes defensive and uses its own culture as a fortress to protect itself from a cultural onslaught weapon (Ting-Toomey & Oetzel, 2001). The more the majority group uses its culture as a weapon, the more the other will retreat within its cultural fortress (Ting-Toomey & Oetzel, 2001). Elements of culture being used as a weapon and as a fortress are portrayed in the following excerpts:

1.2.22 I was defensive even in the addictions team; I became more defensive because I felt like I needed to. I couldn't be honest about what I like to do, this is my job, this is what I was hired for, this is what I thought I was going to be doing, and now I'm being gradually molded into something else. I think they were pretty successful at disheartening us, and at punching a few more holes in our identity, and taking away our spirit a little bit, our enthusiasm for our work ... part of me said I could care less, why should I try and work harder for an organization that doesn't respect me.

1.2.23 Another thing adding to the nightmare situation because the manager wouldn't back us on anything was one time a social worker wanted me to refer her client to a residential treatment centre, and I wouldn't do it because the client wasn't ready. I wasn't going to put my name on an inappropriate referral. The social worker threatened to take me to court, she said, "If you're not going to do that, I'll take you to court, and I'll rake you over the coals, you're going to defend why the client is not going there."

It appears for the most part that the critical role of process in ensuring successful collaboration was vastly underestimated. The participants revealed that the principles of participation, ownership and power sharing were not fostered by the organizational culture (Gray, 1989). Gray (1989) posited that four elements need to be addressed in order for collaboration to occur: (a) that process issues need to be discussed openly, and agreements sought on how the group will conduct itself, (b) that parties must see a compelling reason to try collaboration, and believe their interests will be protected and advanced throughout the process,

(c) that all parties must be included, and (d) that parties need to know up front the scope of the effort to which they are all committing, since differing expectations can derail the proceedings. According to the participants, their experience did not encompass the above noted conditions.

Sub-category 1.3: Emergence of Cross Cultural Conflict

“Intercultural conflict is defined as the experience of emotional frustration in conjunction with the perceived or actual incompatibility of values, norms, processes, or goals between a minimum of two cultural parties” (Ting-Toomey, 1999, p. 17). The conflict is intensified as each group perceives the other to be interfering with their ability to achieve their goals (Ting-Toomey, 1999). Cox (1994) identifies five critical sources or causes of conflict in intergroup relationships that are applicable for culturally diverse groups: (a) cultural differences, (b) assimilation versus ethnic identity maintenance orientation, (c) power imbalance, (d) competing conflict goals, and (e) competition for scarce resources (cited in Ting-Toomey & Oetzel, 2001).

The struggle between the social worker and addiction counsellor cultures expressed by the participants was largely rooted in cultural differences. All 32 participants shared information related to conflict between the disciplines. Eleven key themes surfaced from the data for this sub-category: (a) differing world views, (b) task versus relational effectiveness approach, (c) sense and use of time, (d) client safety, (e) non-voluntary clients from the social worker perspective, (f) non-voluntary clients from the addiction counsellor perspective (g) counsellors not challenging the client, (h) advocacy versus collusion, (i) social workers’ unrealistic expectations of addiction counsellors, (j) social workers’ lack of understanding of the counselling process, and (k) social workers making decisions regarding the addictions’ piece.

Differing world views. World view is a culture's orientation toward nature, life, the universe, the meaning of life and being (Novinger, 2001). Social workers are statutorily obligated to ensure the safety of children at risk of abuse and neglect. They have a social control function to maintain community standards in terms of child welfare. Their clients are involved in the system, for the most part, on an involuntary basis while addiction counsellors have traditionally worked with people who willingly seek help. From a child protection perspective, goals are imposed by the system, which social workers represent. A counsellor concentrates on client focussed goals and the therapeutic relationship. Participants voiced these conflicting perspectives in the following ways:

- 1.3.1 They (social workers) are an investigative branch, their primary role is investigation and data collection, that's why sometimes I call them data munchers. They would make good police people and that's their role, sometimes they switch it, they are the support role; whereas, addiction counsellors don't have the investigative part, ours is sort of background where we are just sort of analyzing information that's been given to us, so it's a totally different perspective, totally different view of the world. Where social workers get into trouble is when they have power, and they think that everyone should be beholdng to them, giving them data. That's where it becomes dangerous.
- 1.3.2 They're mandated so the client is not necessarily even wanting to be there, probably wouldn't want to be there, most of them. It's the systems' goals that are focal, not the clients which are very different.
- 1.3.3 For the addiction counsellor their reason d'etre, their goals are different from ours, the child protection piece is not front and centre for them. For them, maintaining the therapeutic relationship is front and centre, and there's conflict there, there's conflict between those two goals, I don't know how else to call it outlook, goals, perspectives whatever you want to call it.

Task versus relational effectiveness approach. There were aspects of a collectivist versus individualistic culture described by the participants. Members of the addiction counsellor group related goals of establishing and maintaining strong interpersonal relationships, whereas members of the social worker group leaned toward goals of being efficient and getting the work done (Novinger, 2001; Ting-Toomey & Oetzel, 2001). The

individualists strived to get the work done and finish the task at hand, whereas collectivists were geared towards spending time getting to know one another and building trust and rapport among one another before beginning the work or as part of the work being done (Novinger, 2001; Ting-Toomey & Oetzel, 2001). Task effectiveness in contrast with relational effectiveness was outlined by the participants in the passages below:

- 1.3.4** There were actually some nasty comments ... I actually had one of the social workers come down and sort of interview me a little about where I stood on stuff, and this is a person who was in recovery themselves, and had definite ideas about recovery ... what I heard back was that I needed a harder approach, it was a bit too wishy, washy, and a bit too soft. Instead of that whole engagement process with people at the beginning, clients really needed the addiction counsellor to get to the point and be more efficient. They wanted to refer a client to an addiction counsellor that was really going to get there and get to the point - they've got deadlines those social workers.
- 1.3.5** Within our role (social worker), we are very task and results oriented. We just want to see the parent stop using, so the kids are safe.
- 1.3.6** The younger the child it's almost as if their clock goes two to three times faster than an adult, so that's why our interventions are so quick, and so sudden, and so time oriented.
- 1.3.7** To me, forging relationships with social workers is the number one job, and the secondary job is seeing clients. I come to their potlucks, I try to interact with them as much as possible It's the relationship, if there's some kind of relationship going, then things work smoothly, if there isn't, then all the down side comes up.

Sense and use of time. Related to being outcome versus process focused, is the sense and use of time, as well as the pace of the work. The social workers expressed operating under more of a monochronic concept of time, a linear and sequential approach toward time that is rational, suppresses spontaneity, and tends to focus on one activity at a time (Novinger, 2001; Ting-Toomey & Oetzel, 2001). People are punctual, efficient, and get to the point quickly. Addiction counsellors recounted functioning within somewhat of a polychronic concept of time, which is characterized by multiple activity, a matrix framework of time, loosely

measuring time with the symbols of a formalized system of time (Novinger, 2001; Ting-Toomey & Oetzel, 2001). It is time to move on to the next activity when the current set of activities is completed versus according to a set time that has been allotted (Novinger, 2001; Ting-Toomey & Oetzel, 2001). This approach toward time considers activity more important than the abstract measure of time by a clock (Novinger, 2001; Ting-Toomey & Oetzel, 2001).

The different perspectives regarding the concept of time were evident in the following statements:

- 1.3.8** I was really boggled by how slow they (addiction counsellors) moved. OH MY GOD they were slow I mean I'm in child protection I'm like GO GO GO GO GO GO GO GO GO, and I walk in, and I saw this counsellor one day, as they were thinking about where they were going to place their picture, and I was like WHAT.
- 1.3.9** We're not allowed to have children in care depending on their age groups for over 12 or 18 months, but an addiction counsellor focus is well no it may take someone five years, but from the child protection point of view that's just way too long, so in a lot of ways we can potentially clash.
- 1.3.10** It is about where the client is at. The addiction counsellors I've worked with keep saying well the client isn't there, that's not what they want to do, and we can't just send somebody to treatment who doesn't even think they have a problem, but I'm getting the pressure that we have to come up with a plan.
- 1.3.11** What I had said to some of the social workers was you have this person for a short term with a very specific goal of being in their lives, I might have this person for long term, over years, long after they're done with you, they may not be done with our office. With the whole notion of life supports, I have an interest in that so they're my clients in my eyes. We have to deal with the child welfare issues and for good reason, but there's a larger picture here in terms of where this life and this family goes than your (social worker) context, at the end you're closing, you're done, quite often the clients would stay after the file was closed, the clinical issues go on.

Client safety. A strong concern for addiction counsellors was retaining client safety and being able to build a solid, therapeutic relationship, given they were now integrated with child protection services. Some participants, both addiction counsellors and social workers deliberately avoided joint work because they thought it would not be helpful for the client.

Taking the client perspective, the interviewees described the fear and anxiety clients must be feeling when they are mandated to obtain counselling through the addiction counsellor that is in the same office as their social worker.

- 1.3.12** I think there was that whole issue of not feeling like it was going to be confidential because if we would refer them to an addiction counsellor that was at a different site, they would probably have the feeling that it was going to be a little more confidential. They seem to feel that they had no way of really knowing for sure that what they would be talking about would be confidential because it was your office mate right next door that they were going to see. Clients are generally mistrustful of the system anyway, and when we are at the same site, they would see us as all being part of the larger system, which was a system that was set up to be against them, and to take their children away from them.
- 1.3.13** There were times when the closeness with the social worker clearly affected the client. I had clients who could be really clear with me, and say I just can't trust you, I'll go somewhere else for the stuff that's really bothering me, and I would let them know that that's totally understandable.
- 1.3.14** From the client's perspective of contacting us, I've actually had people tell me that they've postponed seeing a counsellor until their children passed the age where they thought the Ministry for Children and Families would apprehend them. Some of the clients that did come were very reluctant specifically around the issues of confidentiality and being hurt through that, they're very hesitant to come in. Others stated that they were open, ready and willing to work; however, it didn't quite ring solid in their actions, their ambivalence definitely showed.
- 1.3.15** I see clients with a lot more difficulty really deciding whether to go for it and tell what's going on or to keep it secret, and really watching people struggle an awful lot more with that particular issue, which from my perspective is definitely not helpful therapeutically to the clients. ... I think before it was much easier without that whole issue to get clients who are in the throes of their addiction and desperate and they just say I've got to deal with it and do this and just lay it out on the table, but when you throw in that wrinkle of everything you say can be shared and here's the document and you can sign here, we'll be reporting back to your social worker, we'll wind up in court and you'll likely not get your kids back, they are sure going to have a hard time committing.

Non-voluntary clients from the social worker perspective. How to work with the mandated client and whether or not they should be coerced into a therapeutic relationship were

major sources of contention cited by the participants. The social workers wanted parents with addiction and child protection issues who do not think they had a problem to be able to get help. They had a child's life they had to plan for, and the plan was contingent upon the outcome of the parent's substance abuse issues. Often, even though the client did not view their substance use behaviour as problematic, the social worker had community reports suggesting otherwise, which prompted the referral to the addiction counsellor. They needed to provide avenues to the parent to resolve the safety concerns, and needed information from the addiction counsellor to determine if the risk was manageable. The following passage indicated the social workers' frustration and concern when they heard counsellors use the client's lack of readiness for counselling as a reason to not provide individual counselling:

1.3.16 I do get tired of counsellors who say they will only work with the client when they are ready, and you can't do a damn thing until they're ready. Well, hell you have people who have to be ready or they are going to lose their family. There's got to be some tools for working with precontemplative folk, and as far as I'm concerned if everyone shows up at your door ready, your job's half done.

Non-voluntary clients from the addiction counsellor's perspective. One of the fundamental premises in the counselling field is to work with clients who identify a problem and want to change it. The goals and direction of counselling are generated by the client. For the counsellor, this feels like a very foreign endeavor and somewhat on the side of social control, rather than the therapeutic realm. Many counsellors expressed a desire for social workers to be realistic that, for the most part, there is limited success with a non-voluntary client:

1.3.17 The challenge that comes up a lot is whether or not what I'm doing is advancing the interests of the client, so by being part of this mandated system whether or not it's actually benefiting the client, sometimes I think it's not. They're jumping through the hoops, I'm one of the hoops, is that useful to the client - no, are we going through any counselling process - no. Where the client doesn't have anything they're particularly motivated to work on, but

they're here because they have to be here or else they're going to reap some type of consequences, I tell them that this isn't really counselling, and that I would understand if they don't come, and then I leave it up to them. ... the social workers get quite ticked off when I say, "Well, we didn't have anything to work on, they didn't want to come here, so I told them I wouldn't come either."

1.3.18 I don't know how many times I talked about the wheel of change and if the person's contemplative great, but if they're precontemplative, there's not a lot we can do. I had a client call saying, "I have to come in because my social worker wants me to, I don't have a problem with alcohol or cocaine, I made a big mistake, and I went out drinking, and I didn't even drink that much, but I used cocaine, and my kids got taken away," and I said to the client, "If I did a history of use, what would I see as your normal drinking pattern." The client said, "I drink about once a month, a couple of beers with my friends, that's it," so I called the social worker and told the social worker, "That's what I'm going to get from the client, I'm not going to get anything different," and the social worker said, "Well, I'm going to have to check with my supervisor because we thought maybe she'd tell you something she's not going to tell us," and so the expectation is that I will gather information.

1.3.19 I probably saw maybe 20 clients in the five years I've been here that stuck it out, that came for more than the intake, there were 100's that were referred, but didn't show up or showed up for the intake and one session, and that was it, but people who were actually engaged in the counselling process, I wouldn't say engaged in any therapeutic process, only one of them was looking at change.

1.3.20 A satisfying experience working with the social worker is where the social worker realizes that with a mandated client there's very little room where things can happen in that framework, if something more than that happens, then it's sort of gravy, but if there aren't large expectations by the social worker of the client and addiction counsellor, then it is a good experience.

Well meaning clashes. The day to day practice involved with the role of the social worker and addiction counsellor often resulted in "well meaning clashes" (Cushner & Brislin, 1996). These clashes occurred when members of the different groups interacted in ways that each believed appropriate from their perspective and according to their values, but were different from what was expected by the other (Cushner & Brislin, 1996). Specifically, social workers became frustrated when addiction counsellors did not meet their expectations and

needs in the following areas: (a) challenging the client, (b) confusing advocacy with collusion, and (c) knowing if the client was using.

Counsellors not challenging the client. Often, throughout the interview process, social workers shared their frustration with addiction counsellors relinquishing their responsibility to be honest with the client. Social workers believed that counsellors only wanted to be in a support role with the client and did not challenge them with “reality” when needed. The “truth bearing” was left up to the social worker, which always placed them in the role of “bad guy”:

- 1.3.21** Child protection is always dealing with people in the community who don't want to be sullied with nasty protection. They want to preserve their relationship, so they say to the social workers, “Don't say I said this because I want to preserve my relationship,” and then of course the counsellors say, “We want to preserve our relationship.” Everybody in the world tries to get us to be the bad guys, it's a cop out. We all have to take some responsibility to look our client in the eye and tell them what we're doing, what we are going to do, what we're not going to do, why we're there.
- 1.3.22** I'm always the hammer which isn't right. Other professionals, like the addiction counsellor working with the clients, should be telling them the truth, mirroring reality. It would be great, as well, if addiction counsellors took on other functions such as finding housing for the client.

Advocacy versus collusion. Social workers also related experiences of counsellors misusing the role of advocate, crossing over the line to collusion with clients in some instances. In these cases, social workers believed that counsellors had stopped being objective and were not helpful in assisting social workers, rather they were working at cross purposes.

- 1.3.23** There are some addiction counsellors ... that have been advocates for the clients, but they don't have the whole picture, so that's been a problem and a challenge for sure.
- 1.3.24** There is a fine line with the counsellor too in terms of the kind of advocacy role they take. There's been an unspoken tension that has come up a few times, as an example, we have had counsellors go to court and act as an advocate for the client, rather than objectively stating the progress with the treatment plan and

that creates difficulty for our work together. The counsellors can get over involved and not challenge the client, leaving that up to the social worker.

Social workers' unrealistic expectations of addiction counsellors. Frequently, social workers expected the counsellor to know if the client was using substances. Social workers are under pressure to insure the child is safe and want to know if the parent is taking any chemicals. It is difficult for the counsellor to get across that they only see the client one hour per week and have no way of knowing what is happening outside this time period. This is much the same for social workers who do not know if abuse is happening unless they receive community reports. A social worker commented that they question the effectiveness of counselling when the counsellor does not know if the client is using:

- 1.3.25** We've had concerns before with addiction counsellors who've spent time with clients and frankly say, "Well, I can't really tell if they're using or not," and so the fact is the client is going to see them, but we don't know if it is really helping or not.

Social workers' lack of understanding of the counselling process. The aspects of social work practice that created conflict for the addiction counsellors were: (a) lack of understanding of the addiction and counselling process, (b) expectation that the client will be fixed, and (c) making decisions regarding the addiction's piece. The statements below reflected the counsellors' perception that social workers had unrealistic expectations of the therapeutic process:

- 1.3.26** Social workers want to know if the client is changing, as if this happens quickly. Here's the treatment plan are they following it, as if it's some kind of magical treatment plan that once it's etched in stone that somehow they're going to follow that plan. It's just not a very realistic understanding that counselling is not that cut and clean of a process, it's a very kind of clumsy process that you kind of wade through.
- 1.3.27** They (social workers) had the notion that there was some magic with addiction counsellors that they would refer people to get. There really wasn't any magic that we do, there was a process and that had a lot to do with relationship

building and safety. They (social workers) were sorely disappointed that they couldn't refer clients for the magic.

- 1.3.28** Some social workers refer to addiction counsellors, but they would rather just do the referral directly to the residential treatment centre. They don't understand that whole process that it needs to come from the client. They clearly do not understand that you can't just send anybody to treatment.

Social workers making decisions regarding the addictions' piece. Social workers stepping outside their domain of child welfare and deciding the addiction treatment plan was a great source of concern and annoyance for the addiction counsellors. Counsellors and clients were left dealing with a plan that was developed by the social worker who has no expertise in the area of addiction:

- 1.3.29** There was a problem that by the time we would see the client, the expectation list was already made by the Intake social worker who had nothing to do with the integrated team whatsoever. There's not been any input from addictions and mental health about what we think might actually be helpful to the client. We're already seeing clients who've been told they should go to residential treatment centres for instance, which is not helpful because after all we do try to do treatment matching for clients, and yet there's somebody who's already done their investigation, and made their decisions about what the client should do in terms of their addiction piece.
- 1.3.30** My colleague went to an integrated case management meeting. There was a plan in place for the client and the client's social worker just totally dismantled that entire plan without any collaboration with my colleague at all. All of a sudden my colleague is finding out about a new plan, the client was going to be doing this, this and this and now all of a sudden something else is in place.
- 1.3.31** There is an issue of social workers thinking they have some type of expertise in alcohol and drug, and trying to make treatment decisions or recommendations, which is utterly inappropriate. I ignore them anyway, but I find it sort of odd that they even have the grandiosity to think they can do that.

The main areas of conflict between the two disciplines cited by the participants were their inherent cultural differences: (a) worldview, (b) voluntary/involuntary client base, (c) collectivist versus individualist orientation, and (d) sense and use of time. These contradictory cultural underpinnings fueled other domains of dissension: (a) the level of client safety and the

impact on the therapeutic relationship, (b) how to deal with mandated clients, and (c) how the daily practices of social workers and addiction counsellors influenced each other. The core issue exposed was that each discipline has a unique role and relationship with the client, and strong beliefs about the best way to carry out the work.

4. Category 2: Reorientation Theme: How Can We Make This Work

In category 1, the participants described experiencing culture shock; the interaction between the newcomer, host and organizational cultures; and the emergence of cross cultural conflict. For category 2, interviewees depicted dimensions of a Reorientation theme. It was not possible for the disciplines to continue to operate with high levels of anxiety, fear and conflict for an indefinite period without facing serious health and emotional consequences. To avoid detrimental results, members of both disciplines were compelled to lower their heightened emotional state by developing adjustment strategies and forming an intercultural relationship.

Sub-category 2.1: Development of Adjustment Strategies

Within the context of intercultural strife, members of both cultures became very resourceful in creating ways to adapt to the new situation of working together. To a degree, there was a realization that the problems were not due to any malevolent intent by either group, but by a real difference in values, beliefs and behaviours. Each culture had valid reasons for having the perspective they had. Ten of the 16 social workers (63% of social work sample and 33% of total sample) interviewed made comments falling into this category. Twelve of the 16 addiction counsellors (75% of addiction counsellor sample and 38% of total sample) shared experiences related to the development of adjustment strategies. Nine key themes evolved from the data for this sub-category: (a) minimizing contact, (b) coalition building, (c) developing network contacts, (d) leaving the system, (e) social workers using their power collaboratively,

(f) developing concrete strategies, (g) countering the high no show rate, (h) structuring interdisciplinary meetings, and (i) including the social worker in the treatment plan.

Minimizing contact. A coping tool implemented was minimizing contact with the host culture and finding ways to continue to do the job as the addiction counsellor envisioned. The counsellor's office became a safe haven and a means to remain true to their cultural roots:

2.1.1 I decided when I shut my door, I do what I want, that's what kept me going. I told myself no matter what label they put on me or whatever they want me to do, when I shut my door, I'll do what I want to do, and I know that I like the counselling side of it, and that's how I managed.

2.1.2 I would basically try and keep my door closed. It was a sanctuary where I could do the work I wanted to do, and get a reprieve from the onslaught awaiting me outside the door.

Coalition building. Some participants engaged in coalition building and interacting with familiar others. Addiction counsellors formed a cohesive group, promising to help each other advance their interests and defend themselves from force-based strategies of the host/organizational culture. By remaining in contact with familiar others, addiction counsellors were able to reveal themselves and retain a sense of identity:

2.1.3 We pulled together as a team and decided that we needed to have a say in how we were going to be functioning within the multidisciplinary model.

2.1.4 I called a lot of addiction counsellors and kept in contact that way. I could share what I was going through with colleagues who would understand.

2.1.5 I could come in and talk with my supervisor even in a moment, say, "Geez, right now I feel like I am going to fall apart, I'm upset," no problem my supervisor gets that I'm competent, I'll pull together, I'll move through it.

Developing network contacts. Some interviewees described developing their network contacts both internally and externally to the system. This resulted in an increased circle of support the participant could draw upon as needed:

2.1.6 I ran groups with people outside of direct service, so I was away from the stressful environment of the office through the week when I did the groups. ...

the facilitator and I were able to talk things through, they were very supportive and understanding.

- 2.1.7 When I received inappropriate direction from upper management, I went to outside contacts to get direction and support. They were able to help me navigate the system, and keep the inappropriate direction from happening.

Leaving the system. Some participants chose to leave the system or strongly considered it as a way to handle the extreme stress they were under. In one participant's words: "I applied for a lot of different jobs, and I found out that the pay we get is good." Many discontented employees managed to remain and do the job for a while, but when they had the chance to leave, they did:

- 2.1.8 I think it shows how horrendous the problems have been as a result of moving into the Ministry for Children and Families. Those of our colleagues that got the opportunity to retire did so, and I don't think if they hadn't had such a horrendous experience the last few years, they would have chose to leave at that time.

Social workers using their power collaboratively. Using power collaboratively was a means that many social workers employed to help clients not feel so threatened by the power inherent in the social worker role. They considered this to be more of a humane and respectful approach. There was also some thought given to how the social worker and addiction counsellor meeting together and getting clear about how they are going to work together could be reassuring to the client. The premise being that by decreasing the client's fear, they will be more likely to engage in an intervention:

- 2.1.9 I mean my personal approach would be that I would offer people the choice - whatever they choose depending on their readiness to change. Some people might be ready to go into detox, some may just be comfortable to go to an Aboriginal service provider somewhere out in the community, some people might just be willing to connect with elders. For me, those are some forms of the unprofessional social worker or the untrained social worker, and there are many in the community, any choice would be fine, it really depends on the client. I don't think a client should be pushed at all.

- 2.1.10** I like to provide as much reassurance as possible about how we (social workers) want to acknowledge their progress and that kind of thing might help, then again the social workers and addiction counsellors getting together and discussing what they would tell the clients about how they are working together, what would happen with all of the information, what needs to be shared, what doesn't, I think that would reassure the client.

Developing concrete strategies. Reflected in many passages was the adoption of a solution focused approach and developing concrete strategies to manage areas of rub between the disciplines. These tactics point to the adaptive personalities that emerged during this cross-cultural experience. This type of personality is able: to alter the structure and attributes of their psychic system to meet the demands of the environment; to think multidimensionally; to have a high tolerance for ambiguity; and to absorb shocks from the environment, and bounce back (Novinger, 2001). According to Novinger (2001), creative adaptation capacity is the metacompetence for intercultural conflict. Some of the creative tactics employed are noted below.

Countering high no show rate. The following excerpt highlights the participant's resourcefulness with figuring out a way to deal with the high no show rate by developing a group:

- 2.1.11** No shows were a really big issue, in fact a tremendously big issue. It's an issue in our business anyway, but it's much more severe with mandated clients, so we developed a group because of that issue to try to conserve our sessions, and not have all no shows, yet try to provide some service for the client. They could actually start to make some improvements in the areas that they needed to, to satisfy their social worker and to provide the clients with some support.

Structuring interdisciplinary meetings. Integrated case management meetings comprising several professionals can feel unsafe to the client. If an addiction counsellor is present, it is announcing to everyone that the client has a substance abuse problem. A creative way to handle this was to ask certain people to leave when sensitive information came up or to

have the counsellor present for only parts of the meeting:

- 2.1.12** During an integrated case management meeting, if the family didn't want certain participants to know about the addictions issues, the manager would ask the particular parties to leave after a certain point, so that not everything is shared unless the client is very open to it.

Including the social worker in the treatment plan. The multidisciplinary model was utilized by many counsellors as a way to involve the social worker in the treatment plan. If the social worker was included in the clients' treatment plan, then they were much more likely to be supportive, and the client's chance for success improved. The multidisciplinary approach was also a means to help the client navigate the system and have it work for them, rather than against them:

- 2.1.13** It's been good to have the social worker hooked in because if the social worker would buy the treatment plan, when it worked, they were very happy to kind of see anything that was happening. If we could define the treatment plan, which they loved to be put down in black and white, and they could see small progress, which they often could not see with the clients, and I would have to tell them what was progress, this is progress, they're here and this is on the way to there, so quite often it allowed the social worker to see the progress, and kind of also to help them reinforce the client, you've done this, you haven't arrived yet, but you've done these things. I think it helped the social worker if they understood the process of treatment, they could be more supportive along the way if things didn't quite go okay, let's step back, and think now we have a plan, it didn't go well, but we have a plan, and they didn't panic quite so much.
- 2.1.14** What I did do when I perceived that there was some confusion around what the client needs to do or where the client was not developing a working relationship with their social worker, I did everything I could to encourage them to be phoning the social worker, to be seeing the social worker, to be clear in terms of the list of expectations so that the client actually really did understand what was meant by what they needed to do, so we did that.

The participants were attempting to make it work cross culturally. The adjustment strategies involved (a) minimizing contact with the host culture, (b) coalition building, (c) developing network contacts, (d) fleeing, (e) using power collaboratively, and (f) concrete tactics covering a wide range of actions from developing groups to including the social worker

in the client's treatment plan. These strategies, to a degree, enabled healthy working relationships to develop.

Sub-category 2.2: Evolution of Intercultural Relationship

Fifteen of the 16 addiction counsellors (94% of addiction counsellor sample and 47% of total sample) made comments touching on relationship factors. Fifteen of the 16 social workers also had something to say about the relationship they experienced with addiction counsellors. Empathy began to develop, which is the cornerstone of any relationship. To be able to identify with and understand the thoughts and feelings of others, enabled the disciplines to start trusting and taking the risk to forge connections. All of the relationships described by the participants represented different places on a continuum of trust versus distrust. Trust is the single most important element of a good working relationship, and will strongly influence the amount and type of communication, level of intimacy, tension, and openness in a relationship (Ting-Toomey, 1999; Ting-Toomey & Oetzel, 2001). Eight main themes emerged from the data for this sub-category: (a) relationship based on individual personalities, (b) guarded relationships, (c) symbolic injury, (d) limited contact, (e) lack of First Nations counsellors, (f) trusting relationships, (g) one-way relationship and (h) different rules of communication.

Relationship based on individual personalities. A common pattern that emerged was that the type of relationship formed with a member of the other group was very individually based, to the point, in some cases, where there was little to no contact. The connections described in a positive light contained the conditions of equal footing and an understanding of the respective roles. The nature of the relationship was contingent upon the individual personalities:

- 2.2.1** So much of the experience depends on the personality of the addiction counsellor. I've dealt with a few, some of them were quite open to the idea of doing this kind of work, some of them had a great deal of difficulty with it.

- 2.2.2 Generally, I think there's variety amongst the counsellors in terms of what they perceive we do, and how open they are to it. Some are very open to it and have the mentality of trying to work things out. Others are a bit more guarded, very protective of the counselling process, and wanting to keep the disciplines very separate, and that's understandable as well, so it varies.
- 2.2.3 The experience has been so varied depending on different personnel. I think that's the major difference, not so much policy as individuals, and how they work within the system, so it's just been a real range, and I think the level of awareness of the person involved, the understanding of addiction affects the working experience.
- 2.2.4 Some social workers were really good, they really did understand and wanted to work together as equals, as colleagues, they wanted to understand. Others wouldn't let go of that idea that I would be their information report person, and there were actually some nasty comments.

Guarded relationships. When the trust level was low, the relationships tended to be guarded and the tension level was high. A negative encounter with a member of the other discipline would shape the ongoing nature of the relationship. Many addiction counsellors remained distant from social workers as a way to protect themselves against leaking client information. Some counsellors found that the indirect communication styles used by some social workers led to hostile, cool relationships:

- 2.2.5 The social workers are very likable, nice people to work with, but there you had to be really careful, if you were asked a question about a mutual client, I noticed I had to be really careful how I said anything even things that I thought were quite innocuous and no big deal about a client, that somehow turned against the client, and somehow it was a negative. I found kind of like WOW how could someone just twist it like that, that particular experience really actually gave me kind of an insight on maybe how difficult it is to be a client working with us professionals, when I experienced this having to be really very careful about what I said to the social worker. My inclination was to not get particularly all that social, to not get too involved with coffee breaks and lunch breaks with them because it's very easy when you're actually friendly with someone professionally, when they start asking questions like well how's so and so doing and it's your client. I'm talking about how easily it could be to move into a place of sharing information about a client that you really shouldn't, and then with the concern of how that's then moved into maybe sometimes a negative about the client. I just felt that I really had to be careful with these people that I actually liked, which I didn't like very much.

- 2.2.6 I think there was a coolness that developed between us and the hostility was there. We'd get comments like there was one social worker who seemed to be the spokesperson for what was said behind closed doors, and it would just come out of her occasionally, she would say things like, "So, how do you guys manage to have a job where there's no stress," and it kind of came out like that instead of a direct way of talking about it.
- 2.2.7 I'm not saying that all social workers are manipulative, but one thing that I did find is that they'd say one thing to my face, and then I'd find out another thing was said behind my back.
- 2.2.8 I am wondering if that's why I'm not connecting too deeply with the social workers because of the possibility of, "How's so and so doing," just off the cuff, which definitely does happen.

Symbolic injury. Some of the negative relational experiences shared by participants described a form of symbolic injury. A type of coercive action, not physical, used during conflict with the intent of weakening the other group by inducing shame, guilt, and fear (Bartos & Wehr, 2002).

- 2.2.9 In the lunch room, I noticed that we'd all be sitting in chairs, and pretty soon the chairs would be pulled in, there would be a circle then, and I would be on the outside, that was outrageous. ... it happened more than once, and my colleague ... would come in, and see me with all these people (social workers) with their backs to me.
- 2.2.10 My colleague got called into the office because social workers complained that they didn't think she was a good counsellor.
- 2.2.11 When we tried to stand up, say what we needed and what we do, the response to us is that we were really difficult, that we were uncommitted to helping children. The other thing that I thought was just really hurtful is this slant that if you try to stand up for what you do, some social workers would turn it around as if we didn't care about what happens to children, and it's really a blaming, shaming kind of behaviour. I think that was pretty prevalent which also gave me insight as to what it must be like to be a client.

Limited contact. In the majority of cases, as the passages below delineate, there was limited contact between the disciplines due to very few referrals ending up connecting with the addiction counsellor, which precluded shared work. However, it went beyond the difficulty

mandated clients have engaging in treatment. A social worker shared that they did not know the referral process to the addiction counsellor after having worked there for a number of years. Instead of referring to the addiction counsellor in the office next to them, they referred to community service providers. The lack of relationship is evident when one social worker in the passage below refers to their fellow social workers as colleagues, but not the addiction counsellors. It also speaks to the practically non-existent dialogue between the disciplines. In one office, the tension was so great, that the addiction counsellors and social workers would not speak with each other when in the lunchroom together:

- 2.2.12** I would say that the interaction has been unfortunately minimal ... I guess for me it's just not too much clarification as to where the clients are drawn from, confusion about the referral process. I know that the addiction counsellors have their own base of clientele that weren't necessarily also Ministry clients, so I wasn't really sure if I was suppose to have gone through other Ministry channels before going through an addiction counsellor, so that to me wasn't very clear. ... when you don't know something and if nobody tells you, you go to what you do know, so I would go to whoever it was that my co-worker said they had gone to before, it wasn't necessarily the person sitting in the office next to me, it would be something that was say Addictions Counselling Inc., let me give them a call as opposed to knocking on the door, and saying hey let's chat about someone.
- 2.2.13** Basically, I would say that we have never gotten to the point of working in a multidisciplinary way. We each have our functional little roles, and they're still very separate, they've never been integrated. We've never got to that point ever where it has been a working together kind of relationship between child protection and addictions.
- 2.2.14** This one situation is the only one I've gotten involved in and worked on, it's the only piece where I've been able to connect the client with a counsellor. Half the time I may put in a referral, the client will come once, and that's it or they just won't connect or they'll insist on an Aboriginal counsellor, so there's no connection made at all. It's only been the one experience where there has been a connection and a collaborative effort to support the client.
- 2.2.15** I keep my door shut because I am very easily distracted by photocopiers and phone calls and that sort of thing. A lot of the time addiction counsellors do have their door shut and I don't know what their days are like. I know what my colleagues days are like, but I don't know if addiction counsellors are doing work, if they have clients, if they've got deadlines, if they've got group

preparation happening, so I'm not really sure of how free I am to actually go and interrupt whatever they're doing.

- 2.2.16** Maybe a mediator would have helped. There was major bad vibes going on between social workers and addiction counsellors. We wouldn't even talk to each other in the lunch room ... they were sucking for social skills, no social skills and very lofty ideas.

Lack of First Nations counsellors. Another reason several participants noted for the minimal case overlap was there were no culturally relevant addiction services options for First Nations clients. This resulted in many Aboriginal parents with child protection and addiction issues seeking services outside the Ministry. Subsequently, less case overlap occurred between addiction counsellors and social workers in several offices where Native clients represent a large percentage of the clientele:

- 2.2.17** For the Aboriginal teams who only work with Aboriginal clients, it's not been easy because the addiction counsellors on the team are not Aboriginal and most of the time the Aboriginal clients ask for an Aboriginal addiction counsellor, so my experience has been I don't utilize the Ministry addiction counsellor much.
- 2.2.18** Our clients were all Aboriginal and a lot of them chose to go to Aboriginal counsellors through Aboriginal agencies, they would prefer to go there.

Trusting relationships. Some social workers and addiction counsellors characterized their relationships as being close and positive. It seems they were able to achieve this state because there was a high level of trust, high level of contact and intimacy or sharing of feelings. Systemically, there is no mechanism for social workers to disclose openly about their feelings regarding their role. In some offices, addiction counsellors would facilitate this type of sharing amongst social workers:

- 2.2.19** The addiction counsellors would be there to help the social workers process their feelings, so in that way I became quite close with a number of social workers, and that was real nice for me.
- 2.2.20** We've had pretty close ties with the addiction counsellors. We met regularly in an interdisciplinary team where we could do case consults, so that was

really good. I think that was really beneficial and the addiction counsellors were in the same office as us, so it was easy to do some informal consultations.

- 2.2.21** Actually, from what I've heard from other networks, I think our counsellors were a bit more open in sharing information than other addiction counsellors were. They weren't as hesitant about sharing information. I think they trusted us in terms of how we were going to use the information, they knew we weren't going to use it against the client or negatively, they could be open about sharing any of their concerns.
- 2.2.22** Developing a relationship with protection workers has been good. I can talk to them, that's been a good part, so awareness of what kind of job they have and how much addiction is a part of that work and developing a rapport with protection workers that I didn't have before, so that part has been positive.
- 2.2.23** I know working with one addiction counsellor attached to this team, they have been quite open. ... they've really appreciated knowing more about child protection and what it brings to their practice that they didn't in the past, that it was all new to them too, but I think they were open, very open to learning and working together.

One-way relationship. All of the social workers interviewed saw the connection with the addiction counsellors as a means to get the information they needed to function in their role as child protection social workers. A few participants pointed out that the relationship between the addiction counsellor and social worker was unique in that it was not reciprocal with a give-and-take interaction that most relationships would possess:

- 2.2.24** I think it is pretty much a one way street kind of relationship. We're asking for information from the counsellors, we're the ones using their services, it's not like they refer to us, so in a sense it's kind of a one way relationship. They're helping us basically, that's how I see it, but it sure helps us do our job of assessing risk and determining whether a kid can go back home etc., it sure helps and it's quicker when you have someone right here in the building.

Different rules of communication. There are different rules attached to communication that each discipline follows, but that the other group is not aware they are breaching. A source of friction for some addiction counsellors was social workers sending emails, rather than coming and speaking with them directly. Addiction counsellors tended not

to recognize that social workers sending electronic messages and talking about clients in hallways, file rooms and lunchrooms was the result of the fast pace their job entails, and the need to debrief and consult as the opportunity arises. The nature of the child protection social worker's job often prohibits organizing set times through the day to speak with fellow colleagues about their caseload. They find time to do this on the way to doing something else, grabbing a file while eating or discussing a case with a colleague they've passed in the hallway. On the other hand, addiction counsellors have been conditioned to only talk about clients in a way that maintains confidentiality, a closed office for instance. Addiction counsellors have more of an opportunity to orchestrate this. Also, for self-care counsellors want to have some down time from discussing clients, and when they walk into the lunchroom and hear case discussions, they do not want to participate. These different communication styles were reflected in the following statements:

- 2.2.25** I have social workers here that will email me rather than walk down the hallway, what do you do with that, it's not right to go yell at them.
- 2.2.26** Being in the same building often really valuable discussions come about in our lunch room or in the hallway or file room, and you can just consult about a family or whatever. Great conversations come up and again that is about getting to know the other person as a professional.
- 2.2.27** Even collegially, the addiction counsellor never felt all that comfortable in having lunch even in the private areas because they're (social workers) always talking work, they couldn't and they wouldn't observe those kind of boundaries.
- 2.2.28** I avoid talking in hallways about clients or the lunch room. When it comes to clients, it's a more formal kind of relationship. It's a bit categorized now, there's sort of how I relate to them (social workers) without clients and with clients; the two are different, one's more rigid, and the other relaxed, they sort of don't appreciate that.

Overall, the kind of relationship cultivated between the ingroup and outgroup depended on where it fell on the distrust versus trust continuum. The more distrust within the

relationship, the more distance, separateness, tension and guardedness were present. The more trust involved in the connection, the more positivity, closeness and enjoyment experienced. There were some differences culturally in terms of methods of communication. Interestingly, these barriers were overcome if trust had developed. When group members felt at ease and could be themselves without fearing how the relationship would affect their role, they were able to forge healthy working relationships.

5. Category 3: Adaptation Phase: Positive Aspects of Inter-Cultural Conflict and Current Status

Thus far, the participant's experience has involved dimensions of a Transition theme and Reorientation Theme. The interviewees also described facets of an Adaptation theme. The newcomer group bringing a foreign culture affects the nation that receives them, even while the host culture in turn reshapes the newcomers (Lederach, 1995). The newcomer culture retains some of their basic native acculturation while partially adapting to traits of the host culture. Some perceived benefits of the amalgamation begin to surface. However, the advantages to integration were limited, leaving the disciplines continuing to operate in large part as separate entities. Several impediments were identified by participants that blocked mutual acculturation.

Sub-category 3.1: Perceived Benefits of Amalgamation

At this juncture, members of the ingroup and outgroup recognize some of the positive aspects of cultural dislocation (Ishiyama, 1995). A pluralistic perspective develops which increases personal flexibility, and expands one's cognitive and behavioural repertoires (Ishiyama, 1995). "There is a reorganization of self from closed to open, from rigid to flexible, from intolerant to resilient, and from habitual to creative" (Novinger, 2001, p. 44). In essence, members transcend some of the binding fetters of their cultural norms and rules and adapt their role somewhat to fit the new cultural paradigm.

Fourteen of the 16 social workers (88% of social work sample and 44% of total sample) and 15 of the 16 addiction counsellors interviewed (94% of the addiction counsellor sample and 47% of the total sample) had experiences depicting this sub-category. Participants described 14 salient themes related to perceived benefits of amalgamation: (a) forming superordinate goals, (b) client benefits, (c) clarity regarding treatment plan, (d) pooling resources, (e) professional benefits, (f) increased understanding of each other's roles, (g) adapted counsellor role as a buffer between client and system, (h) mediator, (i) balancing the situation, (j) supporting the social worker, (k) transformations, (l) treating mandated clients, (m) identified client shifts from the parent to the child, and (n) placement of multidisciplinary experience on continuum of integration.

Forming superordinate goals. Overtime, after experiencing different surface behaviour, parties were able to see they both have similar goals, just different ways of getting there. They were able to transcend the immediate goals of the situation and find an overarching common goal (Ting-Toomey & Oetzel, 2001). The two disciplines on a conceptual level, found a joint purpose and rose above the dissimilar orientations, norms and values. By focusing on superordinate goals, the groups were able to move forward and find a way to work together without feeling as though they were betraying their values. As the passages below delineate, both social workers and addiction counsellors wanted the families to function better and for the child to be safe; to support the client to become healthier; to find a way to make it work for the client, and as a result of the work to have a positive effect on society.

3.1.1 No matter what our differences are, we have the same goal in the end, to support the client to get healthier.

3.1.2 The client can see that you have respect for your colleagues and they're not the bad person. You're not spending the time in your session going, "Oh yah, what did that social worker say," the whole idea rises above that and it's about how

can we make this work for client. Once they can buy into that, then I think you've taken away at least a source of blame for the client.

3.1.3 To work collaboratively, I think means for the good of the client and for the good of society, family and the child.

3.1.4 The Ministry for Children and Families was always very clear that they were working towards integration, that was the overall model, so there was no conflict around that. We all had a sense that that was the common goal we were working towards.

Client benefits. It is a big step when clients can be seen to be benefiting from the multidisciplinary model, given the huge concerns expressed by both disciplines about client safety. The worry that clients would not be able to engage in a therapeutic process, given the close proximity of their social worker and the very serious potential consequences. After working together for a while, some positives the clients were experiencing were acknowledged by the participants: (a) clients had much quicker access to addiction services, (b) it was very convenient for the client to be able to deal with both the social worker and addiction counsellor out of the same office, (c) the most urgently in need were now getting service, (d) there was more chance of follow through with both disciplines working in close quarters, and (e) social workers could facilitate supportive connections to the addiction counsellor:

3.1.5 More families are getting service. ...the families who do get in contact are the ones most urgently in need. ... it's the population I guess that have pretty urgent needs with the welfare of children involved, and my guess is more of those people are getting service.

3.1.6 I think from my experience the one benefit, and I do the front line investigations, is if I have to go out to a home or if I have someone in my office, and we've identified some serious concerns around addictions, and I'm saying to the parent okay we've identified this perhaps your children have been removed, here's what you need to do in order to reduce that risk and one of them is to seek out addiction counselling, it's great for them to have easy access to the service, it's a matter of walking over here and making the appointment because sometimes if that wasn't there, they may go home, think about it some more, and not show up.

3.1.7 I mean there is a benefit and convenience for the client to come and see their addiction counsellor and then to get their bus tickets, they just have to go across the hall, so that was good. I also think there were some people that had access to counselling that wouldn't have previously, the social worker facilitates contact with the addiction counsellor by introducing them to the addiction counsellor because the addiction counsellor is onsite and that sort of thing. There could be a supportive connection if someone already had a good relationship with their social worker, and the social worker introduced the client to the addiction counsellor, it eased the connection. I thought that was beneficial.

3.1.8 I think they get access to us a lot quicker because we were forced to take them on as clients, and it enabled contact with previously unreachable clients.

Clarity regarding treatment plan. Clients are often involved with multiple professionals who do not communicate with each other resulting in confusion. The multidisciplinary model afforded the two disciplines the opportunity to meet as needed with and without the client. This facilitated clarity regarding the treatment plan and risk reduction plan, as well as each professional's part in the process. It also prevented triangulation of pitting one party against another, if intentions were on the table. By everyone knowing who was involved and their purpose, services were not being duplicated and clients overserved:

3.1.9 The integrated case management meetings were good for the client because they could clear up mixed messages or miscommunication about what we're all doing and what's going on.

3.1.10 They've got a one stop location, so often clients aren't getting over serviced by needing to go to too many places at once.

3.1.11 Clients can play one professional against the other, which isn't helpful to them. ... with a multidisciplinary team, everyone knows what page we're on and whether we're on different pages or not. The client can also be there, hear everything that is said, and can say what they need to.

Pooling resources. There was recognition that working with another discipline meant the resources of each could be pooled and accessed. Previously, clients would have been working with the social worker or addiction counsellor in isolation and only had access to what

was in the particular professionals' arsenal. In the context of the multidisciplinary model, they benefited from two spheres of potential resources:

- 3.1.12 Collaborative work could happen because social workers had resources that I didn't have. It was always nice to be able to say, "Can you do some extra funding or can you provide some child care because this person is really working hard on their recovery, and a little bit of just basic support would be great."
- 3.1.13 Social workers have access to more services that we sure don't have, don't even know about half the time, so that was also sometimes a benefit.

Professional benefits. The benefits observed did not only apply to the client realm, but extended to the professionals as well. Multidisciplinary work was found to be very professionally enriching. It helped social workers and addiction counsellors to have a much broader view beyond their area of expertise, which improved their practice and ability to carry out their respective roles. Many participants described utilizing the other discipline in a consultative capacity:

- 3.1.14 If I look at my practice, I probably work a lot better with addiction counsellors now than I did at the beginning. I feel more confident that it's not up to me to change somebody. ... I think okay it's their journey, who's to say what that will be, and I think maybe you're doing them more harm by pushing them where they are not ready to go.
- 3.1.15 I think professionally it's enriching because you have somebody you can ask questions to. ... social workers have very basic training in addictions and in terms of different drugs, what they sort of cause, and how they effect them (and) their parenting and relationships, so it's good to have experts on site that one can refer to I think that is a great aspect of the multidisciplinary team.
- 3.1.16 I think ultimately their strength was consultative capacity. I could talk to the addiction counsellor about what was available, what treatment was around, what I could expect to see by way of change with the client because of the model they're using, and it's different stuff from what we know, so I think it was very educational in terms of supporting a client.
- 3.1.17 A benefit would be that you can just drop down the hall and ask a social worker what's the date that they need something by or how to work with them in their system.

- 3.1.18** Another benefit to having a counsellor on site is the ability to problem solve, to check out available resources, what might be appropriate and even to let them know that a client has been trying to get a hold of them, would they mind calling the client or giving a new number for the client.

Increased understanding of each other's role. Another area of professional enrichment was the social worker becoming better informed about Addiction Services. The understanding for each groups' role grew, evolving into better practice. Supporting one another more meant clients were receiving improved service. Developing in tandem with becoming more informed about the other discipline's function is an appreciation and respect. The following quotes illustrate how addiction counsellors and social workers were able to start valuing one another:

- 3.1.19** Working with the addiction counsellors was really good because we learnt so much about what they did, we could support what they did and they learnt what we did, so they could support what we did. I think we all worked better as a result of knowing more about one another's discipline. Even from an informational stance, it was so helpful. We only have the experiences of what we've gone through, so we have a real wealth of resource information from the other discipline.
- 3.1.20** We shared with the addiction counsellors how beneficial it was for them to be here in terms of working with them, in terms of the groups they were running.
- 3.1.21** It's been an eye opener in terms of my becoming aware of what protection workers do, the issues that they face, the amount of addiction that they see.
- 3.1.22** I think it's helped me to understand social workers more because I also understand what time pressures they're under. There's nobody you can paint with a black brush, everyone is dealing with extremely difficult situations with lots of pressure and danger. I think working with them has brought it further home to me.

Adapted counsellor role as a buffer between client and system. Addiction counsellors adapted their role in the new culture in an effort to find a place to fit, to figure out how they could belong, and ultimately to meet the needs of the client. One role was to act as a buffer between the client and the social worker and the system. Addiction counsellors thought

it would be important to change the punitive feel clients associate with the Ministry for Children and Families and to help make the system work for them:

- 3.1.23** I've got an urgency around that there could be a change to the framework they're (clients) working on, so making their contact with the system as welcoming as possible and being effusive enough that it takes away from the punitive feel somewhat.
- 3.1.24** I think any kind of contact the client had with most of the addiction counsellors I know would be respectful. ... I think for the most part, we are very respectful of people, and so it would be a good thing for the client to experience someone in the system as being respectful of them.
- 3.1.25** It was helpful for the social workers and for the client when the addiction counsellor educated the client to take the treatment plan to their social worker and show them what they did. The social workers would be very pleased like this is a good thing what you're doing ... they could get a little power out of that, so I could see that once it worked, and if people could buy in and support the client, then it was a pretty good thing.

Mediator. To keep the lines of communication open between the social worker and the client, the addiction counsellor acted as a mediator when they were moving in a direction that would close down dialogue:

- 3.1.26** During a case conference, I felt my role became kind of mediating between the social worker and the client. There was so much bitterness and hostility both ways between the social worker and the client that I really was a mediator, otherwise it would have escalated so badly. ... it wasn't my job at all, but if I didn't do something, it would have been a disaster. I just feel whoever has the skill to help, it's up to them to help.

Balancing the situation. When the social worker was directive, the addiction counsellor could put more balance into the situation by taking a collaborative and advocacy stance with the client. The addiction counsellor ensured that positive aspects of the client's situation were made known. The social worker is focused on potential risk factors:

- 3.1.27** (When) the social worker is quite heavy handed and quite directive towards the client, being in that situation is awkward because first of all you want the client to be able to come on a voluntary basis ideally, but not to be in a situation where there's already a power differential. It's a bit difficult being in that situation because the social worker present has clearly referred the client, and

sometimes some of the meetings are very directive, and it's clear that the social worker has the expectation that the client has to come to so many sessions, has to do that, and that's very difficult, especially if that's your first meeting with the client. They're feeling so undermined and put down, to try to put some balance back into that situation and say, "Well, we're only down the hall, this is what we can offer, and we can talk about a lot of issues that have contributed to this," but it's always difficult.

- 3.1.28** At integrated case management meetings, addiction counsellors have very clearly got very positive things they can say about the client that they are aware of around their particular role and around their service, which can balance the negative information the social worker is putting out related to risk.
- 3.1.29** It was a benefit for clients because if we had a good relationship with the social worker, we could kind of say, "Come on give them a bit of a break here maybe there's this circumstance or this circumstance that needs to be looked at or to be understood or to be considered in this contextual person's life," so trying to be an advocate for the client is a lot easier when the client's social worker actually knows you, respects you.
- 3.1.30** I found social workers to be more open when I would advocate for a client, more open to support, more willing, in most cases, to see some of the other aspects of the client's life, not just the drinking or using, being able to help with other stressors, putting in other supports.

Supporting the social worker. Some addiction counsellors adjusted their role in ways to support the social worker. One of the tasks a child protection social worker has is to develop expectations the client has to meet in order to have their child returned or to remain in their care. In addition to doing joint treatment planning, this addiction counsellor made part of their role to assist social workers with devising the list of expectations:

- 3.1.31** I have had some very good planning sessions with social workers ... where we would plan together some type of a treatment plan basically for this particular person, so that was helpful. ... I could support them in their coming up with expectations of this client where I could suggest some things that would be part of a treatment plan, and they could make them part of their supervision order.

Transformations. There were areas revealed by the participants reflecting not just shifts or changes, but transformations. For some of the interviewees, the act of acquiring something new also involved the act of losing something old (Kim, 2001). They were not

simply adding new information to old repertoires, but adopting new responses. Some of these internal transformations for addiction counsellors involved the treatment of mandated clients and who was perceived to be the client which are described below.

Treating mandated clients. Prior to Addiction Services entering the Ministry for Children and Families system, the policy was to only work with individuals who were identifying substance abuse as a problem. The new organizational culture expected that addiction counsellors would see precontemplative clients. After time had elapsed, some participants viewed this shift favourably. It meant that more effort and programming would be focused toward very hard to reach clients:

3.1.32 I mean the good part about coming into the Ministry for Children and Families was that it forced me as a worker to take a look at delivering service to mandated clients that they were requesting and that's good, I mean it sort of broadened my abilities somewhat. ... they want me to deliver service to people who don't want the service, now what do I do, okay well you start to think about how will I go about this.

3.1.33 As a result of Addiction Services moving into the Ministry for Children and Families, it did remove some barriers for clients, Alcohol and Drug Services had to look at why they had these barriers up and remove some of the them, we started seeing precontemplative clients.

3.1.34 I know the Addiction Services system before had a lot of barriers. ... I think we needed to make changes, I don't know if this was the best way to make the changes, but it definitely got the point across that there was a whole group of people we weren't providing services to. I think it helped ... addiction counsellors take a look at what they were doing and how they were ruling people out, not working with people who actually needed help

Identified client shifts from the parent to the child. Being part of the multidisciplinary team, helped some participants become more secure in their roles. It forced professionals to sort out what their part was and to value the service they were able to provide. A major alteration disclosed by one addiction counsellor was from considering the client as the

person in the counselling relationship to seeing the child as the client. This led to a big impact on how their role was carried out:

3.1.35 I think it's made me more secure in my own job and in my part of the whole helping model. It's made me a little bit more secure in that I know that I've got something to offer them and that I don't have to do their job ... professionally speaking, I think it's been helpful to say this is who I am, this is what I do, can I help you, can I offer you some of the services that I can provide, that's become clearer too as the journey has gone on.

3.1.36 I guess another learning for me through this experience has been that whole concept of putting the child first, the child is my client, my primary client and that's been an interesting shift for me. Even in terms of confidentiality, I don't feel that I have to protect the information that the client gives me as much as I use to because it's the child that I'm concerned about.

Placement of multidisciplinary experience on continuum. Participants were asked to place their multidisciplinary team experience on a continuum of integration; see Appendix N. The continuum has four points starting with cooperation moving to coordination to collaboration and lastly integration. Moving down the continuum symbolizes increasing shared decision making and infrastructure. Interviewees whose experiences reflected third culture development had this to say about their team's placement on the continuum:

3.1.37 I would probably say collaboration, a bit of integration, ... I think we integrated as well as we could on our team. I think we had one of the most successful outcomes in the area. I saw addiction counsellors not just as a professional, but as my colleague, co-worker. We felt comfortable sharing information and our manager really pushed for integration.

3.1.38 We just started to get where we were collaborating, but it wasn't regarding shared cases. I think we still collaborated, what can I do with this particular case, what's there, what isn't for this person, so consultative capacity was fully there. I found it very interesting to see different styles and how people worked and where people were coming from even if it wasn't complete overlap of cases, I learned a heck of a lot. I knew I could go and the addiction counsellors were resources and for me to go down the hall and just talk to the other professional instead of playing telephone tag for a week. We got to know one another and I think that was really helpful too, we knew where each other was coming from.

3.1.39 With some of the social workers ... it moved all the way from cooperation, coordination, collaboration and integration and I would be consulted in terms of the decisions ... there are a lot of decisions where I would have input i.e. are we going to give increased visits here or fewer visits, what would be helpful in terms of moving the client along, sometimes you need to reinforce the idea that you've got to clean up or your visits are going down, this is the stick, other times you need a carrot, you're trying so you get some increased visits. Social workers are, for the most part, trying to make things work.

The disciplines perceived some benefits as a result of working together within the context of a multidisciplinary model. A process of unlearning and new learning occurred. The ability to suspend or modify a group's cultural ways to creatively manage the dynamics of cultural differences was applied (Novinger, 2001). The disciplines developed some empathy for the other groups' situation. Advantages for both the clients and professionals were identified. Counsellors were able to adapt their role in the new environment to assist the client and social worker further. In some instances, major transformations occurred with counsellors promoting service to mandated clients, being more open with providing information to the social worker, and a counsellor viewing their client as the child, rather than the parent with the substance abuse problem. These perceived benefits are positive, but limited given most of the work still happened separately.

Sub-category 3.2: Current Status as Separate Entities

Even though some benefits of working together were experienced, most interviewees stories reflected that the disciplines were, for the most part, operating as separate entities. When interviewees were asked to define collaboration, they were clear about what that would look like for them, but only on a conceptual level because it was not the reality of their work experience. A continuum of integration was shown to each participant; see Appendix N. Most interviewees placed their team at the left end, meaning there was little shared decision making

or infrastructure. This reflected the minimal joint work that occurred between social workers and addiction counsellors.

In many offices, the disciplines did not participate in meetings together. In other offices, where there were shared meetings, they were not structured in a way to promote collaborative working relationships. Predominantly, addiction counsellors did not have any input regarding decisions about clients where substance abuse was a major concern. Some participants did not think families were receiving better service as a result of child protection and addiction services working together. All participants had experiences that fell into this subcategory.

The following eight main themes are described hereunder: (a) conceptualization of collaboration versus reality experienced, (b) placement of multidisciplinary experience on continuum, (c) team experience needs to remain at cooperation or lower, (d) minimal joint work, (e) power imbalance interfered with joint work, (f) team experience past cooperation not reflective of joint work, (g) unidisciplinary decision making, and (h) families not receiving better service.

Conceptualization of collaboration versus reality experienced. When the participants described what working collaboratively means to them, the major components involved: (a) respect for each other, (b) trust, (c) joint work with the other professional and the client to determine their needs and how to meet them, and (d) sharing expertise. On a continuum of integration from cooperation to coordination to collaboration to integration, representing increasing shared decision making and infrastructure moving down the continuum, interviewees were asked where they would place their work experience. For some participants, their teams did not make it on to the continuum. One participant's definition of collaboration was as follows:

3.2.1 Working collaboratively means I respect myself, I respect them (the other professional) and I expect them to do the same, so it's about that sort of self-respect and feeling respect for the other person, and talking about trust, how do you get to that place, it may take a while, but once you get there then you can work collaboratively, then you're not thinking I wonder if they're going to think what I say is stupid ... you can't just shove people together and expect it to work if you're going to create a collaboration.

The above participant described how their team was actually functioning:

3.2.2 The work between social workers and addiction counsellors isn't even on the continuum. It's not anywhere near there. It's pre-cooperation whatever that is. How about reserved politeness.

Another interviewee's idea of collaboration:

3.2.3 It would be figuring out what the client needs, who can meet those needs, how to break those down as to who does what, and also with a client collectively, so they know you are working together, they know who's going to do what piece, and in fact I think it would be really important to come up with an understanding of what information would be shared.

Their experience of working on a multidisciplinary team:

3.2.4 I think the potential is really good. The multidisciplinary team was an experimental thing and the overlap of cases was the critical part of it, and that certainly didn't happen.

The definition of collaboration was put forth by another participant as follows:

3.2.5 Team work comes to mind, multidisciplinary so we have people from different backgrounds and experiences working together sharing their expertise to come up with a specific treatment plan to help the client realize their goals.

The reality of the above participant's multidisciplinary situation is described in the following quote:

3.2.6 There is no joint work happening that I am aware of ... I don't even think we made it on to the continuum. I can only say that we're moving towards cooperation, I can see that shift.

Placement of multidisciplinary experience on continuum. Based on the total sample,

seven participants placed their team at pre-cooperation, eight at cooperation, eight between cooperation and collaboration, three at coordination, four between coordination and

collaboration, one at collaboration and one between collaboration and integration. This means that 26 participants placed their team experience at coordination or below on the continuum (81%). The 19% of participants whose teams worked beyond the cooperative level were reflected in the “Limited Third Culture Development” sub-category. Below are passages depicting their team at either cooperative or a lower level:

3.2.7 I don't even know if we are marginally cooperative. We can all be nice to each other just in terms of being people, but in terms of the working relationships, I would say pre-cooperation.

3.2.8 This one situation (case) is the only one I've gotten involved in and worked on, it's the only piece where I've been able to connect the client with a counsellor. ... there hasn't been enough overlap of cases for us to have made it onto the continuum.

3.2.9 In the first office, well before cooperation; in this office, to an extent, there is cooperation, but it's very one sided with addiction counsellors doing most of the cooperating The first office would be somewhere before the continuum like dysfunction or I would say uncooperative, and then you move along to cooperation to coordination to collaboration, so in the first office we were in dysfunction, uncooperative and hostile.

Team experience needs to remain at cooperation or lower. Some participants acknowledged that they did not want the working relationships to move past the mid-point of the continuum. They were satisfied, for the most part, with it remaining in the cooperation to coordination juncture. They did not see it as beneficial for the multidisciplinary teams to be working integratively:

3.2.10 I would put it at the cooperation level. I am not sure I would want it to move any further down the continuum.

3.2.11 I don't know if we could ever actually be considered to be totally integrated because you've got this information about the client that you're not going to share. ... if you were to be that integrated, then you would be ethically incorrect. I don't see from an ethical end how you could actually be integrated in that regard that would be like me sitting there with my client's social worker and just literally talking about whatever the hell the person talked about in my session, and they're not counsellors. If we were to do that, then we don't

actually have an addiction counsellor anymore, the client has two social workers.

3.2.12 I think we had a long way to go to achieve full integration, but then I think that maybe to achieve full integration could have been at the expense of being specialists as well within our field. I don't know if it would have ever been possible to be fully integrated when we have very different mandates, but we described ourselves as an integrated team. I think it got as good as it could have got. I don't know if we could have really gone much further along the continuum than we did, so somewhere between coordination and collaboration, and that's as far as we could have got otherwise I think we would have been compromising ourselves.

3.2.13 I don't think we would have wanted to move further down the continuum because of confidentiality. I don't believe it would be beneficial for the client. I think they would feel that there's a lot of things they wouldn't be able to share with the addiction counsellor that we the protection workers may have access to, especially when it has to do with legal matters. If protection workers can get a hold of certain information, I think the addiction counsellors would not be able to get fully into the therapeutic treatment that they need to do with clients.

Minimal joint work. Most of the participants found that there was very little joint work. The social workers and addiction counsellors continued to work, for the most part, separately. There were very few cases that the disciplines shared due, in part, to the sometimes low referral rate, and very few referrals ending up connecting with the addiction counsellor. Even when there was case overlap, addiction counsellors were often not part of meetings regarding these clients:

3.2.14 I could probably count the number of joint cases with social workers on one hand in the past five years because I think I may have had at the most maybe ten discussions with social workers about specific cases where we were actually planning a treatment plan, and then maybe preparing some kind of a supervision order. I've had a lot more quick conversations with people, informal stuff, but actual sessions like that maybe ten over five years when I think back on it.

3.2.15 Multidisciplinary work never really happened with any of my cases, I mean it could be helpful, but I think of all of my clients that I actually referred to an addiction counsellor in those two years, I think there were two referrals that ended up seeing an addiction counsellor if I remember ... I think I had one joint meeting.

- 3.2.16** I would like to be involved in case conferences with clients that I'm involved with. I have been involved once in a case conference.

Power imbalance interfered with joint work. Another reason for the limited collaborative efforts or joint work between the disciplines cited by the participants was due to the power differential between the social worker and the client, as well as the nature of their role. For instance, this counsellor did not think it would have been appropriate to run groups together:

- 3.2.17** Social workers want so much to be helping the client and I think they have to acknowledge the power imbalance and the threat their role signifies if you're going to work with that client group. Social workers denied this power differential to the point where they wanted to do groups with us, I don't know how good that would be.

Team experience past cooperation not reflective of joint work. Even participants that placed their team experience past coordination on the continuum, did very little joint work together, operating separately for the most part. Some of their accounts reflected a shared infrastructure such as interdisciplinary team meetings and integrated case management meetings, but not joint work:

- 3.2.18** We're probably between the coordination and collaboration stage still because there is that rapport building and understanding of how one works with the other discipline, but not in terms of case overlap or joint work.

- 3.2.19** I would say probably it's between coordination and collaboration. We're not yet collaborating, I think we are coordinating, I think we're moving towards collaboration. There's more work to be done in terms of how that would actually be fleshed out. ... I don't know why we still have so few protection clients, I mean that's still a little bit confusing to me because of the small number of clients that we have. I don't spend a lot of time thinking about work with Ministry clients. The majority of my work is still with people who don't have protection issues.

- 3.2.20** There's been some joint work when the social workers contacted us and wanted some input around how the counselling was going for example for the child protection review that they have to do. I think there's a section on their assessment where if there's any collateral agencies, they need to contact them and there's things in there that they need to know about. I think on the whole as

well social workers have generally asked for usually verbal feedback, sometimes actual reports, which they've had access to, other than that I can't think of any real joint active work.

Undisciplinatory decision making. Social workers continued to make decisions in much the same fashion as they did prior to the transfer of Addiction Services. Primarily, they did not consult the addiction counsellors when planning for families with alcohol and drug issues. The Ministry for Children and Families' report entitled, "Practice Guidelines for Assessing Parental Substance Use as a Risk Factor in Child Protection Cases (August 2001)" indicated that social workers make the ultimate decision regarding a child's welfare:

3.2.21 I would say in the early stages of cooperation because there's no shared decision making at all. When there is a discussion about what to do with clients, I'm never a part of that discussion, yet I know alcohol and drugs is very much a part of the picture.

3.2.22 There is no shared responsibility with the addiction counsellor, there is no input from them regarding the letter of expectations.

Families not receiving better service. Some interviewees did not believe that families were receiving better service as a result of the multidisciplinary model. The comments they made suggested that very few mandated clients ended up engaging in a counselling process; many went to outside agencies, rather than see the government counsellor; and that many potential clients stayed underground because they were afraid to approach the Ministry for substance abuse counselling:

3.2.23 I think for them to receive better service, they'd have to be treated more holistically by their social worker in the first place. Maybe there's the occasional client that got better service just because they took advantage of actually having an addiction counsellor onsite, and were willing to actually make some life changes On the other hand, I think of all the people that were afraid to come and see us that might have seen us before, so where we gained for some people, we lost big time for others.

3.2.24 I don't think families necessarily received better service, well I mean just in direct reflection on my own caseload that I had at that time, the families that I was working with, the parents in question, the clients that did good work with

dealing with their addictions went through more traditional healing methods outside the Ministry because of their Aboriginal status.

The experiences shared in this section characterized social workers and addiction counsellors as largely continuing to operate as separate entities, even though they were under the same employer, occupying the same space. Impediments to moving further down the continuum of integration are explored in the next sub-category.

Sub-category 3.3: Impediments to Mutual Acculturation

In the minds of the interviewees, there were many factors contributing to the multidisciplinary team not materializing as envisioned by Gove. The eight areas the participants believed were not addressed that prevented further movement involved: (a) operating in the dark, (b) lack of organizational support, (c) lack of commitment by management, (d) power imbalance and authoritarian nature of the organizational culture, (e) environment conducive to collaboration not cultivated, (f) lack of mutual clients, (g) shortage of resources, and (h) instability of team. In the minds of the participants, more attention devoted to these areas would have helped the disciplines to function in a more interdependent way. Ten out of 16 addiction counsellors (63% of the addiction counsellor sample and 31% of total sample) and 12 out of 16 social workers (75% of social work sample and 38% of total sample) conveyed material belonging in this sub-category.

Operating in the dark. Listening to the participant's experience of the multidisciplinary model was reminiscent of a late night sea voyage with no one at the helm and all of the navigational equipment compromised. Everyone was in the dark about where they were going, what the journey was going to look like or where they may end up:

- 3.3.1** The Ministry just put us into other jobs without asking us about it, it wasn't very employee friendly in that way, and they didn't give us a working model ... why didn't we sit around a room and talk about how we were going to work together, that was frustrating.

3.3.2 Before we transferred, before we integrated, management from the Ministry for Children and Families came to our office and we said, "What's the plan, how is this going to work," and the manager said, "Well, you're going to go into the offices, and then you'll work it out once you get there," that was management's idea of organizing things.

3.3.3 It was hard to coordinate services and work in a collaborative way because there was no infrastructure or procedures to help us work out what our roles could look like, it wasn't done in a healthy way.

Lack of organizational support. All of the participants related that the necessary planning and structure was not in place to guide the integration process in a successful way. Basically, it was the interviewees' experience that collaboration was left to happenstance. There were not any clear goals delineated, major power imbalances were present, and there was a failure to identify and address all of the issues, particularly from the perspective of the minority group:

3.3.4 There was no organizational support on the local level. It was very haphazard just placing counsellors in the offices with social workers. We were able to intermingle and counsellors were welcome at all of our social functions and team meetings, but it was up to them if they attend. I didn't see much formally that was structured on a management level to encourage the multidisciplinary team. It was always implied that this was a good thing, but nothing to help set that up.

3.3.5 What I found with the Ministry is we were co-housed, but there wasn't a lot of effort put into having a team integrated where you actually have discussions about what it means to be on an integrated team, and how we respect each other's work experiences, knowledge, how we're treated as equals, those types of things, it was just put them in the same place and they can work together.

3.3.6 My experience at one office was that the upper management was not committed to doing the kind of things that help promote getting together as a team. In fact, I would say that as a team leader probably not consciously, but certainly disrespectful of our need as counsellors. We would often have the integrated team meetings cancelled the day of the meeting, no notice, so that we all wasted counselling hours, and this is when we had a wait list of several months, so it was really quite outrageous actually.

3.3.7 There has to be a formal mechanism in place for relationship building. When alcohol and drug became part of the Ministry for Children and Families, there

was a lot of resistance and discomfort and (the attitude of) we're not social workers, we're a voluntary service and that didn't help.

Lack of commitment by management. There was a perceived lack of commitment by management to implement the necessary strategies that would help the multidisciplinary model gel and work cohesively. One strategy, in particular, that was missing for many interviewees was regular, structured meetings which included everyone and facilitated discussion between the disciplines about how they could work as a team. In many offices, the structure of the team meetings involved the addiction counsellor coming in and giving a report about resources, and possibly attendance, then leaving. It was not set up to cultivate a team approach, rather it reinforced separation:

- 3.3.8 If there'd been more discussion, and more sort of collaboration at the upper management levels to see this thing through, and a level of commitment from management that was long term, it might have made a bit of a difference, as it was because we were forced together, we made our peace with each other, as much as we could.
- 3.3.9 At one office I worked at, the team leaders were very committed to having a multidisciplinary team, so they made sure the team met on a very regular basis and encouraged team building as much as possible, but my experience at another office was that the team leader really was not committed to doing the kind of things that help promote getting together as a team.
- 3.3.10 I think it would take very conscious decision making and effort on a higher level, making multidisciplinary work a priority, and that would mean continuing the closeness we have geographically with counsellors and just having us involved in more formalized meetings, having regular case management meetings, making this a priority and a requirement where there could be more collaboration involved.
- 3.3.11 The meeting wasn't structured to allow for interaction between the different groups at the meeting ... I think they probably could have done more of that almost like more of a description of what you do and how we could possibly help each other, there could have been more structure. Most of the time it was almost like a reporting, okay it's addiction's turn to say what they're doing, but there wasn't a lot of attempt to help the others understand what we do, and for us to understand what they do, and then for us to talk about how we could help each other, there wasn't a lot of that. It was just do it, no process and again there was no planning involved in becoming a multidisciplinary team, it wasn't there and

the skill needed wasn't there. It probably would have been best to hire a facilitator to get people functioning as a team, they left it up to the supervisors and that wasn't enough.

Power imbalance and authoritarian nature of organizational culture. A

reoccurring issue, as participants shared their stories, was the power imbalance between the disciplines and the authoritarian nature of the organizational culture. The authoritarian stance of the organization made employees feel disrespected and not valued. These negative feelings combined with unequal relationships kept the multidisciplinary model from progressing.

According to Gray (1989), inequality will sabotage any integration efforts. The parties needed to feel they were equal partners to an integrative effort:

- 3.3.12** There was no input from the staff, basically you were told this is what you're doing, this is how you're doing it. I was really surprised by how much the social workers accepted this, not questioning, whereas the addiction counsellors tended to be a lot more rebellious, and they'd be told something and say, "No, that's not going to happen," and I don't think management was use to hearing that. For us to be working more closely together, management would have had to have listened and not just taken a report and try to institute it. It's obvious when you're working with people, if you want them to work together and make something work, you have to have input from the people that are doing it, it can't just be downward dumped on ... so you've got a bunch of addiction counsellors who are working with adults who all of a sudden are told that their client is the child, well that doesn't work, you just can't do that ... and seeing the social workers respond so submissively was really demoralizing and not being allowed to question ... I think there has to be respect for what you do and that has to come from people you work with and from management.
- 3.3.13** If we could be open about our own personal experiences, I don't know if this makes sense, but I see with a lot of social workers or with the Ministry that it's a we/they mentality, the clients are they and we're we, we know it all, and we never talk about self-reflection, about how personally we've moved through issues in our life, and that obviously clients are going through those kinds of issues, so maybe that would help because it's like we're working in a medical model that you're suppose to refer somebody to get fixed and then that's end of the problem. ... and we need to be able to talk about our feelings related to the work, if we do talk about things, we get it thrown in our face, the message is we can't handle the job.

Environment conducive to collaboration not cultivated. It seems from the inception of bringing the two disciplines together, an environment conducive to collaboration was not nurtured. The experience described by the participants reflected more of a colonization process; newcomer members settled in a new land and became subjects of the host culture. Parties were understandably reluctant to collaborate when they were at a disadvantage to adequately represent their interest and they believed their interest was deemed secondary to more powerful ones (Gray, 1989). Members of the out-group did not feel their interests were part of the host cultures' agenda or that it was open to negotiation, rather that their new reality was being dictated to them:

- 3.3.14 It never really was presented as a cooperative process; it was really that addictions were to serve child protection. We needed to fight for our integrity, like files and confidentiality.
- 3.3.15 We had suggestions when this thing (moving into the Ministry) was on the table as going to be happening. We had big meetings and we were throwing out all kinds of foresight about what might become problems and how might we best prepare for these problems We were pacified by management listening, but they never did anything about it.
- 3.3.16 I don't think a lot about how I could move better toward collaboration with protection workers. I think part of it is still remnants of resentment and resistance and anger about the process that was done ... I'm not going to spend time figuring out how to collaborate more with you people when I was actually forced into this. If they had brought us together as professionals to discuss how we could collaborate, rather than say you must collaborate, I would have been more open.

Lack of mutual clients. The key to multidisciplinary work is having mutual clients. This seemed to be a real obstacle for the addiction counsellors and social workers in this study. Due to the high no show rate, very brief contact with clients who showed, and use of outside agencies by many clients, very little overlapping in caseloads occurred. If this does not happen, then there is no joint work happening, the bedrock of a multidisciplinary team:

- 3.3.17** Looking at the no show rate with mandated clients it is much higher; I would say double compared to voluntary clients. I have contact with most of them, I'd say with 80 to 90% there's some contact either a phone call or initial meeting, maybe 50 to 70% show up, and maybe 1/3rd go on for a little bit longer.
- 3.3.18** The no show rate was so high, we couldn't keep booking individual sessions. We decided to have all Ministry referrals participate in a group as an entry point. Often that group only had one or two people in it.

Shortage of resources. Extra energy and effort is needed to get a multidisciplinary team functioning well. A large number of offices were operating in crisis mode. This left no time to focus on team building activities. A manageable workload combined with more time for the multidisciplinary team to develop was needed, according to various participants:

- 3.3.19** I know the workload for the managers has also been crazy, so I don't think really anyone has had the time or energy to spend on getting people to work together in a closer manner because it is always crisis driven versus long-term planning, it's very chaotic.
- 3.3.20** Many of the offices were incredibly understaffed and over stressed and adding on a new element (working in a multidisciplinary way) was at times almost more than we could handle.
- 3.3.21** We didn't have time to think about a model, we were going from day to day and seriously half the time you'd show up, you'd be the only social worker at the office. I was just getting from day to day dealing with my own caseload, and one crisis after the other, after the other, after the other, so it would have taken a lot more time, and a lot more effort than was available. We couldn't do anything, just put out fires.
- 3.3.22** If our workload is manageable, then we have time to be proactive and coordinate with the counsellor around cases and plan meetings; whereas, if I have a large caseload, these types of linking strategies aren't going to happen, it's just basically bandaid after bandaid, so the Ministry for Children and Families has to maintain a sane level of work.
- 3.3.23** It takes a long time for a multidisciplinary team to be functioning well, it was just starting to work and then it was stopped.

Instability of teams. The instability of the teams, due to the high turnover of staff among management and the front line, contributed to the lack of necessary sustained effort,

vision and planning. In the words of one participant: "You're constantly dealing with new people all the time." Further quotes reflecting the instability of staff are noted below:

- 3.3.24** The only problem is there's such a turnover that if addiction counsellors do an orientation five or six times on how to use their services and how to refer, it gets a little tiring and I mean they can't keep up with who's new and who's only here for one week, and there's so much change with the Ministry itself that a lot of the new workers fall through the cracks, especially with things like that.
- 3.3.25** In the years I have been here, we have had three different people in an upper management position, which hasn't helped the multidisciplinary model.
- 3.3.26** We had such a turnover in staff that you'd find that new workers would come in, and addiction counsellors and addiction services would be a completely new entity to them.

Participants in this study shared their experiences of working within a multidisciplinary team, which reflected dimensions of a: (a) transition theme, (b) reorientation theme, and (c) adaptation theme. It needs to be clarified that this was not a linear process. The derived categories do not represent a developmental sequence with all of the participants completing and moving through each sub-category. Participants may still have had elements of culture shock, but been able to have experienced some positive aspects of the new culture, and engage in the learning and growth facilitating nature of a major transition. "All individual experiences of cross cultural adaptation are both problematic and growth producing. Cross cultural adaptation is a double edged process, one that is simultaneously troublesome and enriching" (Kim, 2001, p. 21). Even though there were some perceived benefits to the amalgamation, in many ways the disciplines continued to carry out their functions independently. The participants were aware of the impediments that blocked a more interdependent relationship between the disciplines.

6. Research Question 2: The Nature of Ethical Situations Experienced

The conceptualization or overarching theme for this question is that both the social worker and addictions counselor are acting as guardians or protectors of their client (child for the social worker – parent for the addiction counsellor). This need to shield their client from harm directly influences all of the decisions being made on behalf of the client. These two professional groups, acting as good sentinel guards for the parent on one hand and the child on the other, end up in skirmishes regarding the handling of confidential information, expectations of respective roles, policy formulation, and the impact of the organizational structure on the client; see Table 3. Both are carrying out their respective missions: the safety and well-being of children are the paramount consideration for the social worker, and to achieve a healthier society by reducing the misuse of alcohol and all other drugs for the addiction counsellor.

As with Table 2, Table 3 lists the major categories and their sub-categories. Next to each sub-category on the right hand side of the table are the number and percentage of addiction counsellors and social workers making responses in that category out of the total number of counsellors or social workers (16). The last column denotes the number of participants that made comments out of the total sample (32). All of the sub-categories share fairly equal representation among both disciplines in terms of the number of participants making responses. The exceptions are the sub-categories under Category 2: Protector Role: Disciplines' Differing Needs regarding Extent of Involvement with Each Other. Sub-category 2.1 pertains to the addiction counsellors' need for less involvement with the social worker to protect the sanctity of the therapeutic relationship, so it is understandable that more counsellors compared to social workers made responses. Sub-category 2.2 relates to the social workers' need for more involvement with the addiction counsellor to protect the child, subsequently the number of

Table 3: Nature of Ethical Situations Experienced

Categories derived from coding the transcripts

	Number of Participants with Responses in Category		
	AC	SW	TOTAL
1. Making Decisions on Behalf of the Client			
1.1 Sharing information	14/16 (88%)	14/16 (88%)	28/32 (88%)
1.2 Reporting child protection concerns	12/16 (75%)	10/16 (63%)	22/32 (69%)
2. Protector Role: Disciplines' Differing Needs regarding Extent of Involvement with Each Other			
2.1 Addiction counsellor need for less involvement with social worker to protect the sanctity of the therapeutic relationship	16/16 (100%)	5/16 (31%)	21/32 (66%)
2.2 Social worker need for more involvement with addiction counsellor to protect the child	4/16 (25%)	15/16 (94%)	19/32 (59%)
2.3 Ways of safeguarding effects of involvement of social worker or addiction counsellor	13/16 (81%)	6/16 (38%)	19/32 (59%)
3. Organizational Framework: Effect on Keeping Client Safe from Addiction Counsellor and Social Worker Perspective			
3.1 Policy direction	6/16 (38%)	3/16 (19%)	9/32 (28%)
3.2 Proximity of two disciplines	16/16 (100%)	16/16 (100%)	32/32 (100%)

social workers with responses outnumbered addiction counsellors. The issue of confidentiality and the effect on the therapeutic alliance is viewed by counsellors as the biggest area of rub between the disciplines which resulted in more counsellors having responses in the sub-category "Ways of Safeguarding Effects of Involvement of Social Worker or Addiction Counsellor." There was limited and vague policy direction regarding confidentiality leading to more counsellors making statements in the sub-category "Policy Direction". Essentially, the number and percentage of responses are included in the table to note how many interviewees made statements pertaining to each sub-category. The participants' experience related to ethical situations is explored in further detail in the sections devoted to each sub-category.

7. Category 1: Making Decisions on Behalf of the Client

In terms of conveying and soliciting information, both the social worker and addiction counsellor are continually making decisions, which they consider to be in the best interests of their respective clients. Information is a very powerful commodity that can have far reaching consequences in terms of the therapeutic relationship and safety of children. The participants noted many factors to consider when sharing client material and reporting child welfare concerns learned through a counseling relationship. Social workers and addiction counsellors are the caretakers of extremely personal and private client information, it is precious, fragile cargo that must be handled with great care, dignity and integrity.

Sub-category 1.1: Sharing Information

The participants recounted eight major issues that surfaced when sharing information: (a) confidentiality perceived to be the largest ethical issue, (b) confidentiality viewed as a myth, (c) violating cultural norms, (d) social workers concerns about sharing client information, (e) need for flow of information to be reciprocal, (f) inconsistencies with sharing of information, (g) access to files, and (h) case notes. Fourteen out of 16 social workers (88% of social worker

sample and 44% of total sample) related information relevant to this category. Addiction counsellors had the same representation.

In a document entitled, “Ministry for Children and Families: Integrated Case Management: A User’s Guide – Draft for Discussion (November 1999)” it states, “service providers need to strike a fine balance between respecting the privacy of clients and sharing information necessary to develop an effective and coordinated service plan” and goes on to say, “the safety of the child is more important than protecting privacy.” The intent is that information will be shared and the safety of children will be the bottom line criterion to use when making the decision to release client material. However, it still remained vague for many of the interviewees regarding the type of information that should be shared.

“A symbol is a sign, artifact, word(s), gesture, placement, or non-verbal behaviour that stands for or reflects something meaningful” (Ting-Toomey & Oetzel, 2001, p.12). A master symbol represents core cultural values, agreed upon and respected by a group (Ting-Toomey & Oetzel, 2001) . “A violation of this master symbol may be an absolute barrier to communication” (Novinger, 2001, p. 34). The addiction counsellor culture is tightly organized around confidentiality, which can be regarded as its master symbol. This makes it difficult to share perceptions cross culturally with social workers in terms of providing client information.

Confidentiality perceived to be the largest ethical issue. Without confidentiality, safety for the client cannot be created which prevents a therapeutic alliance from being formed. There is a need in society for social control over intrusion, and an ability to protect individuals from the overarching control of others (Schoeman, 1992). “Privacy has a role in social freedom, and there are social norms regarding privacy; we invade a person’s privacy when we disclose information that was entrusted to us not to reveal, or when there was a presumption of confidence” (Schoeman, 1992, p. 148). Many addiction counsellors viewed confidentiality as

the largest ethical issue they experienced as a result of working within the context of a multidisciplinary team:

- 1.1.1 There's definitely some rub with information sharing, that's the biggest issue, and it's challenging to walk that strange line of trying to give as much confidentiality to my clients as I can, yet I'm sitting in their social workers office, it's a bit awkward.
- 1.1.2 I think one of the challenges, probably one of the biggest ones is the confidentiality issue, a client has to feel like they can trust you, that you really are wanting the very best thing for them.

Confidentiality viewed as a myth. Many participants believed confidentiality was a myth because Section 96 was available to the social workers to access client information without client consent. Section 96 is part of the Child, Family and Community Services Act which legislatively enables social workers to access any information deemed necessary to assess a child's safety. The ability of social workers to use Section 96 to obtain information without client consent created a power imbalance, giving the social worker ultimate control of client information. Exercising this piece of legislation was viewed as necessary by social workers when they were not getting the information they needed to determine if a child was at risk. However, for the addiction counsellor and client, it was very disconcerting knowing that something so important was out of their control:

- 1.1.3 I mean technically I was covered and in an ethical sense, I was clear with the clients up front that this is part of the deal. A productive way of framing it for the clients came about for me. Right up front when signing these forms with the client is to acknowledge that because the referral is coming through the Ministry, and they know you're here is that they have the power to get anything they want that's written down, and if I write it down, they can get it, so in terms of whether you sign this or not, it doesn't limit their abilities, this is not a consent form, it says consent, but if you don't sign it, it doesn't limit them, so have no security in signing this.
- 1.1.4 I sometimes feel like a salesman or sometimes it feels like a sham because even after you go through all the explanation of the parameters of confidentiality, there is still section 96, so it's hard to explain that level of complexity to a client.

Violating cultural norms. An addiction counsellor described violating their cultural norms. At the outset of the transfer, the message to some addiction counsellors was to not share anything. This particular addiction counsellor was not comfortable with this instruction. The counsellor focused on the common link between the two groups, the clients. By allowing a crack in the wall of silence, it opened up a dialogue between the disciplines about ethics and the changing nature of their work:

1.1.5 It was a very clear, formal rule that I was not to discuss my clients with social workers in any way, shape or form and to tag along with that was the informal rule that you must keep a social distance from them as well. I think in order to make things work, I violated the rules because really what did I have in common with these social workers even though we had different jobs, what I had in common was the clients for starters, and you can't talk about clients without talking about them, so I just started talking about some generalities and then figured out what I could share, what was safe to talk about, what was not, and I think in violating those rules, we very quickly got down to basic principles which is underlying it, which is this whole thing in terms of why are we here, what are we suppose to be doing and those types of ethical conversations.

Social workers' concerns about sharing client information. When thinking about confidentiality, it is often seen as a dilemma exclusive to addiction counsellors, but social workers also had difficulties in this area. Social workers talked about their need to set limits on what they convey to addiction counsellors:

1.1.6 How much information can I expect from the counsellor and how much information is okay to share. With client confidentiality, is it okay for me to say so and so relapsed or should I be waiting for the client to let the counsellor know that, and then I think there's different bounds of confidentiality where we as child protection workers pretty much get as much knowledge as we can, and we can pretty much share it with whatever referring agency or service providers, and I think sometimes that becomes an issue if I am referring someone to the family support worker, do I tell them they have an addiction counsellor or does the client do that, where is my boundary with that. That's the same kind of thing when I wonder whether to actually invite an addiction counsellor to a case conference.

- 1.1.7** If I am calling a counselor, as a collateral, as part of an investigation, I have to be careful of my boundary in terms of what I will share with them. Usually, they are aware of why I am calling because the client has talked to them about it ... in terms of the reported incident and my need to interview them as a reference.

Need for flow of information to be reciprocal. The most common direction of the communication flow between the two disciplines was from the addiction counsellor to the social worker, at the request of the social workers. Some interviewees remarked how it is important to have the flow reversed at times, particularly if a child is going to be removed. The addiction counsellor was then prepared and could help the client to work through this. This echoed the direction in a document entitled, "Ministry of Children and Family Development: Practice Guidelines for Assessing Parental Substance Use as a Risk Factor in Child Protection Cases (August 2001)". It indicated, "it is especially important for both services to communicate with each other when significant decisions are made or events occur that can impact on the work being done with the parent and the family." A counsellor shared about this need for information from the social worker:

- 1.1.8** I kind of initiate contact on occasion with the social worker just to get a reality check, and see if what the client is saying is accurate, but more importantly I like to get a heads up if they are going to be ripping the children out. I kind of want to know ahead of time, so that I can prepare stuff and anticipate sort of explosions in their lives, so sometimes it has been very helpful just to get a little detail going the other way.

Inconsistencies with sharing of information. Both social workers and addiction counsellors identified that there are disparities and differing views regarding the release of client information. One participant commented: "There's a difference from one counsellor to the next where some would feel comfortable in providing something and another very little." For the social workers, this led to confusion and frustration. Social workers could not

understand why they were able to obtain what they needed from some addiction counsellors, but not others:

- 1.1.9** There has been a constant struggle around sharing of information and confidentiality from the drug and alcohol perspective. I think that's unique to this office, and maybe one other office because I have heard of other social workers having different experiences where the addiction counsellors feel they can share information openly. It's all for the good of the client and safety of the children ultimately, but we've never got to that point. We've even had several meetings where the addiction counsellor had come to our team meeting once every few months, and it has always got stuck on confidentiality. We can't even know basics like does the client actually make their appointments. We will sometimes see the client in the hallway and that's how we know, it's a very closed system.
- 1.1.10** The addiction counsellor has explained to us their point of view regarding confidentiality restrictions, and we all have to respect confidentiality, but what I don't understand even when it's with the clients' consent, even written consent, we don't get any information, that's where I don't understand. I have actually had the opportunity to talk with other addiction counsellors, the client has given us their permission to talk to the addiction counsellor, those counsellors have been very open and cooperative about sharing information, and it's been really helpful, very different from what I'm used to in this office, and none of those more open addiction counsellors have ever been attached to this office.
- 1.1.11** I was being a little reticent about giving general information and the social workers response was, "Well, I have spoken to four other counsellors and they have given me this information." I didn't have a good answer at the time and now I'll just say, "Well, other people have lower ethical standards than I do, you run into that kind of thing."
- 1.1.12** From what I've heard from other offices, I think our counsellors were a bit more open in sharing information than other addiction counsellors were. They weren't as hesitant about sharing information.
- 1.1.13** I would err on the more cautious side, I'm just that way where I know other counsellors aren't that way.

Access to files. In many locations, social workers had access to addiction counsellors' files and vice versa. Generally, there was an understanding that each group would not access the other group's files, but there was no way of knowing if this was upheld. Early in the integration process, there was discussion about only having one file for both disciplines. One

participant commented that ethically they would have had to terminate their employment, if this had come to fruition.

1.1.14 I don't have access to the addiction counsellors' files, but the addiction counsellor could look at Family Service files because they are accessible in the file room. It is a general understanding that addiction counsellors won't access these files. I can't keep up with reading my files let alone the addiction counsellors even if I had access.

1.1.15 You really can't say to a client that the information is protected. I also wonder if any social worker did look in the files. In the discussions early on, social workers thought they were going to have the same file with addiction counsellors. It would have been unworkable; I would have had to go back to my former career.

Case notes. Given the ability of the social worker to have access to addiction counsellors' files, it really changed how case notes were handled by a number of counsellors. Some counsellors revealed that, if needed, they were prepared to modify case notes. Other participants decided to be very vague in terms of the information that was included in the notes:

1.1.16 I had a social worker say to me, "I don't need a release of information, I can go into your file right now," and I found out that that's true. The social worker quoted something giving them this right, so I kind of got a bit more lax about what went into the file.

1.1.17 The clients that are really sort of uptight and nervous, I let them know we can modify the record, I can write down only certain things in my notes, and you can review the notes. I can provide them with some level of comfort.

1.1.18 Being with the Ministry certainly changed my way of writing case notes as far as what I put in for information, personal information, it is now mostly theoretical and vague, I never put when somebody was pregnant, there's creative ways of describing that, a life event or something.

1.1.19 Sec. 96 colours everything I say and do, especially what I write. My notes use to be for me, my notes use to be for my professional purposes, now I have to do the same screening that the client has to do when they're talking to me in case it gets back to their social worker. It's not right and we should not be having pinched sphincters, both of us, thinking that on the whim of the social worker, they could have access to anything that we're talking about.

According to most participants, confidentiality is the most contentious issue between the disciplines. After several years of working together, interviewees described continuing to struggle with this concern. It seemed, for the most part, that sharing client material was handled on an individual basis, rather than in a uniform, systematic manner.

Sub-category 1.2: Reporting Child Protection Concerns

Another aspect of sharing information was reporting child welfare concerns. The addiction counsellor shared the many factors they had to weigh when considering making a report. Seven key themes emerged from the data in this sub-category: (a) counsellors feel less duty to report, (b) few child protection reports received, (c) social workers' concern about not reporting, (d) inner conflict and confusion regarding reporting concerns, (e) choice of reporting concerns or keeping therapeutic relationship intact, (f) social workers closing file, and (g) best way to handle report. Twelve out of 16 addiction counsellors (75% of addiction counsellor sample, 38% of total sample); and ten out of sixteen social workers (63% of social work sample, 31% of total sample) shared experiences related to reporting child protection concerns.

Counsellors feel less duty to report. There was this belief among addiction counsellors that there was less duty to report child protection matters when the social worker was involved with the client. Addiction counsellors seemed to be operating under the assumption that the social worker knew everything already when, in fact, they rely on others to keep them informed. This stance by addiction counsellors of the "all knowing" social worker was reminiscent of the magical thinking they attributed to social workers regarding the "quick fix" mentality associated with counselling:

- 1.2.1** I've done more reporting in terms of child protection issues before I became an employee with the Ministry for Children and Families. There is already a social worker involved, most of the information is already known, so the situations where I've done reporting seem to have happened previously.

- 1.2.2 It's interesting I have never reported anything, I've talked a couple of people into reporting themselves, but I've never reported anything. Sometimes I kind of get the shivers and I wonder am I missing stuff or am I too loose on that end because I know there are other addiction counsellors who do and have reported. I kind of wonder about myself sometimes with the fact that I don't. ... I find I have less duty to report because there's always a file, they already know this person, so unless there's something new like they've grabbed a shotgun and they're teaching the children how to use it, then I don't really have any kind of onus to report.
- 1.2.3 I haven't reported anything for a very long time, nothing. ... with child protection cases, all of the information already seems to be out there.

Few child protection reports received. Many social workers remarked that they have never received any child protection reports from addiction counsellors. Several interviewees recalled: "I've never had an addiction counsellor report a child protection concern to me;" "I never got any child protection reports from anybody;" "No, never. I've never received a child protection concern from an addiction counsellor;" and "I have never had one." Some participants asserted that there was no change in their reporting behaviour pre- and post-amalgamation of child protection and addiction services:

- 1.2.4 I would prefer to keep whatever we talk about between the client and myself, unless there is a concern that I have about the safety of the child, and that didn't change from when we were with other Ministries, I had lots of cases with child protection issues over the years.

Social workers' concern about not reporting. A social worker recounted having serious concerns about how an addiction counsellor handled a case. There were child protection issues, which the addiction counsellor did not report. The social worker indicated that the withheld information really changed their work with the family. This passage contradicts the belief of many addiction counsellors that the social worker already knows everything, so there is no need to report:

- 1.2.5 I had issues with a decision one of the counsellors made because some information was given to this person in a session that did impact us. It did impact our family situation. The addiction counsellor consulted with their

supervisor, and it wasn't kind of a life threatening situation. The addiction counsellor wanted to give their client enough room to basically make the decision themselves to report this piece of information, which ultimately the client did and so the gamble paid off, but I had difficulty with it. It was information that really directly impacted how we dealt with this client, and in fact it changed how we dealt with this client dramatically. I thought the addiction counsellor was taking a bit of a chance by withholding it, and besides how was the addiction counsellor going to know whether or not this client had actually come and spoken to us. I just thought that was a bit dodgy, I just thought to myself oh boy you're really kind of playing with fire here.

Inner conflict and confusion regarding reporting concerns. The addiction counsellors experienced a lot of uncertainty and inner conflict about whether or not to report certain situations. Some of the areas of confusion noted by the participants included: (a) whether or not they should share concerns with social workers only when the child is at imminent risk or should they be reporting when the parent relapses, but the kids are safe, and (b) if the social worker does not hear anything about the parents' ongoing drinking, are they under the impression the family is doing well and base their decisions on erroneous thinking. This amount of ongoing confusion seems to attest to the lack of dialogue between the disciplines regarding some very pertinent issues. Much appears to have been left unsaid, leaving the two groups operating in the dark:

- 1.2.6** All we could do is try to educate the social worker about relapse and harm reduction. For instance, one case I worked on the client was relapsing, but always had a good caregiver to look after the children. However, the social worker wanted to know whenever the client was drinking. This is a big dilemma. I ended up not telling the social worker because the children were not at risk. I'm not a monitor, I'm not going to share information with the social worker unless the kids are in danger. The parent was using drugs and drinking, but an extended family member was looking after the kids. Eventually, the children did get taken into care and placed with this family member. The social worker was upset and asked me why I hadn't reported the parent's drinking. I explained the kids were fine. The social worker maintained that I should have reported and was very upset. They believed in the abstinence model and any deterrence from this was reportable in their minds. I was supported by my colleagues and supervisor to not report the relapses, which made a huge difference. It's just not realistic expectations for certain clients who have been using for many years in a dependent manner to be able to abstain, at least right

away. The imposed treatment plan by the social worker and court becomes meaningless.

1.2.7 Whether or not an addiction counsellor reports really does come down to sort of your own background, your own sort of life experience and your own social status, but sort of like you're in a situation where you have to look at "good enough parenting." It might not meet every social worker's standard, but the family is thriving, there's no actual active harm going on, but it's a very deprived family.

1.2.8 I often wondered in terms of what client's disclose to me in sessions whether I had the obligation to report. It was all around whether they were using or not, how successful they were, and I guess that's where it was still uncertain in terms of how the social worker was going to interpret the information and what they needed to do from their side. Could they return the child if this person was in a sense still struggling a little bit with their sobriety, that was a dilemma for me often, is the social worker under the impression that it's total abstinence, and does the supervision order stipulate abstinence or are they obliged in terms of their own jobs to work out of a total abstinence model.

Choice of reporting concerns or keeping therapeutic relationship intact. Some

addiction counsellors shared ethical binds they had experienced. Their decision ultimately was to not report in order to protect the therapeutic relationship. By keeping the therapeutic alliance intact, the addiction counsellors' reasoning was that more beneficial outcomes could result compared to reporting, and potentially severing the counselling relationship. It appears in the minds of many addiction counsellors that reporting child welfare concerns and retaining the therapeutic relationship are mutually exclusive. One addiction counsellor related that they spend time forewarning the client about what specifically would have to be reported. The client then knows what is and is not safe territory to enter during the counseling session, but the quality of the work suffers:

1.2.9 I am always sort of in that choice do I risk rupturing the relationship by reporting or am I the last defense against this person acting out, am I the only person here that has the actual ability to improve this scenario, and therefore should I gamble on working harder and trying to pull them up, and extract them out of this dangerous situation, I've always gone for that one.

- 1.2.10** My client's child had been taken away and he was being told that he wasn't suppose to see his wife, legally he was under a no contact order. During that no contact order, he did get together with his wife and she got pregnant. He told me about it somewhere along the line before anyone else knew. He was concerned about whether he was going to be in trouble with the law because he had broken the no contact order. I didn't share this with a social worker, some people might say well hey that's pretty relevant stuff, but I felt well theoretically you're apart right now, but it was definitely an ethical bind.
- 1.2.11** At an integrated case management meeting with the client, we were discussing the situation and I could tell the client had been drinking, I could smell it on the client during the meeting. I really felt holy shit should I say something right here. I didn't ended up saying anything, I waited until after the meeting was over and I met with the client alone, and I said, "I could smell alcohol on you during the meeting, do you realize how much you put yourself at risk here, you're coming for a case conference over your children, and you smell like you've been drinking." I was caught in a bind there, what the hell should I do, there's all these professional people who are talking about returning the child, that was a real ethical bind. ... you could argue both ways on what would be the right thing to do.
- 1.2.12** I try to catch any reportable incidents beforehand. I tell clients if you go there, I might have to report it, if you talk about this, I might have to report it in which case they don't talk about it. If the social worker wants to know if there's been relapses or if there's drug users coming into the house, I'll tell people, if you give me that information, I'll have to report that, so they don't. It's kind of a really stilted relationship where they know there's many areas they can't go.

Social workers closing file. Another problematic area for counsellors occurred when shortly after the counsellor had connected with the client, the social worker would pull out as though the situation was now covered. If the counsellor had concerns, the social worker that was familiar with the family was no longer involved and could not be consulted. In some instances, the counsellor believed the social worked needed to remain involved:

- 1.2.13** Another thing that was kind of surprising would be that I would be working with the client and the social worker had either closed the file or thinks the client is out of the woods and was off doing something else that was of more importance and just kind of leave me and my client ... they should be monitoring certain cases longer ... there is more monitoring with an impaired charge, for a year or two and you'd be reporting to your probation officer and expected to work on your issues, so why would a social worker close down a file so fast on a child, okay six months, your fine, magical thinking.

Best way to handle report. Once a decision has been made to make a child welfare report the addiction counsellor has to determine the best way to approach it: (a) client reports alone to social worker, (b) counselor, social worker and client meet to go over the concern, or (c) the counselor reports directly to the social worker. The preferable option seemed to be to have a joint meeting with the social worker, client and addiction counsellor:

- 1.2.14** Sometimes I wonder if it's different perceptions in our authority because I know there's been some cases even where the client has disclosed protection concerns to the addiction counsellor, and the addiction counsellor forces them to report to us, rather than having a more amicable process such as the three of us getting together and discussing the concerns that came up. I know of one case in particular that the client refused to see that counsellor again because they felt really set up by the addiction counsellor and just felt that it was dishonest, so part of me wonders, okay they want to keep a therapeutic relationship, but sometimes the way they go about things doesn't seem to help this.
- 1.2.15** I handled reporting child protection concerns in different ways. Once I went actually with the client to see the social worker, other times I think I have reported and then talked to the person, and sometimes the person has reported themselves, depending on the degree of risk.
- 1.2.16** It has worked out quite well in the past when a counsellor and the client came to the social worker together with a concern.
- 1.2.17** How I dealt with child welfare reports varied, sometimes with the client, if that was an option and that's the preferable one, a lot of times no, it's the way it's gone where the client isn't accessible, they've maybe relapsed.
- 1.2.18** In these situations where something the client was sharing was reportable, I would just discuss it with the client, we're getting into that place, let's bring your social worker in to talk about how we can reduce the risk here. I've never had a client either that's said I really and truly don't care what happens with the kids. Then there are some concerns whether the client can actually make that happen, reduce the risk in their lives to protect their kids.

In the mind of many counsellors reporting any child welfare concerns to the social worker would have resulted in the therapeutic alliance dissolving. From this perspective, there was a tendency to not share concerns, thinking the situation would have deteriorated further if the client cuts themselves off from treatment and support. There was also much confusion

about what information needed to be reported and at what point a child was deemed to be at risk. The counsellors tended to operate with the false sense of security that the social worker already knew what was happening with the client. Reporting child protection matters was an issue far from resolved at the time of the interviews.

8. Category 2: Protector Role: Disciplines' Differing Needs regarding Extent of Involvement with Each Other

The primary focus of the social worker is to protect the child. In order to do this, they needed involvement with the addiction counsellor. The addiction counsellors were concentrating their efforts on keeping a solid therapeutic alliance, which prompted the need for less involvement with the social worker. These diverging needs resulted in dissension, some compromise and the development of strategies to safeguard their respective roles.

Sub-category 2.1: Addiction Counsellor Need for Less Involvement with Social Worker to Protect Sanctity of Therapeutic Relationship

From the perspective of the addiction counsellor, less involvement with the social worker was more amenable to creating the safety necessary to develop an effective therapeutic relationship. Sixteen out of 16 addiction counsellors made remarks belonging in this sub-category. Five out of 16 social workers (31% of social work sample, 16 % of total sample) provided material relating to the addiction counsellors' need for less involvement with the social worker. The key themes that evolved from the data for this sub-category were: (a) social worker effect on therapeutic relationship, (b) therapeutic neutrality, (c) working at the pace of the client, (d) remaining within the parameters of the counsellor role, (e) evaluative assessments, (f) fear about how the social worker would use client information, and (g) counsellor initiating contact with the client.

Social worker effect on therapeutic relationship. The biggest concern for the addiction counsellor was how their involvement with the social worker would affect the

therapeutic relationship. Addiction counsellors described how they felt the strain the client was operating under during the session; how some clients communicated that they would do the real work later; how just being in the same office with their social worker could have been perceived by the client as collusion; and how it was necessary to make social workers accountable in terms of why they wanted certain information - was it to help protect the child and at what cost to the counselling alliance:

- 2.1.1** I have had clients say to me that they thought they were being videotaped, imagine how that's affected their willingness to expose themselves and be vulnerable.
- 2.1.2** I can just feel it, I can just feel how they tell me what they think I want to hear and of course they need to do that. I will often congratulate them for getting through the session and just saying what they think is most appropriate for the social worker to know, particularly if they are truly precontemplative, all I am trying to do with them is to build a relationship. I let them know that I see them working hard to just give me the information they think is appropriate for their social worker, and I'll let them know that it must be very hard for them to just give the right information and I congratulate them, and say, "I wish you didn't have to work so hard."
- 2.1.3** Clients have said I'll find another counsellor later, and really work on this stuff or what are you going to tell my social worker, it really probably affected what they shared with me a lot because they have a lot to lose versus if I was just seeing them as a private client. When the social worker is in the same office, there's more I want to use the word collusion, I don't think that's appropriate, but there's more togetherness maybe that's not so healthy for the client.
- 2.1.4** The social worker wanted to know if this particular woman was back out on the street prostituting, and so they Sec. 96'd that information. It was shocking to me, it seemed like that was too much power. I think it would have been more useful if they had have went to a team leader, and that team leader went to someone else where that kind of power is carefully handled. It just seemed like the social worker and team leader came over and just said we want this information, so I sat down and talked to the team leader about what the consequences would be on the relationship between me and the client, and how useful this information would actually be to them, so what if she's hooking on the street, how is that affecting the children, would you be able to do anything with that information in isolation, so the team leader actually backed up, but it just seemed with that kind of power, it had to be more carefully monitored.

Therapeutic neutrality. Addiction counsellors were unaccustomed to discussing clients outside their closed door offices. It was a concern because counsellors did not want to compromise their therapeutic neutrality by hearing client information, which could influence their picture of the person they are working with. Also, it was very easy to get drawn into the conversations, which opposes addiction counsellors' prior training and ethical commitment regarding confidentiality. When some members of the addiction counsellor group engaged in casual conversations regarding clients with social workers, it became difficult for the remaining counsellors who avoided this. The tug of war between the old and new culture was strongly felt by the participants:

- 2.1.5** Social workers will come in and tell me stuff about the client and I find that can jaundice my view of a client when they walk in, 'like you did what, to whom.'
- 2.1.6** There's a lot of work that needs to be done in terms of boundaries with social workers, like quit the conversation in the lunch room, I've almost thrown my arms up. I was having a nice lunch just recently and a new, young social worker came in, they're talking a mile a minute about a client, and it's like okay this system isn't going to change, these are suppose to be the new trained people, like give me a break, and I'm not faulting them, I think they're going in with the best of intentions, but there is a problem still.
- 2.1.7** At the beginning, I probably was seen as very rigid, but I was just behaving in the way that I always behaved, and I learnt how to behave, which is sticking pretty much to the rule of confidentiality, and then especially when I moved to this office because social workers will talk about their clients in the hallways, in the lunchroom, I mean they're careful not to talk about anybody in the front waiting area, but I noticed that I kind of slip into that, and I try and keep the policy that I was trained with, but it's hard because other addiction counsellors are now doing more of the in the hallway consultation.
- 2.1.8** Ethical things like casual discussions over the lunch table, in the file room, became uncomfortable sometimes where a question gets asked about a client, and I start feeling like I'm in this confidentiality bind, ... where I felt that I might be divulging information that was breaking confidentiality that I had with this client. It took me a while to work that one out and I think where I'm at now, I probably err more in being open about stuff than I do about holding it back. I don't know whether that's better or not ... I still get a light going on that says you never told the client you were going to tell the social worker this, so I just said something because I felt that the social worker had a right to know

it without asking the client or informing the client that I was going to tell the social worker this or that. In a sense, I probably bent some of the ethical code I had initially, ... I'm bending stuff much more than I used to and I feel okay about it just because I think it is for the good of the client and for the good of the child.

Working at the pace of the client. Social workers not familiar with the counselling process often had a hard time understanding why the addiction counsellor was working with the client where they were at. There was this sense that it was a waste of time, it was not mirroring reality. The addiction counsellor needed to get to the point and make the client face reality. "Different cultures arrive at their concepts of reality in different ways. Their perception of reality may come through faith or belief, independent of fact. It may come from fact based on evidence, which is the most predictable concept of reality" (Novinger, 2001, p. 38). The addiction counsellor had faith and a belief that the client would get to where they needed to go in their time, while the social worker made profound decisions based on evidence with the court clock ticking in the background. These different orientations are present in the passages below:

- 2.1.9 I have had this discussion with social workers, this has been a point of contention because I have said to social workers that generally, my modus operandi is to believe the client, that's what therapy is an opportunity to be as honest as you actually can, I have to presume honesty or it isn't safe. You go with the client where they are, therapy doesn't happen unless you are there with the client in their view of the world, and together you go to that side by side.
- 2.1.10 I think it is important for the addiction counsellor to have all of the information to help the client, just having a self-report isn't helpful, often it isn't mirroring reality.
- 2.1.11 Why is counselling based on what the client shares because in many of our situations maybe the client has even denied any drug or alcohol use, yet that was clearly the reason for the referral. I don't understand if your counselling about the 'sunshine' how helpful is that, why not actually get into the issue. I know that part of it is moving at the pace of the client, but sometimes clients need not a confrontation, but motivation.

Remaining within the parameters of the counsellor role. Addiction counsellors focused their energies on remaining within the parameters of what they saw as their role.

Often, addiction counsellors were pushed by social workers to take on duties beyond the scope of their role, which was detrimental to the therapeutic relationship. Two of these functions were acting in the capacity of a monitor and/or evidence gatherer. A report designated “Ministry of Children and Family Development: Practice Guidelines for Assessing Parental Substance Use as a Risk Factor in Child Protection Cases (August 2001)” reflected the monitoring and evidence gathering activities the Ministry was hoping the addiction counsellor would fulfill. The report indicated that the implementation of the relapse prevention plan and harm reduction strategies would be corroborated by the addiction counsellor; the social worker with the addiction counsellor would ensure the parent was meeting the terms and conditions of the supervision order; and the harm reduction plan required that the parent notify the addiction counsellor of any breach of the agreement, the addiction counsellor would then assess and decide whether or not to report. In the words of one social worker:

2.1.12 We are so evidence based, everything an addiction counsellor says can be a piece of evidence. We need factual information, admission of the problem, where they’re at, progress or lack of (movement).

Evaluative assessments. Requests from social workers for evaluative assessments were denied because this would have changed the counsellors’ role with the client from therapeutic to evaluative. When the addiction counsellor sensed they were moving toward a monitoring or evidence gathering function, immediate extrication was sought:

2.1.13 If we get into that role of doing evaluative assessments, we would become more closely linked with being social control agents, and in that role there isn’t the safety necessary to help a client disclose really deep struggles, how can they, they can’t possibly disclose those deep struggles and work through it in the presence of someone who’s controlling and evaluating them.

2.1.14 I think part of it was a real misunderstanding of what we do, I really do feel that. When people would ask for an assessment, I would send back an assessment of what the client told me, and they’d say why haven’t you done a background check, well that’s not my job, I’m working with the client, the client tells me they only drink two beer a night, then they don’t have a problem.

- 2.1.15** That's not what our kind of assessments are about, not evaluative, and so when I would be clear about what our assessment is about, the intention of it, ... they weren't interested because interestingly enough it's client reported, and they're only interested in corroborated stuff.
- 2.1.16** They wanted me to assess the client which means they want me to apply some sort of tool or criteria to label this client an addict and which drugs they're addicted to. Also, I had social workers ask me about my assessment of their prognosis, what's the likelihood that this person would relapse ... that kind of thing would happen ... what I did is that I met with the social worker first, whenever I got one of these requests for an assessment, to clarify what they were looking for and let them know what I do. I assess for treatment, part of the process of assessment is building rapport with people, it's getting them to organize in their own mind a little bit about their own history, and help them to start to look at how things are connected, that's part of the assessment, it's really not just for me, it's for them ... I don't expect what they tell me right up front when I don't know them from Adam and they're under a lot of duress, is the gospel. What good would it be for me to give that to you ... that isn't useful in terms of a court document, and for that you need to hire a psychologist with tools, and it will cost you money and then they're mad. ... an evaluative assessment is at cross purposes with our role, no one is going to tell you anything, if it's going to be used against them.

Fear about how the social worker would use client information. Some addiction counsellors expressed concern about how the social worker was going to use the information released to them, and related some negative experiences. One addiction counsellor disclosed that they advised the client to keep certain information from their social worker, fearing it could be used against the client. There was anxiety on the part of the addiction counsellor that the information they disclosed to the social worker would be abused, either by being passed directly to the client and even to outsiders with unfortunate results. However, it was apparent that when there was trust, if individuals knew and respected each other, less difficulties arose from confidentiality (Hallett and Stevenson, 1980). Social workers described finding the addiction counsellors more open when social workers had taken the time to be very clear about why the information was needed and how it was going to be utilized:

- 2.1.17 An ethical problem happened for me once where what I had said was misinterpreted by the social worker and stated back to the client in a way that was not my intention, so that taught me a lesson of being very clear on how I speak with social workers because often what I said and what was heard were two different things.
- 2.1.18 I have had that experience where information I have shared with the social worker has ended up back with the client.
- 2.1.19 Social workers are only interested in corroborated stuff that they can prove one way or the other, and quite frankly I think they can take the information and make it look whatever way they want.
- 2.1.20 The client would say, "Well, do you think I should tell them this?", and if I knew the social worker was somebody who might be really hard line, I'd been in a position to say, "That might not be in your best interests," which ethically could be an issue. I mean I tell the client it's important to be honest, but how much information do you share, knowing that certain social workers would take that information and run with it, that was probably the biggest ethical dilemma, saying to the client, "Maybe being honest in this situation isn't the best idea," and it wouldn't necessarily be around substance use, it could be around disclosing childhood sexual abuse, knowing that that would be a risk factor in the social workers' eyes, really should they share that, I don't know. When I became aware of how they did their risk assessment with points against the parent for having trauma in their histories, I thought maybe the client shouldn't share that, it might not be in your best interest.
- 2.1.21 I would say the addiction counsellors here are much more open to sharing information once there's some clarification, once there's some discussion with the client about it. I think a lot of times from what I've seen the addiction counsellors aren't actually sure of the kind of work we do, so they have questions too about where the information is going, why do we want the information, that kind of stuff, but once that is ironed out, then I think it's pretty open.

Counsellor initiating contact with client. The addiction counsellors ended up conceding to the social workers' request that they call the client after receiving a referral prior to hearing from the client. The rationale was that they are a very difficult client group to engage, so the more effort the better. However, one addiction counsellor came to the realization as they were discussing it during the research interview that it may come across to the client as coercive, rather than caring and helpful:

2.1.22 I guess if I'm pursuing enough I can see where that would also reinforce that punitive framework in the minds of clients, OH MY GOD, it could work both ways. I think because I've worked for so long with voluntary people that there is a blind spot of what their experience might be around being forced to be here.

2.1.23 I end up telling the social worker to have the client call me and I end up calling most of them if I don't hear from them. I don't think I should have to phone, but because it's this group I end up doing it. It gives them a double chance to connect.

The counsellors' primary motive was to nurture and build a solid therapeutic alliance, a necessary foundation for any growth to occur for the client. Any threats to the counselling relationship were met with protective measures. If the alliance was not formed or was broken, then the counsellor and client's work was not possible.

Sub-category 2.2: Social Worker Need for More Involvement with Addiction Counsellor to Protect the Child

The other side of the spectrum was the social workers' need for high involvement with the addiction counsellors to keep them abreast of how the parent was doing, so they could do appropriate planning for the child. In the report "Ministry for Children and Families: Practice Guidelines for Assessing Use as a Risk Factor in Child Protection Cases (August 2001)" it stated that information sharing was a key part of an integrated case management plan; information from the addiction counsellor would help the social worker better understand and address the level of risk to the child; and the addiction counsellor may use the information the social worker provided about specific child protection concerns in developing an effective treatment plan for the parent. The entire intent of the integration plan was to facilitate integrated case management plans through sharing of information to decrease the risk to children. Four out of 16 addiction counsellors (25% of addiction counsellor sample and 13% of total sample) and 15 out of 16 social workers (94% of social work sample and 47% of total

sample) gave information connected to the social worker need for more involvement with the addiction counsellor to protect the child.

The major themes emanating from the data for this sub-category include: (a) need for evaluative assessments, (b) meagerness of information from counsellor, (c) social worker need for information to function in role, (d) social workers' view that counsellor needs client information to protect child, (e) counsellors see the "real" client, (f) type of information needed by social worker, and (g) social worker can offer supportive versus punitive interventions.

Need for evaluative assessments. When Addiction Services transferred to the Ministry for Children and Families, social workers were really hoping addiction counsellors would provide written evaluative assessments. The social workers' rationale was that addiction counsellors should be able to be very open with the client, even in the court context, and still orchestrate an effective counseling experience. Some social workers believed that addiction counsellors had been "sucked into an alliance" with the client, when they would not share information openly:

- 2.2.1 Addiction counsellors really ought to do assessments, written assessments because as it is, we have to contract out They don't want to go to court because they saw it as interfering with the counselling process ... I've dealt with other counsellors though who didn't see that as an issue at all, who could perfectly well see themselves sitting in a therapeutic system with a client, and going to court, and telling the truth because they didn't feel they were sucked into any kind of alliance with the client, and whatever they had to say was an open book We contract out with a psychologist who has training in alcohol and drug, so she does our assessments now, it's \$650 a pop, they're costly. Addiction Services didn't do that for us and they ought to.
- 2.2.2 It would be helpful to have substance abuse assessments in regards to making my decision around the safety of the kids, and where the parents are at, it would be an important piece.
- 2.2.3 I can think of a handful of clients right now who I would absolutely love to show up at an addiction counsellor's office, and tell them what is going on, and have some sort of assessment done, again because we gloss over this in our training, this isn't our area of specialty.

Meagerness of information from counsellor. Many participants commented on the meagerness of information the counsellors were willing to share. Some social workers attributed this to the addiction counsellors' lack of understanding of their role:

- 2.2.4 The addictions team was very tight lipped, I felt that they wouldn't talk to us about what was happening with the families they were working with. They were very protective of the clients, and I felt they didn't understand the role of a social worker. Our team was very frustrated with this.
- 2.2.5 I (addiction counsellor) try to err on the side of nothing, not giving any client information, pretty tight lipped. I always try to make sure that I talk to the client very early, first session, about information sharing and what kind of permissions do I have from the client to share information.
- 2.2.6 Addiction counsellors can be quite protective of the client, and so the information that I do get is quite minimal. We worked on that, but there's never been a sit down meeting of this is what we've gone through, these are the goals, this is the plan because I guess their respect of confidentiality to the client who puts a lot of trust in them because they tell them when they screw up, so I found that to be a little lacking.
- 2.2.7 We can't even know basics like does the client actually make their appointment. We will sometimes see the client in the hallway, and that's how we know if they've come in for a counselling session. It's a very closed system where we in this office have got to the point where if drug and alcohol use is the concern, we cannot count on a referral to the addiction counsellor to assure ourselves that that is part of the safety plan for the child in the home because it's useless.

Social worker need for information to function in role. The bottom line in the mind of social workers is they need input from addiction counsellors to be able to do their job adequately. However, addiction counsellors do not need social workers to carry out their function, in fact it works against it. A social worker shared how an addiction counsellor blocking any information flow between them helped to make the situation worse for a client:

- 2.2.8 I mean this client's problem never got any better, they would miss appointments and it was just very problematic. I would find out from the client because they would always self-report, and they would always sign the consent form. It was always fine with the client for me to find out information, but in terms of me actually having that monitoring role and gathering information, this wasn't

possible because I didn't get the information I needed from the addiction counsellor.

- 2.2.9** I would approach the addiction counsellor for an update based on some new concerns. There would be the run around, and you'd have to actually quote Section 96 of the Act, to me that's just game playing. If I'm asking, it's not because I'm gossiping or something, and in that situation even when I had another consent signed by the client, one of our formal consent forms, there was some run around with the counsellor saying that their perspective was, "The way I read this is the client is giving their consent for the social worker to release information to the counsellor," I'm like no and that went on for a period of a few months, and I mean that woman's problem never got any better.

Social workers' view that counsellors need client information to protect child.

When social workers shared information with addiction counsellors, the purpose was to protect the welfare of a given child. The intent was to fill out the picture of the client's situation, so the addiction counsellor was not just working with information from the client, but the social worker as well. This was reassuring to the social worker because they did not want the addiction counsellor to be missing something important:

- 2.2.10** I felt comfortable to share enough information with the addiction counsellor to give them a good picture of what my concerns were, and what the situation or my interpretation of the situation was, especially in situations where the child is still in the home. We have to share information to protect that child.

Counsellors see the "real" client. Another social worker suggested that due to the power inherent in their role, clients do not let their guard down and social workers do not get to see clients as they typically are. The social worker believed the addiction counsellor would be in a better position to get to know the "real" client:

- 2.2.11** When clients usually see social workers, their best faces are put forward, and we only ever see the best side of the client, unless we're seeing the ugliest side of the client, so the social worker doesn't gather the information from the client, they're gathering it from people working with the client. When the social worker is misinformed and we do our risk assessments, we go on what we've been told. I just have to have faith that the addiction counsellor would be telling us what we need to know, according to their ethics.

Type of information needed by social worker. The type of information a social worker wanted reflected what they needed to assess a family's situation. In the document entitled "Ministry for Children and Families: Protocol Framework and Working Guidelines between Child Protective and Addiction Services (February 1999)" it stated that "a social worker may request information when assessing a report about a child's need for protection; deciding if a child needs protection; completing a comprehensive risk assessment; developing a risk reduction service plan, and reassessing the level of risk to a child." The following excerpts illustrate more specifically what kind of information social workers were seeking:

- 2.2.12** If the addiction counsellor had information that mom or dad were using, I'd like that information, if the counsellor had some information that the client came in and was in fact intoxicated, high on something, I would like that information, that's what usually is required by the courts.
- 2.2.13** I like to know where the client is at in terms of their chemical dependency and in regards to their readiness for change, if they do have long standing misuse issues because at some point it does affect parenting, and I guess that's what we need to assess. People are still capable of parenting if they do use, it depends on how much they use, how often they use, what they use and so on and so forth, so as a social worker, I guess it's important to know what they are using; how often they are using; is getting drugs at the centre of their attention; are they substituting drugs for food; if they are suppose to go and buy diapers, are they buying diapers or are they going to buy their next fix; and all that sort of thing, in that sense it would be helpful to know that.
- 2.2.14** Social workers want to know the trend, is it getting worse, is it getting better, how much rope should we give the client, will she do this, will she do that, they're not clear cut decisions.

For this social worker, a key piece of information to assist the social worker role was knowing the motivational level of the client:

- 2.2.15** The kinds of information that I would find useful are the level of motivation the client has for making changes in their life. For instance, if a counsellor says they are just here warming a seat or they are very motivated, they are struggling, but they are really trying, this kind of information is very helpful to me, that piece is really key. Also, the concrete stuff such as what the planning is, are

they open to looking at some long term options, are they dedicated, what kind of plan have you talked about.

Social workers can offer supportive versus punitive interventions. Social workers hoped addiction counsellors realized that by including the social worker when concerns arose, social workers could intervene in a supportive versus punitive way before the situation became unmanageable. When addiction counsellors withheld pertinent information, there was more chance the circumstances would deteriorate to the point that more drastic measures needed to be taken:

2.2.16 I'm just trying to get whatever information I can. I'm hoping that the addiction counsellor realizes my role, and that children are never put at risk by not sharing information ... if I have a more open relationship with the addiction counsellor, I would be less tempted to send clients for drug and alcohol testing, and even if the test was positive that doesn't necessarily mean a bad thing for the client, it just means we need to work on another plan, and I think that's part of the issue, clients don't see that and addiction counsellors may not see that. They use once, so does that mean all the work has gone out the window if I go report it to the social worker. As long as I know the children are safe, if mom or dad has a relapse and the kids are somewhere else such as a family friend, relative, it doesn't matter, as long as it's safe.

2.2.17 I need to know if the client is getting something out of the counselling, and if they're attending I don't really care if they are drinking alcohol occasionally as long as they're not with the kids, and using marijuana as long as it's not in front of the kids. I guess if they were using hard drugs like coke and heroin and crack, I'd want the counsellor to tell me if the client is really craving right now, she's going to go out, and she doesn't have supports in place because then that would help me I can help put supports in place, I can get a homemaker for her and I understand people obviously relapse, so I'm not going to penalize them for it. If the counsellor's talking with me, I can make plans and save people a lot of hassle.

The social worker has the profound responsibility of protecting children from abuse. In order to fulfill this function, they needed to gather information from people involved with the particular families. If they did not have the necessary information, they were not able to make sound decisions to maintain a child's safety. The struggle to balance this need for information with the need to create a safe therapeutic space for the client was keenly felt by the participants.

Sub-category 2.3: Ways of Safeguarding Effects of Involvement of Social Worker or Addiction Counsellor

To buffer the involvement of the social worker, addiction counsellors developed ways of safeguarding the therapeutic relationship. In turn, to protect children's welfare, social workers devised methods to get the information they needed. The understanding of each discipline of the other professionals' relationship with their respective client has increased, and subsequently their resulting needs. This has helped both social workers and addiction counsellors acquiesce somewhat within limits. Thirteen of the 16 addiction counsellors (81% of addiction counsellor sample, 41% of total sample); six out of the 16 social workers (38% of social work sample; 19% of total sample) had something to say related to this sub-category. The key themes that emerged related to ways of safeguarding the effects of the involvement of the social worker or addiction counsellor included: (a) transparency, (b) joint meetings, (c) social worker informs clients what information they need, (d) defer to the client, (e) disclose regarding one client and hold back regarding another, (f) nature of information changed depending on how client is doing, (g) counsellor acknowledgement that social workers need information, (h) referral to outside agencies, and (i) lack of information sharing can be perceived as not caring.

Transparency. One of the means addiction counsellors employed to maintain the therapeutic relationship was to be very transparent with the client about what was going to be shared:

- 2.3.1** I explained the parameters of confidentiality at intake. The addiction counsellor needs to be transparent with the client about what's going to be shared with the social worker and at the integrated case management meeting.
- 2.3.2** It worked really well I thought, I would let my clients know if I had a conversation that was fitting or anything that I said to the social worker, and I think there was an expectation on their part that I would talk more I think in general terms with the social worker.

- 2.3.3 When I first met with the client, that would be a discussion point, what would be shared and reassuring the client that their file wasn't going to be read, hopefully.
- 2.3.4 I think we must have really pushed the point about confidentiality, and what we were able to share and not share in our office because it never really came to be too much of a problem. I found that on the whole it worked well because we were always very clear when we went through the confidentiality slips with them as well, if there were child protection concerns, we'd have to report it to the social worker. I think generally people have been pretty clear about what they can and what they can't share in the first place.
- 2.3.5 I always tried to let the client know before I shared anything with a social worker. When I meet with a client, I explain to them that one of the reasons I'll breach confidentiality is if I believe the child is at risk of harm or abuse, and that I will always tell them that, I'm not going to phone the Ministry behind their back.

Joint meetings. If a social worker wanted information the addiction counsellor was not comfortable disclosing, the addiction counsellor often suggested a joint meeting with the client. An advantage to meetings was the client was present to share their piece and more clarity regarding planning could occur with everyone in the same room:

- 2.3.6 I use my ethical boundaries and it seemed to work always keeping the intention of the client foremost, and even when I say to someone look I'm uncomfortable right now, what I'd rather do is let's have you, me and the client come together, and then I can talk more freely.
- 2.3.7 A way of influencing social workers was to say, "Well, let's bring the client in." ... I usually found a way that attending meetings was okay for me. Often the client was there as well. I've also been to court case conferences, and what tends to happen is a good thing. The Judge will say, "Why isn't this person going to residential treatment," and I can say, "Well, there's a two month wait for treatment," I can provide information or I can say, "Oh, I didn't know that was the plan, yes I can do that." I would focus more on the actions I can take, not evaluating the client.

Social workers inform clients what information they need. Some social workers also used the tool of transparency with the addiction counsellor and the client to get the information that was necessary for them to do their job. They made it clear to clients that they

were not interested in content, the information shared during the session, but rather their overall progress. Their preference was to gather all information with client consent:

2.3.8 We need factual information, admission of the problem, where they're at, progress or lack of, but in order to get anywhere with a client you need to ensure their safety. I mean some workers might want to know everything, I only want to know what's pertinent, and I even tell the client that it's none of my business, unless it relates to the safety of the child.

2.3.9 The only time I have met with the client and counsellor at intake is when I've needed more information than simple attendance, if I wanted to get a sense from the counsellor of how mom is doing, should the kids be with mom or should the kids be with dad etc. ... but once that's done, once they've consented to that information, usually we sit down and discuss the issues and where the parents are at, and what they think about treatment recommendations that kind of thing. ... so far they've been great, there hasn't been any problem with that, but I think you obviously need to clarify and have the parent give clear consent for that kind of discussion.

2.3.10 We are always doing the referral with the client who sees the information being given to the addiction counsellor.

Defer to the client. Another addiction counsellor always deferred to the client, letting them share what they wanted with the social worker about their life and counselling situation. In this addiction counsellors' mind, it was more important what the client was thinking, not the addiction counsellors' views:

2.3.11 The way I have handled social workers wanting information is through my client. I try to give the client as much control as possible, so I'm not the one doing the yakking. When I did a group, I got them to write out what their experience was like, giving them the control, it's their lives for Christ sake what does anyone care about what I have to say about you.

Disclose regarding one client and hold back regarding another. An addiction counsellor described working out a system whereby they would earn credibility with a social worker by being very open and candid about a client, and then be able to hold back where other clients were concerned. An interesting choice of words used by this addiction counsellor to

indicate sharing information with the social worker was “tell on”, which harkens back to the childhood message most of us have been conditioned to “do not tattle”:

2.3.12 I obviously had some obligation to maintain my credibility, and the credibility of my position, so lying wasn't going to do it ... it was sort of like coinage and I had so much telling that I could do. At some points, I would tell on more than others like this isn't going to work with this certain client. It's not a wonderful ethical decision to make, but there are sometimes where I've got to be brutally honest about this one, and build up some credibility in coin, and then I can stretch it a bit on this other client within limits.

Share what client is doing versus providing therapeutic progress. An addiction counsellor shared a creative approach they utilized when talking to social workers about clients. Rather than take on an evaluative function, the addiction counsellor conveyed what the client was doing and included the social worker by asking how they could be helpful with the treatment plan:

2.3.13 If a social worker approached me for information, I usually tried to slant it towards what the person is doing about the problem, how they're getting help, and it gives me the opportunity to say, “What can you do to help.”

Nature of information changed depending on how client was doing. This counsellor described an imaginative way to balance the social workers need to have information to protect the child and keeping the therapeutic alliance alive. It is interesting that participants did not view being open with positive client information as a violation of an ethical code. Obviously, the potential consequences were very different compared to releasing negative particulars, but it was still conveying confidential information:

2.3.14 When the client is doing well, there's an awful lot more you can share and disclose, where I cheated on this, and I don't know I'm pretty sure the social workers figured it out, but it never got openly discussed was that when the client wasn't doing well, I would continue to give the same or even greater volume of information, but the information I would give them would change in it's nature from the therapeutic progress, to a lot more details on what they did, how many appointments they showed up for. It probably was essential to keep a steady flow of information to social workers, it's just the nature of that

information would change, according to how well the client was doing, so in some senses I'm ratting out the client, and telling the social worker what is going on, but I'm not directly stating it, and it's also cheating with the client in terms of no, I haven't told the social worker you're doing poorly, I very specifically omitted that information, but I am no longer telling them how wonderful you are doing, and I'm giving them detailed reports on the shows and misses of scheduled appointments and punctuality, giving them lots of crap information, so it was sort of one of those games that was never formalized or formally acknowledged. I felt that my obligations to the system and social workers were met because they need to know how their clients are doing, and at the same time, I technically met my obligation to the clients to not pass on nasty information about how many relapses they've had, and how they're doing, so it was a bit of a dance.

Sensitive information not shared. An awareness was present that very personal, sensitive client information would not be shared. It was important that clear and firm boundaries regarding confidentiality and anonymity be established and upheld. Otherwise, there would be a blurring of boundaries, which undermines effective counselling practice:

2.3.15 I certainly want to respect the privacy of the client as much as possible and certainly intimate, historical abuse issues or others are very private issues, and I want to work separately in respect of the client's privacy on that.

Counsellor acknowledgement that social workers need information. Some of the addiction counsellors realized that social workers did need to know how the client was doing, and as a result started sharing more information within designated parameters. However, the level of disclosure varied among addiction counsellors. They sorted out for themselves what they would be comfortable conveying to the social worker:

2.3.16 I would usually share about the client's treatment progress with the alcohol and drug issues, sometimes I might have said to the social worker if there were earlier abuse issues ... if they were staying clean, or they appeared high or loaded during the session that would be something I would tell the social worker or if they stopped doing treatment activities and attending sessions, and domestic violence issues, anytime I thought a child might be at risk.

2.3.17 I made it really clear and I have pretty strong beliefs that the protection in all situations has to go towards the kids. Adults have some power and they have decision making abilities, they can pack up and leave town, kids cannot, they're depending on people for their survival, not only that, but their development. I

make it pretty clear with clients right from the get go that any situation that endangers the kids or the development is something that we're going to have to deal with, not that I'm going to report on you, but that we're going to have to deal with that. I have never had a client ever say, "Oh, that's a really bad idea," I've always had clients saying, "Well, of course if the kids are at risk."

- 2.3.18** I shared what was ethically okay to share which meant those two things, attendance and substance abuse, but I certainly didn't share when they relapsed if the child wasn't with them because I didn't feel I really had to share that at that point. As long as the child wasn't with them, the child wasn't at risk. When I did need to report something, I would encourage the client to tell the social worker, or I did or we both would.

Referral to outside agencies. The addiction counsellors' value to social workers was the information they were able to provide. If social workers were not able to get the information they needed, clients were referred to outside agencies. The in-house addiction counsellor was relegated to dealing with the less serious, voluntary clients:

- 2.3.19** There are a group of social workers who have told me that they would never refer anyone to alcohol and drug services because what's the point, you guys don't give us any information. They don't see counselling as having any value, there's no information.
- 2.3.20** Essentially, with our most serious alcohol and drug cases, we're relying on drug testing or usually parenting issues are always explored with the family support program that is put into the home to work with the parents. Basically, in terms of the safety plan, we need to know if some change is being made and we can't rely on our addiction counsellor to tell us that, but I know that experience isn't felt by other offices.
- 2.3.21** In those cases where alcohol and drug use hasn't come to the point of being a real child protection concern, I have been able to refer the clients to the addiction counsellor and close the file. In those cases, it doesn't matter to me what happens, the client is volunteering and is accessing services.

Lack of information sharing perceived as lack of caring. When addiction counsellors would not provide information, social workers saw this as not caring and not wanting the client to succeed:

- 2.3.22** It ticks me off when addiction counsellors don't share what I need, and then I just don't refer to them. ... I wouldn't even bother referring to them, I would just send them to a regular counsellor because at least the counsellor is probably

from a small community organization that is usually really dedicated to helping clients and wanting them to succeed, as opposed to someone in an ivory tower not wanting to divulge anything.

Many counsellors found ways to safeguard the relationship with the client, while releasing some client information. It still felt awkward and uncomfortable, but more of an understanding had developed that social workers needed this information to meet their mandate. When social workers were unable to get any information from a particular counsellor, they stopped referring because they were unable to do their job.

9. Category 3: Organizational Framework: Effects on Keeping Clients Safe from an Addiction Counsellor and Social Worker Perspective

The policy directives, as well as the lack of policy, influenced the addiction counsellor's and social worker's role. The organizational structure of having the two disciplines co-located also strongly shaped the day to day functioning of these professionals. In turn, the relationship with their respective clients was also affected.

Sub-category 3.1: Policy Direction

The Ministry is a service organization where the client group, the child, is the primary beneficiary. The client's best interests may not always coincide with organizational goals and policy. The social worker and addiction counsellor must balance the needs of clients and ethical responsibilities with the objectives of their organization. In a document entitled "Ministry for Children and Families: Integrated Case Management: A User's Guide – Draft for Discussion (November 1999)" it stated, "service providers need to take extraordinary care to only share information necessary to develop a collaborative plan." There was obviously a recognition on the part of the organization of how consequential releasing confidential information was to the client. However, this direction was not helpful in defining what was truly necessary information. In another document "Ministry for Children and Families: A

Guide to the Privacy Charter (February 1999)” attempts were made to shed more light on information sharing:

Guideline 1: Must Share – we are required to share under the law, by Court order or specific written policy that stems from relevant legislation; and it is our duty to share to protect the health, safety and well-being of our clients or others.

Guideline 2: Should Share – we should share information that is necessary to support continuity of care, integrated case management or quality of service.

Guideline 3: Should Not Share – we should not share information that is not relevant to the case, or share information that is not absolutely necessary to assist our clients and fulfill our job requirements.

The above guidelines are very much open to interpretation. For example, a social worker believes that a parents’ relapse must or should be shared, while an addiction counsellor may not view it as relevant because the children were with appropriate caregivers at the time of the relapse. Which position is correct? Is there a correct position?

In this category, the participants discussed how policy direction, lack of formal guidance and common practices affected their work, and subsequently their clients. Six out of 16 addiction counsellors (38% of addiction counsellor sample, 19% of total sample); and three out of 16 social workers (19% of social work sample; 9% of total sample) related experiences relevant to this sub-category. The key issues that emerged from the data related to policy direction included: (a) counsellors not following policy, (b) need to know sharing protocols, (c) lack of clarity regarding confidentiality, (d) impossible messages perpetuated by management, (e) confusion about who is the client, and (f) counsellors taking responsibility for administrative piece.

Counsellors not following policy. Some social workers were very frustrated that addiction counsellors were not following policy regarding addiction counsellor input into risk assessments and sharing of information. The document the social workers referred to in the

passages below was “Ministry of Children and Family Development – Practice Guidelines for Assessing Use as a Risk Factor in Child Protection Cases (August 2001)”:

- 3.1.1** Some policy came out a few months back between Addiction Services and us, and what it was basically for was working relationships. As part of our risk assessment, we’re suppose to get a whole assessment piece from the addiction counsellor, as I was reading this I thought this is laughable because we don’t even get a verbal assessment. This was a policy made in consultation with both parties (Addiction and Child Protection management), so it would have been great from our perspective if it could work that way, but these directives from top down haven’t funneled down to the addiction counsellors, basically they do their own thing at the local level.
- 3.1.2** I was actually able to locate the document that said in good faith we share information, and the addiction counsellors seemed very unresponsive to it.

Need to know sharing protocols. Initially, social workers wanted information from addiction counsellors with no set limits. A working committee “Ministry for Children and Families: Child and Family Addictions Specialist Working Group (July 1999)” was established and a policy developed. It was clarified that the information gathered for child protection and information gathered for addictions counselling were bodies of information gathered for two different purposes. Therefore, “need to know” sharing protocols and consent forms had to be implemented:

- 3.1.3** This whole policy had to be evolved whereby information couldn’t be shared because you had to consider the source of the information, where did it come from and what was the purpose of the information, and that was across the board with every other agency.

Lack of clarity regarding confidentiality. The magnitude of the issue of releasing client information dictates that as much clarity as possible be obtained regarding sharing client particulars. Yet, many participants pointed out that confusion and lack of direction were prevalent. The right to privacy as well as a lack of clear policies and guidelines for disclosure of information interfered with effective collaboration. There were also liability issues to consider which created feelings of fear of punishment should an employee release information

resulting in a complaint, and the action taken by the staff was later interpreted as not appropriate. The following passages reflected the struggle participants go through, as well as the lack of discussion between the two disciplines regarding such a key issue:

- 3.1.4** I don't think we ever managed to ever really, truly successfully navigate the confidentiality problem.
- 3.1.5** I mean we didn't even have a confidentiality agreement or nothing, there were no policies, and it was probably a year into being co-housed that they actually started thinking about how do we do this as far as confidentiality. I remember having the lawyer talk to us and they didn't know what you could share, what you couldn't share, how much access they could have, and that was a lawyer from the Ministry. I left that meeting more confused, and I think for the lawyer too, they were giving us the honest stuff, they didn't know, they had no idea of what the legalities were around what we were doing. ... it felt like if you screwed up, even given that your supervisors didn't know how to handle confidentiality issues, then you would be hauled on the line to dry.
- 3.1.6** There has to be clarity about what needs to be shared, and I think the addiction counsellor would have to draw some lines about what they would require to keep a safe relationship and how they could also do that with sharing certain information to social workers.
- 3.1.7** I'm always a little unsure of what to put down on the referral form most of the time. If there's a violence issue, I will put it down just so the addiction counsellor is aware of that issue, in case there's safety risks. There's times when I might just put something down I'm aware of and later on, after I've put it down, I'll think about it, maybe I don't need to put that down because ... sometimes I feel like I'm just sharing it with another social worker. It's a bit of a tough one because sometimes you're in a rush when you're doing it and you don't quite think about it, so it's an issue for me as to what to put down and what not to.

Impossible messages perpetuated by management. This addiction counsellor talked about the impossible messages perpetuated by the Ministry for Children and Families system of 'eliminate all risk' and 'do not make any mistakes'. This displaced pressure from the system to the social worker who in turn pushed the addiction counsellor for information to prevent anything negative from happening. This culminated in a very taut system that could only be loosened through dialogue about what was truly possible:

- 3.1.8** In the social work system you've always got this conflict between rights and privileges and what's good for the parents. You need to take risks in order to have room for them to grow, and you've got the child's needs which requires safety and security, ... and you've got this crazy bureaucracy that tries to do things in absolute terms like eliminate all risk, which immediately fails and puts everyone in great risk. It's an environment which requires more discussion of ethics and values in order for people to remain healthy.
- 3.1.9** From the bureaucracy, the continual message is don't make any mistakes, reduce the number of children in care, do exactly what you're doing and reduce the number of kids in care ... which is an irrational message from above.

Confusion about who is the client. A major issue for many participants was the matter of who is the client. Whether your client was the parent, the social worker or the child dramatically changed your focus and role behaviour:

- 3.1.10** A whole other ethical issue for me is who actually is the client. If I'm telling the mandated clients that are coming in here, I don't see the purpose of you coming, there's nothing you want to work on, you're just jumping through hoops and I don't want to be another hoop you jump through, but then there's another client who is the social worker who's upset, ... so who is the actual client, are we serving them or are we serving the client, so that gets very mixed up, trying to make sense out of that, it's fuzzy sometimes.

Counsellors take responsibility for administrative piece. There was very little structure or policy in place when the transfer occurred regarding confidentiality, consent forms or file management. For the most part, this administrative piece, a huge undertaking, was done by the front line addictions staff, in addition to their counselling function. The social work staff viewed addiction counsellors need for certain structure and organization as nitpicky:

- 3.1.11** Addiction counsellors had to develop consent forms, set up a whole new filing system and separate the files. All of these things had to be reinvented and there was very little thought on the part of Ministry about any of this, they didn't see any need for this, they all saw addiction counsellors as being very sticky, asking what are you doing this for, what do we need this for, our files are in there too, we don't read your files, you don't read ours.

Social workers posited that there was policy formulated outlining the information addiction counsellors were suppose to share, but in their experience often did not. Much of the

policy was open to interpretation, leaving the individual counsellors and social workers to bumble through it. Confusion was present at many levels, even with defining who the client was - the child, the parent or the social worker. The unrealistic messages that filtered through from management to the front line added to the stress and puzzlement. The counsellors ended up taking matters into their own hands and developed a filing system and a consent form.

3.2 Proximity of Two Disciplines

The organizational structure of having the two disciplines housed together raised many issues regarding client safety. Every participant had something to say about the proximity of the disciplines. The majority of interviewees wanted the addiction counsellors and social workers to be in different locations. It is interesting that in a document entitled, “Ministry of Children and Family Development – Practice Guidelines for Assessing Parental Substance Use as a Risk Factor in Child Protection Cases (August 2001)” when giving suggestions to social workers about conducting parent interviews it stated, “it is important for the social worker to be aware that substance abusing clients are often mistrustful and anxious. They often believe that any admission of problems associated with their use will automatically result in the removal of their child, if at all possible conduct the interview in a non-threatening place, sometimes **the local Ministry office is a major barrier.**” It begs the question of how it would be for clients to come into a Ministry office for counselling sessions. Three main themes emerged for this sub-category: (a) client safety, (b) maintaining links between child protection and addiction services, and (c) close proximity permits relationship building.

Client safety. Specifically, 22 participants advocated to keep the disciplines geographically separate, while ten wanted addiction counsellors and social workers to remain in close proximity. The reasoning for wanting the disciplines separate was mainly anchored in client safety. These participants did not believe clients would be able to let down their guard

enough and divulge what they need to in order to make any life changes. In their mind, this concern overrode any benefits the multidisciplinary model may offer. With the disciplines being separate, these participants believed, clients would be more able to direct the process and request coordination if they wanted it. By being physically apart, the interviewees asserted more equal footing and less power imbalance could be achieved, and the counsellor could be more client versus professional centered:

- 3.2.1 When I think about going to a counsellor about my own personal issues, I would go outside the government and not access an EAP (Employee Assistance Program) counsellor as an employee, so you can understand why clients wouldn't want to see a government counsellor on the same site as their social worker.
- 3.2.2 It was just easier to start that personal relationship going with the client, with the Ministry as this abstract concept that was out there and not present within these walls.
- 3.2.3 There were really good intentions behind the multidisciplinary model, but clients don't want to come into an office for counselling where their child was removed.
- 3.2.4 The disciplines feel very separate, which is probably a good thing because I don't think that child protection clients are very open when they come for counselling in a child protection office. For any real work to happen, the client needs to open up and go underneath what's going on.
- 3.2.5 My experience hasn't been the most positive experience, I can explain a bit about it. I think that being child protection is obviously not a voluntary service, were in there being somewhat the police of child welfare, and addictions is a very voluntary service, and by forcing the clients to go and some of the information we need for court, mandated information from counsellors, it doesn't make for a very good working relationship at times, and despite being respectful on both sides, it's a difficult position to be in for both the addiction counsellor and the social worker.

Maintaining links between child protection and addiction services. It should be noted that none of the participants that advocated for the disciplines being separated wanted a return to the prior status of having no links with each other. They believed this could be

managed through such activities as integrated case management meetings, regular intermangerial meetings, cross training workshops and annual conferences:

- 3.2.6** I don't think we should be in the same office space, but perhaps the same building. If that wasn't possible, then there are other ways to stay connected such as an interdisciplinary newsletter or email, and interdisciplinary conferences every year. We could talk about new programs, new theories and we'd tell each other about where our policies are taking us.
- 3.2.7** Just because we're not housed together doesn't mean we can keep links. We could have a Protection Liaison and an Addictions Liaison who exchange information about their referral process, policies, offer consultations that kind of thing. The Liaisons could come to each other's meetings every three months or so.

Close proximity permits relationship building. The ten participants who would like to see the disciplines remain together asserted that it provides an opportunity to build relationships, to build rapport and to understand the respective roles better. They were also concerned that separating would mean a return to working in isolation from one another:

- 3.2.8** Co-location helps because the addiction counsellor is there and you're having lunch and you meet each other in the hallway and this kind of stuff, so you're able to build relationships, develop trust and talk about clients.
- 3.2.9** There's something about being in the team and team meetings ... it gives you more of a sense of understanding the different roles and clarity.
- 3.2.10** If we go our separate ways, there's not going to be the same ability for each of us to build relationships and know each other's roles ... and I think we would get more and more fragmented and lose the connections built altogether.
- 3.2.11** I want to see addiction counsellors and social workers remain together, I think we'd be going backwards if we were separate. I think it's great to be in one location with different professionals ... I tend to get a lot more understanding of the addiction process just having people here, you can ask questions of them.

It is a sign of growth that none of the participants interviewed wanted to return to working completely independently. Despite the issues with confidentiality and client safety, both disciplines perceived a return to pre-amalgamation status as a regression. Through the disciplines' work together over the past few years, they developed more of an understanding for

each other's roles and figured out some ways to safeguard their role with the client within an extremely challenging context.

10. Research Question 3: Influence of Working Together on Knowledge Base

As noted previously, Question 3 and 4 were not coded due to the overwhelming volume of material and time constraints. Instead, a summary of the participant's comments are provided.

In terms of knowledge level, eight participants (25% of the total sample) commented that their understanding of the other discipline area had not increased, while 24 interviewees (75% of the total sample) believed there was an increase in knowledge. One of the areas noted that changed significantly was the view of harm reduction as an approach to substance abuse treatment. Two social workers (13% of the social work sample, 6% of the total sample) responded that they are abstinence based and 14 social workers (87% of social work sample, 44% of total sample) indicated that they support harm reduction treatment plans. Three addiction counsellors (19% of addiction counsellor sample, 9% of total sample) stated that in their experience they found the majority of social workers to be abstinence based, five addiction counsellors (31% of addiction counsellors sample, 16% of total sample) indicated that the social workers they have dealt with are predominantly in favour of the harm reduction model, and eight addiction counsellors (50% of the addiction counsellor sample, 25% of the total sample) found that it really varied from social worker to social worker.

Some of the reasoning behind the above figures is that social workers advocating abstinence do so because harm reduction is a very frightening prospect, in their mind the children are still at risk. With social workers supporting harm reduction planning, they believed that only recognizing abstinence as a risk reduction plan was not realistic because people with substance abuse problems do not just stop, and it allows clients to be more honest

about their situation, and to work on their issues. Some social workers who were proponents of harm reduction were still concerned that safety plans created in the event parents relapse could be a slippery slope, almost permission for the parents to overuse. Also, that unless the parent was motivated and honest, the safety plans were meaningless.

When addiction counsellors talked about their child welfare knowledge increasing, they mainly referred to having more empathy and understanding of the social worker role. Some addiction counsellors commented that they did not have any interest in learning more about child protection beyond Section 96 legislation, which they perceived as having the most affect on their role. For other addiction counsellors, they thought their child protection information did not increase because of the extreme inconsistencies in practice they observed. One addiction counsellor commented that if they were a client, they would keep changing social workers until they found one in sync with them because of the horrendous variation between them from “apprehension crazy” to others who seldom remove children. Furthermore, dealing with relapse varied from social worker to social worker from tolerance for severe relapsing to intervening at one relapse.

Another issue that came up when Question 3 was asked was the need for more training. Five participants (16% of total sample) expressed the need for more cross training. The targeted areas were: (a) to help social workers understand how to deal with a counselling service, (b) to increase the social workers’ understanding of the addiction and counselling process with one of the hoped for results being less over-servicing for clients who are often referred to multiple counsellors when the addiction counsellor could address some or all of the presenting issues, (c) to increase the addiction counsellors’ skills in the area of working with mandated/resistant clients, (d) to raise counsellors’ awareness of the legislation social workers

operate under, and (e) to familiarize addiction counsellors with the constraints social workers contend with such as court proceedings and time lines.

11. Research Question 4: Future of the Multidisciplinary Model

Participants were given the opportunity to look ahead and envision what they would like to see happen with the multidisciplinary model. It was already discussed that 69% of the participants wanted to see the disciplines work separately, while 31% would like them to remain co-located. Whether separate or together every interviewee had comments about the future of the multidisciplinary model.

Among the components of a future model, according to the participants, would be more disciplines being represented. Instead of just addiction counsellors and social workers they advocated having other professionals such as mental health counsellors, income assistance workers, public health nurses, and outreach workers, among others on the multidisciplinary team. Due to the lack of supporting infrastructure experienced with the Ministry for Children and Families, a better organizational framework to facilitate working together, building relationships and increasing case overlap was stressed. Structural elements that could buttress multidisciplinary work, according to the participants, included: the disciplines reporting to the same manager, more inclusive team meetings, and having a neutral manager not affiliated with either discipline, and not in a direct supervisory position responsible for integration.

Some participants wanted to move away from big bureaucracies toward community boards, which they believed can be more client friendly and accessible. After experiencing the use of power and power imbalance issues, it was thought a study should be designed to learn how to use power appropriately, compassionately and constructively. Having one addiction counsellor on each social work team was mentioned as a possible configuration. A standardized intake process was proffered with the addiction counsellor, social worker and

client meeting together for the first session to clarify the treatment focus and address client concerns.

It was clear that many participants wanted to see a continuing trend of reducing barriers for the mandated/precontemplative population such as keeping the referral process simple. By working with this population, some addiction counsellors identified that mandated clients are not a homogenous group, making it worthwhile to tease out the different categories, and come up with varying treatment strategies. If the disciplines separate, as a way of keeping the connections built alive, management from child protection and addiction services could continue to meet on a regular basis. Lastly, and perhaps most importantly, include the client in designing a model.

The findings are discussed in the next chapter. The relationship of the results to the literature is explored. The significance of the research is examined, and the limitations and implications of the study are considered.

CHAPTER V

Discussion

1. Results and Relationship to Literature

Parity among intergrating parties needed. The results of this study reflect some findings in the literature. It is asserted in previous research that equal status among integrating parties is needed (Clague et al., 1984; Corrigan & Bishop, 1997; Krueger, 1990; Powell et al., 1999; Rice, 2000; Schofield & Amodeo, 1999). An organizational design that will facilitate this parity is a necessity for collaboration to succeed. The findings concur with Meyers (1993) and Morrison (1996) who found that staff were powerfully affected by agency cultures, management styles and organizational structures. It was clear throughout the derived categories that power imbalance and a monolithic organizational framework negatively influenced interdisciplinary work. An authoritarian and centralized systemic approach contaminated the pluralistic character of the multidisciplinary team. Dominant paradigms were reinforced, suppressing diverse values (Hallett & Birchall, 1992). Gray (1989) posited that parties must see a compelling reason to try collaboration and believe their interests will be protected and advanced through the process for collaboration to occur, which this study also found. Participants experienced pressure to conform to the needs of the host group and organization, pushing aside the newcomer's own unique perspective; see Quote # 1.2.1, 1.2.2, 1.2.3, 1.2.4 under Question 1.

Dilution of services. Another finding that resonated with previous research was the dilution of the provision of services (Anciano & Kirkpatrick, 1990). This was evidenced when social workers decided on the treatment plan to deal with the client's substance abuse issues and/or referred their clients directly to residential treatment centers without any treatment

matching or consultation with the addiction counsellor; see Quote # 1.3.29, 1.3.30, 1.3.31 under Question 1.

Relinquishment of responsibility. A relinquishment of responsibility occurred when social workers would close files shortly after the addiction counsellor became involved with a family or when the addiction counsellor did not feel a duty to report child protection concerns because, according to many participants, “the social worker already knows everything.” Galvin and McCarthy (1994) stressed that issues of accountability, competence and responsibility are often not meaningfully addressed on multidisciplinary teams; see Quote # 1.2.2, 1.2.13 under Question 2.

Attitudes to confidentiality. Attitudes to confidentiality were not made explicit among the team members. It is very important that this issue be worked through for the protection of the client, counsellor and functioning of the team (Crowther, Dare & Wilson, 1990; Kell, 1999). After five years of working together, there was still much confusion regarding confidentiality; see Quote # 3.1.4, 3.1.5 under Question 2. There were few protocols written, which were not well distributed, and were vague and ambiguous. The data showed that very little dialogue occurred between the disciplines about confidentiality or other important issues; see Quote # 1.1.6, 2.2.12 under Question 1.

Unidisciplinary assessment. Unidisciplinary assessment remained the norm, which Galvin and McCarthy (1994) found in their research as well. Minimal joint work happened between addiction counsellors and social workers, leaving assessments to be completed separately, and, for the most part, not shared with the other professional; see Quote # 3.2.21, 3.2.22 under Question 1.

Prior attempt at integration. The results in this current study were very similar to the findings of a prior attempt at integrating various social service providers (Clague, Dill, Wharf,

& Seebaran, 1984). The Local Area Approach project was announced in 1965 by the Community Chest and Council (Clague et al.). This project was motivated because the welfare system was too fragmented to deal effectively with the combination of problems associated with poverty (Clague et al.). The intention was to combine health, social welfare, education and recreation services in a concerted attack on social problems in selected areas of Vancouver, emphasizing coordinated and integrated services in place of fragmented, unilateral services (Clague et al.).

The Local Area Project failed to achieve its goal of coordination of effort among these social agencies, leading to legislation being introduced in 1974, the "Community Resources Boards Act" (Clague et al.). Clague et al. (1984) identified the following five barriers. First, there was no overall design that would serve as a basis for legislation and a guide to implementation. Second, the process of reform appeared to be random, ad hoc and operating by trial and error, causing considerable confusion in the field. Third, the staff of the Ministry were feeling excluded with no organized effort to consult them or to inform them about what effects the legislation would have on their work. Fourth, the reality experienced was that the issues of confidentiality, differences in working styles and hours, disputes about who belonged where in the pecking order, and variances in opinion about and commitment to the very notion of integration combined to make the transfer of integration from ideal into a reality extremely difficult. Fifth, although physical integration occurred, professionals tended to structure their work into relatively traditional approaches.

Prior knowledge not used. There was all of this knowledge to pull from, yet the most recent attempt at amalgamation, which this study focuses on, demonstrates none of this wisdom was harnessed to instruct the Ministry multidisciplinary model resulting in the same mistakes being repeated. The staff felt excluded from the process; there did not appear to be a plan in

place to facilitate the integration; there was varying commitment to integration; and even though there was co-location, predominantly the disciplines worked separately. It suggests that the administering of social services is too politically tied with the most important objective being to give the perception of something being done to address particular social problems while substantive outcomes, if they occur, are a random byproduct.

2. Significance of research

Perceived benefits of amalgamation. Despite the various hurdles, there were some positives associated with the multidisciplinary model. A deeper understanding of each other's roles evolved. A mutual appreciation, respect and empathy were cultivated. Some advantages for both clients and professionals were discovered such as quick access to services, convenience for the client, a broadening of the disciplines' perspectives, and removal of barriers for precontemplative clients; see Quote # 3.1.7, 3.1.16, 3.1.32 under Question 1. However, for the most part, little joint work occurred and the disciplines carried out their functions separately; see Quote # 2.2.12, 2.2.13 under Question 1.

Intensity of feelings. The breadth and depth of the culture shock experienced by the addiction counsellors and the lasting negative, intense feelings associated with the amalgamation process speaks to the lack of a collaborative approach. It makes sense that if the dislocating party prepares in advance, it will smooth the transition. However, in this case, it antagonized the situation further when the Ministry did not listen, and the problems the newcomer group forecast came to pass. At the root of these intense feelings was the threat to the addiction counsellor's identity; see Quote 1.1.2, 1.1.7 under Question 1. If this need is not met, collaboration is not possible. The difference in level of responses between addiction counsellors and social workers in terms of experiencing culture shock is understandable given the addiction counsellors experienced the displacement from their original culture.

How to handle ethical conflicts. Some insight was gained regarding how to handle ethical conflicts as a result of working on a multidisciplinary team. A few of the strategies developed involved: being transparent with the client and the other professional; holding joint meetings; and not taking on a monitoring or evaluative role; see # Quote 2.3.5, 2.3.6, 2.1.14 under Question 2. Interestingly, most of the addiction counsellors were fine with sharing information that placed the client in a positive light even though this still breaches confidentiality.

Effect on the therapeutic alliance. The effect on the therapeutic alliance when working alongside social workers was experienced by most addiction counsellors as negative which differs from the literature that found service improved to clients as a result of multidisciplinary work (Huxley & Oliver, 1993; Schofield & Amodeo, (1999). It resulted in trust issues with the client. Sessions involved very stilted communication with the client often only saying what was thought to be desirable, and some clients voicing that they intended on seeking outside counselling services to deal with their “real problems”; see Quote # 1.3.14, 1.3.15 under Question 1 and 2.1.2 under Question 2.

Magical thinking. An element of magical thinking was revealed from all perspectives. The system perpetuates absolute and unrealistic messages for instance, “all kids will be kept safe”; see Quote # 3.1.8, 3.1.9 under Question 2. The client often believes the addiction counsellor will fix them and that their children are in care and will remain there because they have no control over the situation. The social worker believes the addiction counsellor will cure the client quickly, hopefully by the next court date, and often expects a chronic substance abuser to suddenly be able to abstain; see Quote # 1.3.26, 1.3.27 under Question 1. The addiction counsellor operates as though the social worker is all knowing and seeing, precluding the need to report child protection concerns; see Quote # 1.2.2 under Question 2.

Relationship key. A pervasive theme was that the relationship between the professionals is key. If trust develops, much more creativity occurs and the benefits of interdisciplinary work shine through regardless of the constraints inherent in the system. There is more joint work, open communication and better moral when the working relationships are strong; see Quote # 1.3.7 under Question 1.

“Is integration even a goal?” This question percolates from the results of this study. The sources of conflict between the disciplines are rooted in basic ideological differences, differing values and a huge imbalance of power. Gray (1989) noted that when one stakeholder has the power to take unilateral action or has unchallenged power to influence the other group, collaboration does not make sense. Not everyone is expected to change, only those that do not fit with the vision that the group in power holds. Several participants pointed out that they would not want the multidisciplinary team to move past cooperation on the continuum of integration because this would cause addiction counsellors to compromise their role and really become quasi social workers; see Quote # 3.2.11, 3.2.13 under Question 1. This study demonstrated that when the distinctiveness of one group is denied by another, identity and recognition become central to the conflictual relationship. Intractable conflict is always linked to the symbolic level of identity and meaning making, rather than material resources and communication (Conflict Research Consortium, University of Colorado, 1999). This type of conflict is the least amenable to change because identity and meaning are so fundamental to our sense of self and position in the world (Berghof Research Centre, 2000).

The concerns voiced by the participants in this study suggest that statutory and non-statutory services should not be combined. Integration between counsellors and child protection social workers comes at too high a cost. The principle of affinity holds that clients value confidentiality in the counselling relationship and this needs to be protected by

separation, otherwise the value to the client is lost. Clague et al. (1984) stated: “in retrospect many of the architects of the Community Resources Boards would now do things differently. The most desirable form of integration sees a distinct division between statutory and non-statutory services (p. 264).”

Most participants advocated for disciplines to be separated. The findings differ from the literature which advocates for multidisciplinary team work or integrated delivery systems (Doherty, 1995; Keene & Woolgrove, 1997; Rice, 2000). In this study, most of the participants (22/32 or 69%) wanted the disciplines to be housed separately. Although the majority of the interviewees wanted the disciplines to be housed in different locations, it was clear that this did not mean a desire to return to how they were functioning pre-amalgamation, isolated from one another. Both social workers and addiction counsellors want to see linkages maintained. In the words of one participant:

The neural pathways have been established, we've started talking to each other, we've got a lot of the ground rules done, we've made some connections with each other. Whatever infrastructure is created from here on in, we need to nurture these neural pathways and the beginnings we've made.

Being situated at different sites, but keeping and building connections is a way to balance the needs of children with maintaining the therapeutic alliance.

Shared infrastructure necessary, but not sufficient. Integration did occur in terms of joining together a number of previously separate programs into a single administrative structure, but this did not transcend to the day to day work of social workers and addiction counsellors, which was still conducted largely in categorical and traditional means; see Quote # 3.2.8, 3.2.14 under Question 1. A shared infrastructure is necessary, but not sufficient to facilitate integration. Informal networking was still the norm between the two disciplines even with the joint infrastructure. They never really came together as a team with a common goal

and agreement that the only way to reach it was to work together. More concrete steps needed to be taken to encourage the building of working relationships. "At first glance it might seem reasonable to assume that gathering several disciplines around the [client] might provide adequate opportunity to explore the problem and plan a therapeutic course. However, a successful and functional interdisciplinary team is never the byproduct of a series of serendipitous events" (Day cited in Klein, 1990, p. 36).

Ignoring the totality of addiction services. Integrating Addiction Services with the Ministry overlooked the total population that addiction counsellors serve other than parents with child protection and addiction issues; see Quote # 1.2.3 under Question 1. Addiction counsellors also provide service to single adults, people with co-occurring disorders, families, youth, couples and seniors. By ignoring the totality of this service, a parallel addiction system was developed by the Health Authority Board in Vancouver. There is always the concern when bringing statutory and non-statutory services together that all of the staff time and attention will be spent on statutory responsibilities, which legislation requires must be provided. According to the participants, this did not occur to the degree that they feared it might, but I believe this was due to low level of collaboration occurring between the disciplines, which resulted in little case overlap, rather than any deliberate action on the part of the Ministry for Children and Families to not subsume the service. Once responsibility for Addiction Services transferred to the Ministry of Health Services, even though the infrastructure remained intact, the referrals from social workers dwindled and the team meetings ceased, which strongly suggested there were no embedded connections forged as a result of the multidisciplinary model.

Necessary prenegotiations. The findings suggest that the transition would have met with more success if the necessary prenegotiations to bring the disciplines together were implemented initially. Instead, addiction counsellors experienced an attitude of "you will do as

you're told" and "you're role is to help the social workers"; see Quote # 1.2.1, 1.2.2 under Question 1. The success of a multidisciplinary model depends in large part on the process of legitimizing parties' interests (Gray, 1989). Addiction counsellors perceived real risks to collaborating and had concerns about co-optation and lack of fairness, which needed to be addressed for any collaborative effort to succeed; see Quote # 1.1.3 under Question 1. Both groups needed to feel safe to explore differences and all voices needed to be heard. The lack of dialogue between management and front line staff and between addiction counsellors and social workers about very key issues retarded any substantial progress.

Organizational practices. Based on the results of this study, the main area needing intervention is at the organizational and procedural level. The participants experienced the Ministry as only reflecting the norms of one culture. When the amalgamation of the disciplines occurred, a few middle managers with an addiction services' background were placed in the Ministry administrative structure. The vast majority of management had already been part of the Ministry resulting in little representation of addiction services at the upper management level. The system needed to be more sensitive to the cultural ways of both groups. A cultural dominance model was adopted versus a cultural compromise or cultural synergy configuration (Landis & Brislin, 1983); see Quote # 1.2.12, 1.2.13, 1.2.14 under Question 1. It was an ethnocentric model that neither recognized nor valued cultural differences in the interactions between people (Landis & Brislin, 1983). Diverse cultures within this context will feel oppressed and dominated by the majority and organizational culture (Landis & Brislin, 1983). This lack of integrative framework is evidence that the Ministry thought there was no need to meet the needs of the newcomer culture; the Ministry's stance appeared to be, "we already have what we need in place and the minority culture will have to adapt." This organizational approach led to covert and overt resistance, minimal intercultural learning and overall

ineffectiveness (Landis & Brislin, 1983). Egan (1985) noted that the major resource of any organization is the staff who implement the programs that lead to the accomplishments of the system. If fundamental staff requirements are not met such as the need for validation, affirmation of identity and belief in competence, as was the case in this study, there are detrimental results in the financial, resource and service realms.

A change in organizational practice that would promote healthy working relationships is the use of collaborative dialogue and a collaborative model of power. Respectful and active listening about deep rooted feelings, beliefs and experiences can lead to the discovery of common ground. Parties can better understand each other and establish a positive relationship with each other without being pressured to change their own views. A more collaborative and constructive model of power can be achieved by: (a) practicing mindful self-restraint in activating power currencies, (b) delegating responsibilities evenly to members of diverse groups, (c) soliciting feedback from less powerful individuals, (d) taking the proactive step to approach the minority group, rather than wait for them to come forward, (e) acknowledging interdependence with each other, and (f) looking for constructive opportunities and challenges for the less powerful individuals (Ting-Toomey & Oetzel, 2001). There also needs to be an atmosphere of acceptance that conflict is a pervasive and inevitable element when any two diverse parties are attempting to coordinate their actions.

Conceptualization of two disciplines as two separate cultures. Derived from the results was the conceptualization of the two disciplines as two different cultures coming together and experiencing intercultural conflict. The two disciplines of child protection social worker and addiction counsellor have differing: (a) knowledge bases, (b) professional experiences, (c) beliefs, (d) values, (e) role expectations, (f) worldviews and (g) time concepts. It is useful to conceptualize these professions as separate cultures because if the underlying

differences in beliefs and values are not attended to the situation can spiral into a complex, polarized conflict situation. Essentially, by overlooking the core characteristics of these disciplines that suggest they are separate cultures, a truly collaborative effort will not be achieved. A potentially creative way to integrate various disciplines could be to apply intercultural conflict models to effectively manage interdisciplinary differences (e.g. Ting-Toomey & Oetzel, 2001).

Relatively little studied area. It is still quite rare for addiction counsellors and social workers to work together on a multidisciplinary team together. An integrated, interdisciplinary framework still seems to be the goal, rather than the reality. Mostly voluntary services are studied in the literature. The nature of child protection work is different from other kinds of multidisciplinary work with its legislative responsibility and subsequent power. Furthermore, still little is known in a systematic way about the experience of multidisciplinary work for team members despite the large number of initiatives (Brown, Crawford, & Darongkamas, 2000).

This study provided the opportunity to explore the experience of addiction counsellors and social workers working within a multidisciplinary model. It uncovered the personal meaning of the transition and integration experience for each of the participants. They did not feel they had been heard previously and found that the study provided a venue for their voice to be heard. Many of the interviewees commented on the therapeutic effect of sharing their experience. There was a sense of relief to speak honestly about their experience, and as they shared there was a recognition of all they had been through.

Without this study, the experience of these two disciplines working on a multidisciplinary team for five years would not have been documented. It is my hope that we learn from this experiment and not repeat the same errors again in the future, which occurred after knowledge was gained, but ignored from the Community Resources Board initiative in the

70's. Future practice and program structure can build on what has come before. The next sections explore the limitations and implications of the study.

3. Limitations

I have worked as both a child protection social worker and an addictions counsellor. This could have hampered the study in the sense that I have internalized assumptions and perceptions outside my immediate awareness, preventing certain areas from being explored because I believe I already have the answers. However, I think the opposite occurred. As a result of my dual experience, I believe I was able to take the study to a deeper level that would not have been possible had I no prior knowledge of the work.

The sample size is very small for the social workers and not representative of the total social worker population. On the other hand, the addiction counsellor sample size is a large percentage of the total population and can be considered to be representative. A potential limitation of qualitative content analysis is it can be overly inferential. Precautions put in place to prevent this from happening were having the data coded by a colleague and having participants review it.

Some of the participants were known to me because I have worked with the Ministry for over ten years. This familiarity could have inhibited their sharing, but the level of sharing by the participants seems to belie this potential barrier. I believe there was more trust and safety, which led to more disclosure.

Interviewing participants in their offices may have affected their level of openness. Their immediate supervisors on-site did not know about the research. Interviewees did present as very forthcoming with free flowing responses and a high level of feeling attached. It was also their choice to be interviewed in their office after numerous options were provided.

The co-coder had my categories and may have devised an alternate coding scheme without my conceptualization. The participants did review the results as well and related that the categories accurately described their experience.

4. Implications

Policy Implications

Intervention at administrative level. The findings are clear that change needs to occur at the organizational level, if a multidisciplinary team is going to function effectively. The potential of the Ministry multidisciplinary model was far from realized due to some inhibitory organizational practices. On an administrative level this has serious implications in the dimensions of financial expenditures, resource management and service delivery. When the staff morale is low, there are more staff leaving the system and new staff needing to be hired and trained. The productivity of the staff who remain is decreased. There is more sick leave, less creativity and enthusiasm for the work. In human service settings, the clients suffer when optimal service is not provided. Egan's model of System Design, Functioning, and Assessment offers a step by step process to effectively intervene and manage the work of the system, the staff who make the system work, and the functioning of the system (Egan, 1985). Administrators could employ this model to facilitate positive organizational change.

Collaborative dialogue and use of power. Taking what was learned from the participant's experience in this study, it is important to shape policy within an organization to promote collaborative dialogue and use of power, to validate the identity of all parties, and to promote inclusiveness. The structure of team meetings can be a powerful forum to nurture collaborative working styles. It is essential to ensure that everyone's agenda is given attention during meetings and to make it safe to have open discussions about how parties envision working together, any perceived risks to collaborating, and how their group is perceived in the

context of respect and interest in each other's culture. Cultivating a cultural norm that one party can not force another party to do something, will reinforce equal footing between groups. Collaboration transforms adversarial interaction into a mutual search for information and for solutions that allow all those participating to insure their interests are represented (Gray, 1989).

Ongoing consultation and task group. The Ministry needs to have as part of their policy ongoing consultation with staff regarding any major decisions and changes. Staff feel very demoralized when they have no input or control over the work that they do daily. A task group could be set up to address each party's needs and concerns, and to develop a common language. Through an open airing of the issues in an environment of acceptance and respect, trust can be built, leading to the two groups struggling side by side versus moving away from one another (Ting Toomey, 1999). An understanding is fostered that conflict is a normal and vital component to collaborative work.

Training. An integral part of policy that enhances interdisciplinary work is ongoing training. Addiction counsellors would benefit from acquiring more expertise in how to work with mandated clients. Increasing social workers' knowledge about how to work with a counselling service and about the addiction process, would lead to better working relationships. Educational opportunities keep the work thriving, vital and current.

Treating the disciplines like two different cultures. Berghof Research Center (2000) indicates that culture is always relevant, if culture is defined broadly, including many types and levels of difference, all conflicts are ultimately intercultural. This view admits culture as an element of every conflict analysis and encourages seeing things the way another sees them (Berghof Research Center, 2000). Treating the disciplines like two different cultures can provide a framework to assist with multidisciplinary work. A thorough and ongoing cultural

assessment of all conflicts can be conducted. Intercultural conflict management techniques can be implemented such as those described by Ting-Toomey and Oetzel, 2001.

Distribution of study. The agencies providing approval to conduct this research and my direct management will be provided with a final report, a synopsis of the thesis, which may influence policy and program structure. By making this study accessible to decision makers, my hope is some of the above policy implications will be implemented. This could result in an organizational atmosphere and structural configuration conducive to collaborative practice.

Counselling Profession (Practical) Implications:

Graduate training. These results point to many practical implications for the counselling profession, particularly when a counsellor is part of a multidisciplinary team. Since many counsellors end up working with government funded agencies that service in large part non-voluntary clients, it makes sense for graduate programs to include in the curriculum how to work with mandated clients and with statutory services such as child protection and probation services. Other fruitful training areas would be: (a) how to handle the issue of confidentiality when working on an interdisciplinary team, (b) how to engage in interdisciplinary practice, being more of a generalist rather than a specialist, and (c) how to manage conflict between diverse groups would also benefit the functioning of a multidisciplinary team.

Client safety. The participants in this study dealt with the issues of client safety, social control and confidentiality by being as transparent as possible with the client. Therapists working within the context of a multidisciplinary team need to keep the client fully informed as to what is being shared, why it is being shared, how they think the information will be used, and preferably any sharing of client material will be in the company of the client. The lack of dialogue occurring between the disciplines regarding their work together stands out as a major

barrier to effective practice. The counsellor on a multidisciplinary team is in a unique position to bring the underlying issues into the open where they can be worked through instead of being kept in the shadows where tension and friction ferment. The counsellor has the necessary skills to fulfill this needed function within a multidisciplinary team.

Separate locations with linkages. The findings suggest that addiction counsellors and social workers need to work from separate locations, which will address the power imbalance to a large degree and client safety issues. However, due to the large overlap of substance abuse and child protection issues links between the disciplines need to be maintained. Some of the ways these connections could be forged and help serve the client better are having a single intake process, multiple disciplinary assessment process, and sharing certain information electronically. This would facilitate the client being treated in a holistic manner, conducting a thorough assessment, but being able to see their counsellor in a different office than their social worker. It would also prevent the client from having to retell their story multiple times to various parties.

Dissemination of study. A brief synthesis of the study will be disseminated to the participants. It may serve to instruct their practice and create healthier working relationships with the other discipline. Furthermore, I will continue to speak with colleagues about the results to stimulate ongoing dialogue. If we can be more effective as child welfare and substance abuse professionals, parents involved in the child protection and addiction system will be better served, which is ultimately what really matters.

Theoretical Implications

Wisdom of several disciplines needed. As noted in the literature review, the wisdom of several disciplines needs to be drawn upon to assist multidisciplinary practice given the

complex nature of developing successful collaborative endeavors: political theory, leadership, administration, dispute resolution, adult education, program evaluation, and technology assessment, for a start (O’Looney, 1994). There is not one specific knowledge area or model that covers all of the multifaceted aspects of a multidisciplinary process.

Inter-cultural conflict theory. From the results of this study emerged a picture of two diverse cultures suddenly in the position of living together, an arranged marriage of sorts, and the struggles and achievements they experienced while trying to co-habitate. With this conceptualization in mind, it makes sense to explore intercultural conflict theory and apply an appropriate model. One such model is “The Culture-Based Situational Conflict Model” (Ting-Toomey & Oetzel, 2001); see Appendix O.

Culture-based situational conflict model. The Culture-Based Situational Conflict Model lends itself well to assessing and identifying the factors that contribute to lack of collaboration between professional groups on a multidisciplinary team. The conflicts can then be addressed that arise when various disciplines are attempting to coordinate their services. If each group is more aware of the other group’s cultural characteristics, it is possible to meet each other’s needs in a more mutually satisfying way.

In this model, each cultural group has “Primary Orientation Factors” including: culture value patterns, personal attributes, conflict norms and face concerns. The “Situational Features” of each group mediate between the “Primary Orientation Factors” on the one hand, and the “Conflict Process Factors” on the other. “Situational Features” involve: ingroup-outgroup perceptual boundaries, relationship parameters, conflict goal assessments and conflict intensity and resources. The “Conflict Process Factors” are the communication behaviours that groups employ during intercultural conflict: conflict interaction styles, emotional expressions, facework behaviours and conflict competence skills. Depending on how well the groups have

handled their differences with respect to “Primary Orientation Factors”, “Situational Features” and “Conflict Process Factors”, will dictate “Conflict Competence Criteria and Outcomes” involving four elements: appropriateness, effectiveness, satisfaction and productivity.

The authors advocate including factors that are reflective of the particular situation. Adapting this model to this study, we could say that addiction counsellors have a more collectivist and small power distance primary orientation, while social workers are oriented to individualist and large power distance value patterns. The mediating situational features between the orientation and conflict process factors for addiction counsellors include cooperation and affiliation relationship parameters with social workers having more competitive and control relationship parameters. The orientation and situational factors lead to conflict process factors: addiction counsellors have more of a compromising conflict interaction style and dialogue competence skills, while social workers and the Ministry for Children and Families organization display a competitive interaction style with monologue competence skills. This all leads to “Conflict Competence Criteria and Outcomes” with neither group feeling very satisfied because their desired identity images are bypassed nor very effective due to not achieving mutually shared meaning and integrative goal related outcomes.

Journal article. I plan to put this research into a journal article format and submit it for publishing. I want to spread the findings as widely as possible. The more practitioners, researchers and policy makers have access to this research, the more likely it will have an impact. It will take concerted effort by many parties to improve services to parents with substance abuse and child welfare issues.

Research Implications

Identifying organizational factors. As was observed with this research, the organizational context within which the multidisciplinary team is embedded has a powerful influence on the functioning of the team. Research examining the organizational factors that help and hinder the interdisciplinary process between addiction and child protection services would be very worthwhile. We need to look more at what keeps already known knowledge from being implemented. A great deal was learned from the Community Resources Board initiative in the 70's, but it had no bearing on the Ministry for Children and Families' amalgamation effort. If it proves to be that social services are too entwined with the political process, perhaps creating a commission to administer programming would combat this somewhat because it is more detached from the political agenda.

Applying culture-based situational conflict model. The collaborative, compassionate and constructive use of power needs to be further inspected. The misuse or imbalance of power sabotages integrative efforts. When working with statutory services, balancing social control and coordination is a major concern, which needs to be better informed through research. The Culture-Based Situational Conflict Model could be applied to an interdisciplinary setting to work through intercultural (group) conflict when teams are forming and when they have been operating for a while. It could be determined how effective the model is with building satisfying and productive working relationships between the parties. "Culture provides ways of seeing and ways of not seeing; ways of action and ways of inaction" (Morgan, 1986). This model offers a way to see through the lens of our culture, but to also have a glimpse and understanding of the other culture. Kline (1995) posits that "there is a good likelihood that if all experts understood the relationship of their particular disciplines to her disciplines and to the

totality of human knowledge more clearly, the problems of mutual communication and understanding would be ameliorated” (p. 4).

Best approaches to confidentiality. More work needs to occur regarding the best approaches to confidentiality on a multidisciplinary team. The participants used the tool of transparency with the client when releasing information, but the sharing of client information still remained a confusing, vague and nebulous area. Examining how best to keep the client feeling safe in the context of needing to share information to do collaborative work, could help to uncover more concrete approaches and offer more clarity.

Homogeneity of mandated population. The mandated or precontemplative client population could be studied to discover further distinctions. Presently, they are all lumped together, yet the experience of the participants in this study reflects that there are differences. Some are more ready to engage in a counselling relationship than others. If we were able to identify the different subgroups, appropriate treatment strategies could be developed.

Is counselling involuntary clients beneficial? There are many areas of future research that are a natural progression from the findings of this study. More work needs to be done on whether or not counselling involuntary clients is beneficial. The current studies mainly speak to compliance such as completing the designated programs, but do not do follow up work to see if changes have been internalized and clients are more satisfied with their life situation long-term. It not very ethical to be forcing clients into counselling when we do not know if it is effective.

Studying generalists. Bonafide generalists are in short supply. Professional preparation typically includes little exposure to other disciplines. It is important to look at how interdisciplinary work is actually done. Studying generalists who are truly effective interdisciplinarians could help to elucidate what the necessary components are to achieve this

status. Egan (1985) stated that universities should be, at least to some degree, interdisciplinary, but are often so protective of their own turf that interdisciplinary cooperation is almost impossible.

Further areas of study: There are other realms of study that would be worthwhile exploring: (a) it is important to know what programs, services and disciplines are compatible in terms of integrative efforts. Do the benefits outweigh the costs? (b) the literature lacks any type of conceptual approach regarding the actual formation of multidisciplinary teams, highlighting this as another key area to focus on, (c) data on outcomes are also limited and equivocal in relation to child protection, suggesting this is a gap that needs to be filled with more knowledge, (d) researching the client's experience when receiving service from a multidisciplinary team providing both voluntary and non-voluntary services would be an important and vital piece to improve professional practice, and (e) based on further research ethical codes could be altered to better reflect the therapeutic work occurring within interdisciplinary teams. The findings in this current study point to many more potential research paths to pursue.

CHAPTER VI

Conclusion

The Ministry multidisciplinary model did not reach its potential, engendering a sense of missed opportunity. This initiative entailed the massive undertaking of amalgamating over 100 programs from various ministries. The energy and resources needed for this project was truly daunting. It was understandable, at the outset, that there was much hope for what the model could facilitate in terms of collaborative work between addiction and child welfare professionals. Instead, many of the participants described powerful feelings of frustration, confusion and distress. The findings indicated that, despite the multidisciplinary model, the disciplines continued to operate, for the most part, as separate entities.

The majority of participants advocated for a separation of the disciplines, but within the helping field, prompted by the desire for more holistic treatment and fiscal considerations, there will most likely continue to be a movement to place various disciplines together. There is much discussion within human service settings about community partnering, integration and coordinated efforts. There have been prior efforts at integrating social service providers such as the Local Area Approach project, as discussed previously, which also failed in terms of not meeting its intended goal of facilitating integrative working relationships among several disciplines. Unfortunately, none of the knowledge gleaned from this initiative was utilized by the Ministry who in turn repeated many of the same mistakes. It is critical that we learn from the experience of the Ministry multidisciplinary model, so we are not in the same position a few years in the future, implementing the same flawed design with the same results.

The financial cost of reorganizing large human service systems is staggering. The inefficiency of the Ministry multidisciplinary model had incredible tolls on many levels. Many staff were spending much of their energy staving off the threat to their identity, which detracted

from their role and service to clients. There was a wealth of expertise among the social workers and addiction counsellors that was underutilized. Collaborative working relationships, for the most part, did not form resulting in little case overlap, which undermined the major intent of the model to share clients and coordinate casework.

This study illustrates the importance of making organizational changes to reap the benefits of multidisciplinary work and not the deficits. To cultivate third culture development or growthful potentials, adjustments at the administrative level needed to have occurred. The disciplines can then let their walls down and support each other in their daily work, which improves the quality of service to the parents with addiction and child protection issues. Specifically, management may find the following recommendations helpful: (a) meet staff needs to have identity validated, to be valued and appreciated, and to have their competence recognized through respectful and active listening about deep rooted feelings, beliefs and experiences, (b) conduct necessary prenegotiations that legitimize parties' interests and address concerns, (c) implement ongoing consultation with staff to foster an atmosphere of inclusiveness, (d) employ collaborative dialogue to cultivate a safe environment so all perspectives are respected, (e) exercise a collaborative model of power by delegating responsibilities evenly, not activating power currencies in an authoritarian manner and soliciting feedback, (f) embrace conflict as a normal and healthy part of interaction among diverse parties, and (g) respect the totality of service a discipline offers, which may include responsibilities outside the organization's jurisdiction. Egan (1985) offers a practical working model that addresses the design, functioning and assessment of systems which may be helpful in providing further direction. As well, to gain further clarity, the Culture-Based Situational Conflict Model may be useful in assessing and identifying the factors that contribute to the lack of collaboration between professional groups which can then be ameliorated.

This research suggests that a fertile area for future researchers to explore would be what organizational configuration and factors support multidisciplinary work among child protection and addiction services. If human service settings can be helped to function more effectively, the benefits to clients and society are far reaching. The multidisciplinary team with its inherent multiple perspectives is an intriguing venue to move further with life's complexities.

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Appendices

- Appendix A. Recruitment of sample through email
- Appendix B. Demographic survey
- Appendix C. Letter requesting approval to conduct research - Ministry of Child and Family Development
- Appendix D. Letter requesting approval to conduct research - Vancouver Coastal Health Authority
- Appendix E. Letter requesting approval to conduct research - Fraser Health Authority
- Appendix F. Organizational chart - Ministry of Child and Family Development
- Appendix G. Organizational chart - Fraser Health Authority
- Appendix H. Approval to conduct research - Ministry of Child and Family Development
- Appendix I. Approval to conduct research - Vancouver/Coastal Health Authority
- Appendix J. Approval to conduct research - Fraser Health Authority
- Appendix K. Certificate of approval from Behavioural Research Ethics Board
- Appendix L. Interview guide
- Appendix M. Participant informed consent
- Appendix N. Continuum of integration
- Appendix O. Culture based situational conflict model

Appendix A**Notice of Recruitment of Sample through Email**

Appendix B
Demographic Survey

Demographic Information

Date: _____

Name: _____ D.O.B. _____

1) Gender: Female Male

3) Educational Background:

_____ Undergraduate Degree (specify)

_____ Graduate Degree (specify)

_____ Post-Graduate Degree (specify)

4) Number of years in current role of addictions counsellor or child protection social worker:

_____ # of years – Addictions Counsellor _____ # of years – Social Worker

5) Cultural/Ethnic Background:

6) Marital Status:

single married common-law

divorced widow

7) Do you have children?:

yes no

8) Indicate how satisfied you are with your experience of working within the context of a multidisciplinary team?

Very Satisfied Somewhat Satisfied Not Satisfied

9) Do you think children and families are receiving better services as a result of the multidisciplinary model?

Yes No

Thank-you for taking the time to fill this out.

Appendix C

Letter Requesting Approval to Conduct Research -
Ministry of Children and Family Development

The study would be of a qualitative design utilizing a semi-structured interview format. The sample will comprise 16 addiction counsellors and 16 child protection social workers working within a multidisciplinary team setting. Each participant will be interviewed for 45 to 60 minutes. The participant's confidentiality will be assured by coding all material numerically. As well, all information collected will be kept in a locked filing cabinet to which only the researcher and co-researcher (my Faculty Advisor, Dr. Ishu Ishiyama) have access. The master key with the names of participants will be secured in a separate locked filing cabinet. It should be noted that I am interested in the social workers' experience working within a multidisciplinary team. The information collected will be anecdotal in nature and will NOT require any data about our clients. In the event participants want to share a case example to illustrate their experience, it will be overtly stated at the beginning of each interview to not refer to the client by name, only as their client. The interviews will be audio-taped and transcribed by myself, the researcher. If any identifying information should end up on the tape, it will be erased immediately.

Once all the data have been collected content analysis will be applied to help organize the information and draw inferences. Participants will check the results to ensure that the data are valid, which will take up to ½ hour, and can occur via telephone or email contact. All participants will complete an informed consent and be made aware that the process is voluntary, and they can choose to stop at any time without prejudice of any kind.

The creation of this interdisciplinary model was prompted by the tragedy of Matthew Vaudreuil's death. It was revealed that many professionals and service providers involved with Matthew and his family did not share information, resulting in a very fragmented approach. With the transfer of Addiction Services to the Health Boards, it would be unfortunate to regress to an uncoordinated, insular orientation. In Canada, at least 40% of the families involved in the child protection system have substance abuse concerns as well (Canadian Incidence Study of Reported Child Abuse and Neglect, 2001). The effects of these dual concerns on children, their families and society are devastating. I view this study as an opportunity to learn more about how to balance the needs of children through sharing of information and coordinated case planning, while maintaining a solid therapeutic alliance, which assists the parent in making healthy changes in their lives.

I realize that the timing of this project is occurring when there are dramatic changes underway with our government structures. When I commenced my Master's Program three years ago, and decided to focus my thesis research in this area, these changes were not part of the picture. Nonetheless, in other ways the studying of multidisciplinary team practice is very timely because it affords the opportunity to explore aspects of the model that will be helpful to retain, given transformations are on the horizon. Historically, there have been many attempts to coordinate services because of the realization that the complex nature and subsequent problems associated with addiction and child welfare are too broad and pervasive for any single discipline to manage on their own. The Gove

Appendix D

**Letter Requesting Approval to Conduct Research - Vancouver
Coastal Health Authority**

Appendix E

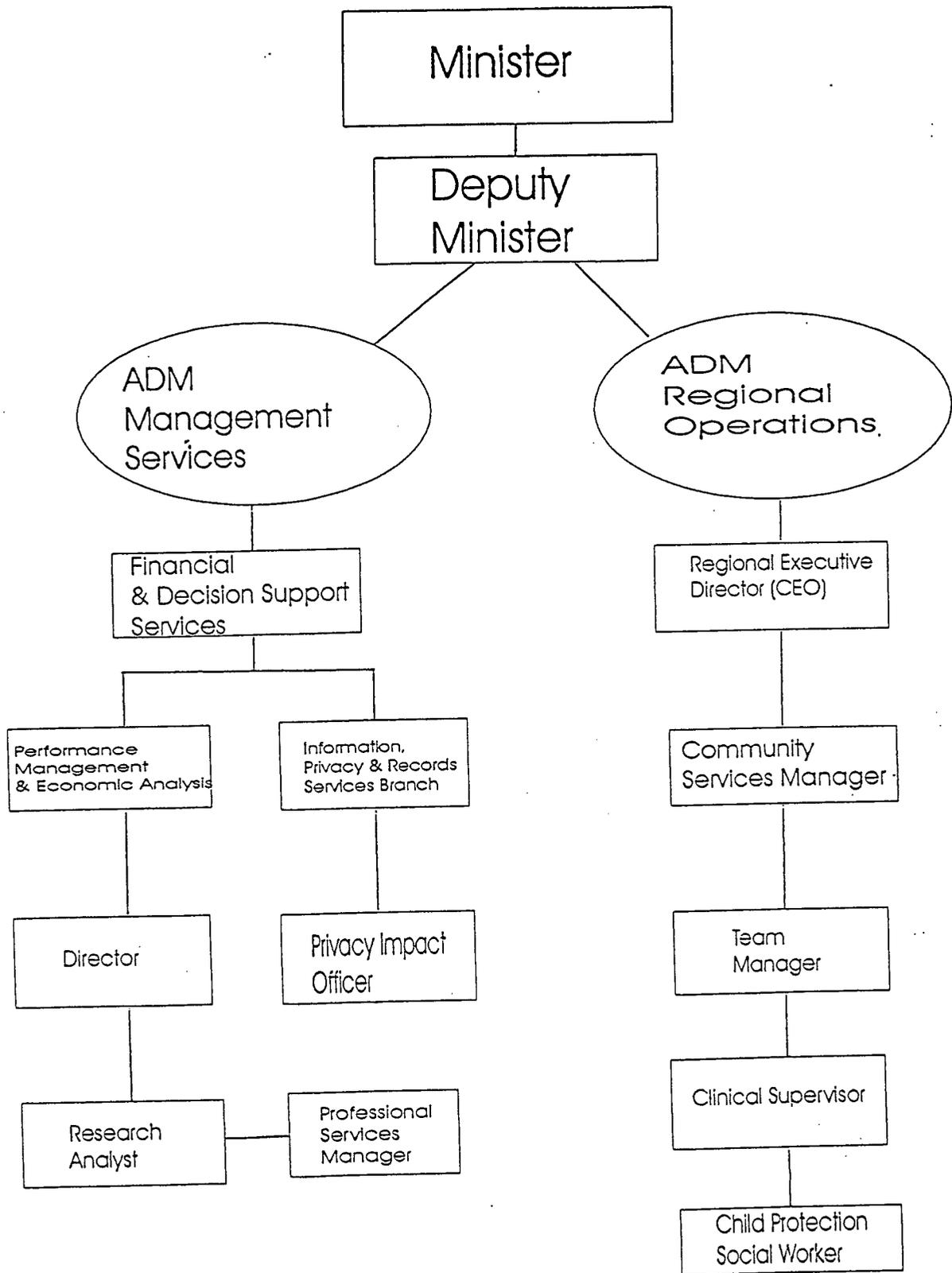
**Letter Requesting Approval to Conduct Research -
Fraser Health Authority**

Appendix F

Organizational Chart - Ministry of Children and Family Development

(I requested an organizational chart, but the Ministry was undergoing another reorganization and did not have one available. I created this one based on my knowledge of the Ministry)

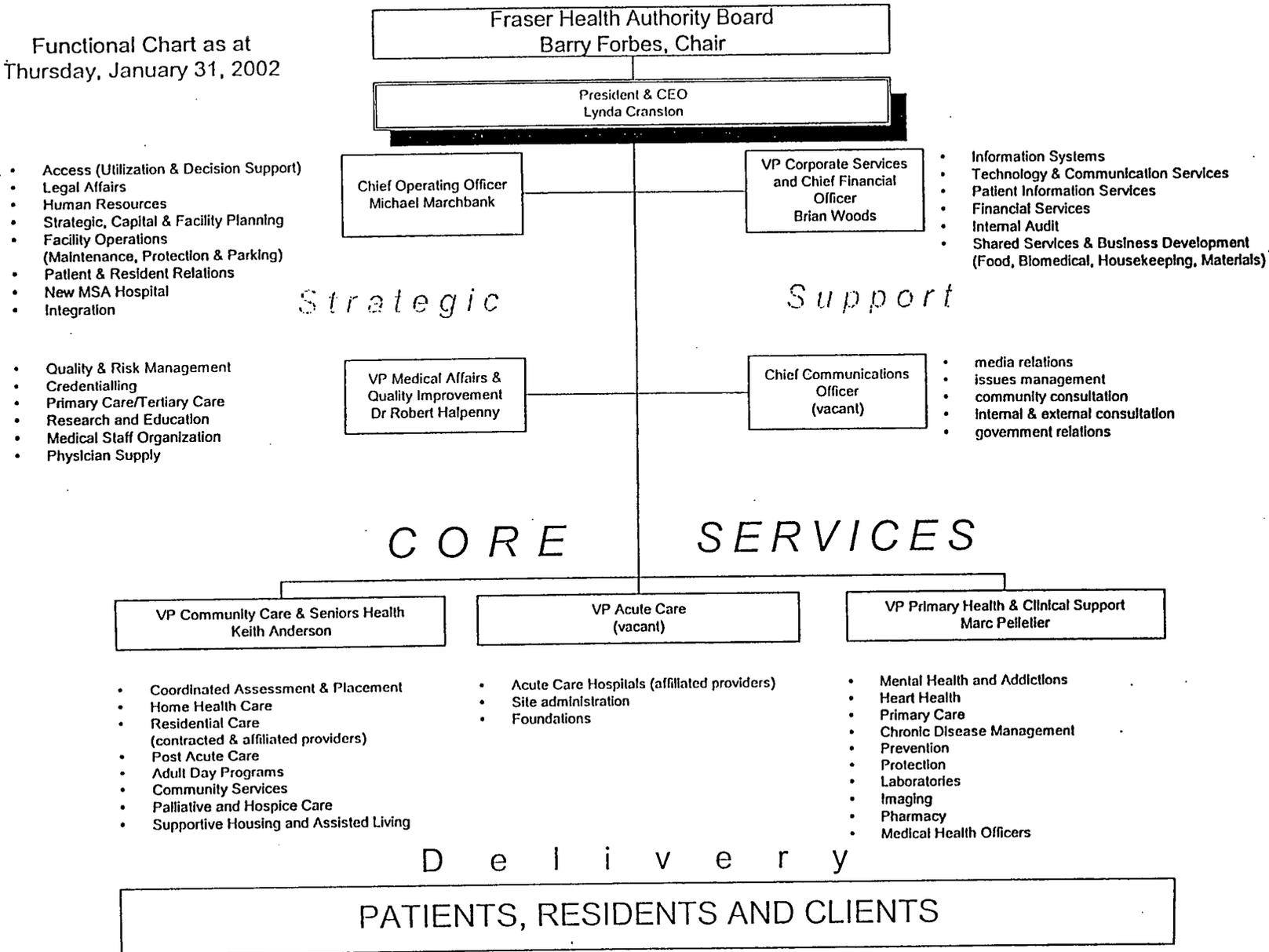
MCFD



Appendix G

**Organizational Chart -
Fraser Health Authority**

Functional Chart as at
Thursday, January 31, 2002



Appendix H

Approval to Conduct Research - Ministry of Children and Family Development

Appendix I

**Approval to Conduct Research -
Vancouver/Coastal Health Authority**

Appendix J

**Approval to Conduct Research -
Fraser Health Authority**

Appendix K

Certificate of Approval from
Behavioural Research Ethics Board

Appendix L
Interview Guide

Interview Questions/Guide

1. What has been your experience working within the context of a multidisciplinary team with child protection social workers/addictions counsellors?

- Describe some of the benefits and challenges of your multidisciplinary team experience?
- What aspects of your work require you to work alone/together?
- How would you describe the communication between the two disciplines?
- What does working collaboratively mean to you?
- How did the organizational structure affect the functioning of the team?
- Based on your experience of the multidisciplinary team, when considering a continuum moving from cooperation to coordination to collaboration to integration, which signifies an increasingly shared decision making process, as well as infrastructure, where would you place your team? Why?
- In your view, should the disciplines be located together or separately? Why?

2. What ethical situations have you come up against?

- How did you handle sharing of information with the other professional?
- What ethical conflicts were experienced as a result of the differing roles?
- How were they resolved?

3. How has your knowledge base been influenced as a result of working with the other discipline?

- What is your understanding of the addiction/child protection process?
- How do you work with relapse with your client? Harm reduction?
- How are the parenting issues addressed (e.g. safety plan; how substance abuse is affecting parenting).

4. What would you like to see happen with the multidisciplinary model in the future?

- With the transition of Addiction Services to the Health Authority Boards, what would you like to see happen?

Appendix M

Participant Informed Consent

I understand that my participation in this research is entirely voluntary and that I may refuse to participate, or withdraw from the study at any time. I have received a copy of this consent for my personal records.

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

Version 1 - March 11th, 2002

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Appendix N

Continuum of Integration

(This continuum was shown to participants. They were then able to indicate where their multidisciplinary team experience fell on the continuum. The results were reported in the Limited Third Culture and Current Status as Separate Entities sub-categories)

Continuum of Integration



—————> **Increasingly shared decision making process, as well as infrastructure**

Appendix O

Culture Based Situational Conflict Model
by Ting-Toomey & Oetzel, 2001

