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A COLLABORATIVE MODEL FOR THE COORDINATION OF ASSESSMENT SERVICES FOR EXCEPTIONAL CHILDREN & YOUTH IN THE NORTHERN ONTARIO REGIONS

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A COLLABORATIVE MODEL FOR THE COORDINATION OF ASSESSMENT SERVICES FOR EXCEPTIONAL CHILDREN AND YOUTH IN THE NORTHERN REGIONS OF ONTARIO

By

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ABSTRACT

A COLLABORATIVE MODEL FOR
THE COORDINATION OF
ASSESSMENT SERVICES FOR
EXCEPTIONAL CHILDREN AND YOUTH
IN THE NORTHERN REGIONS OF ONTARIO

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The Ontario Government's Social Policy Field, was established to ensure interministerial collaboration on policy development. Northern Ontario has been identified as a priority area for program development and/or consolidation within the Social Policy Field. This assessment-needs study was the result of a cooperative effort on the part of the staffs of the Ministry of Education, Community and Social Services and Health in developing an interministerial policy position which clearly identified the role and responsibility of each ministry. Participating Ministries have agreed to the following:

1. That Education conduct relevant assessments for purposes of diagnosing children's learning needs,

and providing programs and/or services to respond to these needs.

2. That Community and Social Services ensure provision of relevant assessments of children for purposes of diagnosing children's social, emotional and children's mental health problems, defining children's psychosocial needs, and providing programs and/or services to respond to these needs.

3. That Health ensure provision of assessments for purposes of diagnosing children's health problems, defining children's health needs, and providing programs and/or services to meet these needs. This report details the gap between what is, and what should be. It offers recommendations which, if implemented, would achieve the creation of an integrated and responsive service for children in need between the ages of two and twenty-one years.

The major assumption behind the project was that children's needs in the North could be served most effectively by a model that was developed to coordinate the delivery system, and make it more accessible.

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CHAPTER I - INTRODUCTION

Background

The Ontario Government's Social Policy Field was established to ensure interministerial collaboration on policy development among its constituent Ministries. The Deputy Minister's Ad Hoc Committee on Children's Services was one of the processes established to ensure compatible and complementary program delivery. Northern Ontario has been identified as a priority area for program development and/or consolidation within the Social Policy Field. As a result, the participating Ministries launched several new initiatives within the Northern Region. One was a proposal developed by the Ministry of Education in 1979 for "The Provision of Assessment and Psychological Services in Northern Ontario". Of significance in this proposal was the recommendation that:

> The availability of in-depth assessment and treatment services throughout the North be reviewed at an Interministerial level involving the Ministries of Education, Community and Social Services and Health to ensure that:
>
> 1. Resources currently available in existing

centres can accommodate the full range of exceptionalities referred to the centres;

2. Children in all communities within the catchment area of existing centres are provided equality of access;

3. Where necessary, additional resources are provided in accordance with a well-defined, phase-in plan.

It was noted in this report, that while community schools are able to provide for the majority of children's needs, there are still those children whose needs warrant additional servicing by other agencies. Therefore the need for coordination of service delivery was recognized.

As a result of this report, the Deputy Minister's Ad Hoc Committee directed the Ministries of Education, Community and Social Services and Health to formulate a long range strategy for the development of assessment resources in Northern Ontario. To accomplish this, a Steering Committee comprised of Senior Managers within the Ministries' operations at the regional level was established. The Steering Committee subsequently appointed an Assessment Task Force to design a system of assessment resourcing.

This initial Task Force (the "Northern Region Interministerial Task Force on Assessment Resources") which met from October 1980 through June 1981, presented their final report to the Deputy Minister's Ad Hoc Committee in the fall of 1981. The following recommendations defining jurisdictional responsibility were accepted from that report:

1. That Education conduct relevant assessments for purposes of diagnosing children's learning problems, defining children's learning needs, and providing programs and/or services to respond to these needs.

2. That Community and Social Services ensure provision of relevant assessments of children for purposes of diagnosing children's social, emotional and children's mental health problems, defining children's psychosocial needs, and providing programs and/or services to respond to these needs.

3. That Health ensure provision of assessments for purposes of diagnosing children's health problems, defining children's health needs, and providing programs and/or services to meet these needs.

Although it was acknowledged that psychosocial assessments were primarily the responsibility of the Ministry of Community and Social Services, it was agreed that for clients showing mild to moderate dysfunction, the Ministry first presented with the case would act as its own assessment agent. (Elaboration of the terms "mild", "moderate", "severe", and "very severe" appear in Appendix A).

The underlying philosophy for this assignment of assessment responsibility is that the Ministry of Education (usually through their Boards) is fully responsible for provision of educational assessment and the Ministry of Community and Social Services is responsible only for the behavioural (i.e., psychosocial) assessments of children which cannot be performed within the normal community setting (i.e., by schools, family doctors, clergy, etc....).

The deliberations of the Task Force were guided by a philosophical approach that favoured service provision to the total child within the context of his/her environment to ensure that each child shall have access to assessment services to meet his total needs. The "whole child" approach favours service provision from a client's point of view which is

holistic, taking an ecological view of the child. In addition, the Task Force determined that the service delivery system should be developed in such a way as to maximize the use of existing resources and results between Ministries. While it was important that the mandate for responsibility for assessment services be clearly defined for each Ministry, it was equally important that the integrity of the concept of the holistic child approach be maintained. Therefore, while there may be separate and distinct responsibilities assigned to each Ministry, these should be of consequence only at an administrative level, with the actual assessment process being conducted in as united a manner as possible.

Through an initial review of the assessment data available from Education and Community and Social Services, it became apparent that the formats for data collection varied greatly, to the point where it became difficult to determine what the impact on both systems would be with the adoption of the above recommendations. Since a common data base was critical, approval was given to the Steering Committee to field test the recommendations through a process of data gathering and consultation. In short, a data

collection process was required to document the status of assessment services currently functioning within the Northern regions of the province. It was also recommended that the process of consultation be extended to, and include participation by the Ministry of Health.

As a result of the above direction from the Deputy Minister's Ad Hoc Committee, a study to focus on the implementation of the recommendations of the Task Force and the issues raised by it was initiated.

Although agreement for jurisdictional responsibility for each Ministry in relation to assessment services to children was achieved at the senior level of government, considerable work and consultation was required to refine and operationalize a comprehensive assessment system. Through the collaborative efforts of the three Ministries and their respective delivery agents, an integrated and responsive assessment service system for children and families in Northern Ontario is presently being proposed. This study has operationalized the recommendations of the Task Force Report accepted by the Deputy Minister's Ad Hoc Committee and has provided

terms of reference for their successful implementation. The following discussion is a result of these efforts.

Statement of the Problem

In the past, the North has suffered from a lack of resources and services for children. Historically, those services that were available, have tended to be located in major urban areas. However, with this advantage little formalized coordination has developed among the various providing agencies to ensure that children's needs were being met. The following factors were identified as having contributed to this situaiton: small communities sparsely located and unable to support full-time service provisions; vast distances between any "major" centres; small enrollment schools; limited resources; limited provision of specialized personnel; distances that limit the provision of in-service training; cultural and linguistic differences; and insufficient Francophone and Native services in some specialized areas of need.

Ministries serving our child population have experienced mandate problems in relation to specific children as described by D. McKinnon in her report (Needs of and Resources for Children of Two Northern Ontario Boards, 1976). Children not clearly the responsibility of a single ministry have been difficult to serve. This has resulted in the duplication of

services in some situations, and a dearth of services in other situations.

The scarcity and unequal distribution of assessment services for children in Northern Ontario necessitates a need for a systematic approach on the part of Ministries and their agencies to provide opportunities for exceptional children. This need was documented by a committee composed of the three Regional Directors of Education for Northern Ontario, and three members of the Provincial Special Education Branch. The report, entitled (A Proposal for the Provision of Assessment and Psychological Services in Northern Ontario was submitted to the Deputy Minister of Education, on November 29, 1979).

To prevent a duplication of services between Ministries and their agencies, services need to be delivered as much as possible by the appropriate ministry and agency in the local area according to a role definition agreed upon by each ministry and its agencies.

Therefore the research problem is to develop and pilot a coordinated interministerial model for the delivery of assessment services to exceptional children and youth in the Northern Regions of Ontario.

Objectives

To develop a long range, coordinated, interministerial model for the delivery of assessment services to exceptional children in the Northern Regions of Ontario, a number of distinct tasks were undertaken. These were:

1. To compile an inventory of existing assessment resources within the Northern region through the completion of a comparable data- collection exercise by all three Ministries in order to identify the amount and type of assessment activities being done by each Ministry.

2. To analyse the data and make recommendations for the development and/or realignment of assessment resources consistent with statements of assessment responsibility which are acceptable to all three Ministries involved in the exercise.

3. To define and to document the scope and level of assessment requirements for each Ministry in order to achieve this realignment. To identify decision points and procedures in the assessment system where inter-agency coordination should take place, including the development of a mechanism for conflict resolution in the system.

4. To prepare a long-range strategy for the implementation of the recommendations presented to the Steering Committee.

Research Questions

To proceed with the development of the model the following exploratory questions of a qualitative dimension were delineated:

1. What model will best provide this service given the whole child philosophy and the respective mandate of each ministry?
2. Who are the children that will require the services?
3. What services do children require?
4. Can the model be designed collaboratively?
5. Who will provide the service?

Rationale for the Study

This study describes the tasks completed to meet the identified objectives. A project of this scope when fully operational will bring to the Northern Region a number of necessary assessment services that presently do not exist. The proposed delivery system will facilitate the sharing of information and assessment resources. Each participating Ministry will become more knowledgeable about, and have greater access to, the other's differing and complementary assessment capability. As a working model, the system may be duplicated by other provinces to provide services for their children in need.

Project Development Stages

A work plan was developed by the researcher for the purposes of cataloguing and sequencing the objectives. A planning guide in the form of a critical path bar chart was initially constructed to display the scheduling of the many activities involved in the project. Project goals were achieved through the following sequence of developmental stages:

1. The collection of data on assessment activities, capabilities and needs from M.C.S.S. agencies, Ministry of Education school boards, and the Ministry of Health was collected by the project team.

2. The preparation of an integrated interministerial model for the delivery of assessment services was carried out by the researcher and amended by the project team members.

The work plan provided a summary of activities and a review of the tasks to be completed. Not all objectives were achieved in precisely the same manner or sequence as was initially intended. Revisions in dates were necessary as a result of delays in resolution of provincial policy issues of an interministerial nature, and because of a longer time period needed for data collection and analysis. As

will be discussed in Chapter III, it was necessary to re-do the data collection phase. This necessitated a new questionnaire and definitions which were cooperatively established by the participating Ministries.

Throughout preliminary discussions and activities, representatives of Education and Community and Social Services acknowledged the need to include representation from the Ministry of Health. At that time, however, it was felt that this would occur only after Ministry of Community and Social Services and Education, the two Ministries primarily involved with the assessment of children, had achieved agreement on their respective responsibilities for assessment services and resource requirements. The extent of the Ministry of Health's involvement in the preliminary stages of this project could be termed "process partnership" or "passive involvement" as Health was provided with updates as decisions were made. Generally, these decisions were considered fait accompli unless Health had a concrete counter proposal. Nevertheless, Health initially met with the project team to determine the applicability of both the

categories of dysfunction and the operational definitions to their service system.

Overall, as matter progressed there were a number of operational policy issues that required resolution and that had implications for the assessment services provided by the Ministry of Health. For the proposed model to be truly reflective of the activities and needs of the Northern Region, a higher degree of support and participation was eventually required and obtained from the Ministry of Health.

Scope and Limitations of the Study

The findings of the study are limited in application to the time specific to the completion date of the assessment survey. However, it should be noted that while the volume of referrals/assessments made by agencies/boards may change, general patterns may still remain. In addition, the findings may or may not be generalized to geopolitical settings other than Northern Ontario.

In theory, the effectiveness of enterprises of this nature are limited by the goodwill present among the participants at all levels. At the corporate or ministry level a great deal of goodwill was required to establish a positive feeling about cooperative efforts and to build rapport for cooperative agreements. This goodwill present among Ministries extended to determine the extent of the "rapprochement" among the various professionals involved and was a determining factor in whether successful collaboration in formulating and implementing a new service delivery model could be achieved. While ideally the emphasis is directed to the common good (i.e. providing assessment services for children in need), goodwill is essential in promoting linkage efforts and resolving questions about the

status of standing practices and agreements and complex administrative issues. Goodwill affects differing outlooks, perspectives, interests, ideologies, and professional rivalries (turf protection relating to which ministry provides what service or which ministry incurs the costs of servicing), all potential factors and which could limit a multidisciplinary, cooperative, interministerial project of this kind.

Definition of Terms

Education Act (Bill 82)

Provincial legislation ensures that all exceptional children in Ontario have available to them appropriate special education programs and services without payment of fees by parents or guardians. Bill 82 provides for the parents or guardians the right to appeal the appropriateness of the special education placement. It requires school boards to implement procedures for early and ongoing identification of the learning abilities and needs of pupils, defines exceptionalities and prescribes classes, groups or categories of exceptional pupils. And it also requires school boards to employ such definitions or use such prescriptions.

Exceptional Child

An exceptional child is a child whose behavioural, communicational, intellectual, physical or multiple exceptionalities are such that he or she is considered to need special services.

Hard-To-Serve

A pupil who is deemed to be unable to profit by instruction offered by a board due to a mental handicap

or to a mental and one or more additional handicaps is Hard-to-Serve.

Identification, Placement and Review Committee (I.P.R.C.)

The I.P.R.C. places exceptional pupils in special education programs and services, and reviews such placements yearly or on parents' demand (Ministry of Education Regulation).

Ministry

Is a government department established to enact a given area of legislation.

Special Services

These are facilities and resources, including support personnel and equipment, necessary for developing and implementing a special program.

Unusually Difficult Service Situation Committee (U.D.S.S.)

This is a committee that examines unusually difficult service situations due to multihandicapping conditions or needs outside of the normal service system (Ministry of Community and Social Service Memorandum).

Inter-Ministerial Assessment Planning Team (I.M.A.P.T.)

The I.M.A.P.T. is composed of the Director of Education, the Area Manager for Community and Social Services, and the Area Program Planner for the Ministry of Health.

Service Stream Agency

A service stream agency is any agency funded by a ministry to carry out the services dictated by the mandate of that particular ministry.

Overview of the Study

The following is an overview of the remainder of the study. Chapter II will contain a Review of the Literature. Chapter III describes the model for coordinating interministerial assessment. It will offer a model for coordinating the delivery of assessment services which identifies decision points in the assessment system where interministerial coordination should take place at an agency level, and the development of procedures for how this will happen. It provides a mechanism for conflict resolution in the system, and suggests an implementation plan. It also presents sources of data, data analysis, and procedures used in the research of the study. Chapter IV describes the Pilot, and Chapter V presents a summary, conclusions and recommendations.

CHAPTER II - A REVIEW OF THE LITERATURE

Section 1 - Introduction

1.1 Background of the Review

The primary thrust of the literature review was to gather information regarding possible models for coordinated assessment service delivery. Despite the significance of the topic, the literature in this area was somewhat modest with general lack of attention being given to the complex organizational and decision making processes within systems and between systems. Much of the research on child assessment has generally "focused its attention upon the learner and the teacher" (Gallagher 1978, p. 25). Initially, the investigation sought to gain an impression of the work outside Ontario in order to identify major trends and issues in the field. In tracing information about coordinated assessment work in Canada, except Ontario, secondary sources were scarce and primary sources such as provincial government policy statements and programs were not readily available.

> The reporting itself is not difficult but one runs the risk of reporting something which may be completely out of date by the time the completed

> document is in the hands of interested professionals (Kelsey 1978, p. 5).

Nevertheless, a brief survey and description of the present Canadian situation has been attempted.

While this process has produced scant Canadian data, there is an overabundance of American sources from which to choose. Woodill provides perspective to this situation by stating:

> Cultural domination from our neighbour to the south is not just a matter of an overabundance of American books, records, and movies. It is seen whenever we Canadians lose our sense of history and identity and look to the U.S. for our models and precedents in any area of endeavour. This would seem to be the situation in the field of working with exceptional children. Most of the textbooks on special children used in Canadian universities and colleges are American. The majority of journals and books in our libraries are from the United States. Most of our large conferences are dominated by non-Canadian speakers (Woodill 1981, p. 1).

The literature suggests that research and development is an area neglected by all provincial

governments. Educators are aware that little money is being spent in Canada on basic and applied research concerned with improving services to the handicapped. However there are examples of some provinces that have assigned money to policy-making and administrative research (Perkins 1975, p. 22). Since Canada does not have a national centre for the study of special education, we have become very dependent on American research.

> When will Canada have a national coordinated research and development focus in special education? We still suffer from a frontier mentality both at the federal and provincial level when it comes to making a full commitment to handicapped children and to ensuring comprehensive and quality services based on sound planning, research and management (Perkins 1979, p. 33).

Thus, the intent of this review is to focus on the general aspects of service delivery which could lead to possible action guidelines in developing and supporting the model presented in a later section.

1.2 History and Problem

The following is a general historical perspective.

According to Korteweg (1983) the current problems and issues in special services in Canada exist because of our historical and political development and because of our attitudes and values.

One problem in Canada is the dispersion of responsibility among the vast array of unrelated and independently functioning helping agencies for children. Each agency offers its own unique set of services and is often unaware of duplicate efforts and sometimes, even, of the existence of sister agencies involved in providing similar services to the same client groups. Separate services have acted independently and fragmentation of effort has resulted.

A document of particular significance to Canada in the area of special service delivery is "The Report of The Commission on Emotional and Learning Disorders in Children", the Celdic Report (1970), entitled One Million Children. The Celdic Report made numerous recommendations affecting all aspects of special service provision for children and youth. The Report noted that:

> The lack of integration is largely a reflection of the fact that these services were established as an individual, a voluntary association, a private group or a government department saw a particular need and acted to develop programs to meet the need as they perceived it (p. 294).

In short, legislation involved piecemeal social engineering, which has resulted in a variety of services fragmented in terms of departmental responsibility and objectives. Services developed in this manner were capable of meeting only a part of the total community need in a quantitative sense. 'In most instances service programs were so designed that they offered only a part of the range of programs required to solve the problems presented around any particular child' (Lazure & Roberts 1970, p. 294). Today, it is generally agreed that a wide variety of services and 'a total spectrum of service delivery capabilities is essential' (Gearheart 1980, p. 53).

Closely related to the lack of coordination in the planning and delivery of services, and a part of the same problem, is the fragmentation at the provincial government level into departments of education, welfare, corrections and, in some provinces, manpower.

The lack of coordination among these various agencies in their efforts to plan and implement services was outlined in the Celdic Report as a major reason for duplication of, and gaps in, services to handicapped children in Canada (p.295). While many of the various service providers do perform some highly specialized functions, in large part they are not significantly different from those performed by many other helping services. 'This unnecessary specificity of function only fragments the delivery of services to the child and his family' (p. 296).

Therefore, complementary and alternative services are administered by separate ministries with different policies and practices. These different ministries and agencies are influenced by different helping professions with different outlooks and ideologies. The end result is that the problems of children in need have been, and are being, treated in a piecemeal fashion.

1.2.1 The Problem of Service Delivery in the Smaller Towns and Rural Areas

There is basic agreement that services are seriously underdeveloped in the smaller towns and rural areas, and tend to be concentrated in the larger

centres of population (Perkins, 1979; Korteweg, 1983). Even where services do exist in more adequate numbers, they often lack coordination and are characterized by overlaps and gaps. Wide variations have existed, and continue to exist, from one jurisdiction to another (Goguen and Leslie, 1980; Perkins, 1979).

According to Korteweg (1983) it is vital that the problem of service provision and adequate support personnel in the marginal areas be faced and tackled.

> Ontario and other provinces with a large northern hinterland as well as the territories, must establish special units for the provision of support services in those regions. The least policy makers and implementors can do is to ensure that travelling resource teams and teachers are regularly available to schools along a northern railroad track or within the flight path network of bush planes (p. 8).

Perkins (1979) notes that while children in isolated and remote parts of a province should be able to obtain special services similar to those obtained by children living in urban areas of the same province, to deliver such service may require "differential financing of special education because of the low

incidence of handicaps in sparsely populated areas" (p. 35). In sum, the problems of geography and distances demand "a higher staff-to-student ratio to deliver comparable service" (p. 35). The author concludes that this requirement does not appear to have been recognized probably because of the politics involved (p. 35).

1.2.2 Geopolitical Boundaries

The geopolitical boundaries of the various servicing agencies was recognized to be an important issue in the Celdic Report. The report recommends that geographic boundaries of the education, health and welfare components of the network of service programs be the same (p. 310). It is generally recognized that ill-defined and ambiguous boundaries in service districts generate confusion and friction between departments and their staffs (Williston 1971, p. 92). This is seen as a major obstacle in providing service since it creates difficulties for the parent who is trying to find help for a child, and also creates major barriers to communication between the helping professions (Lazure & Roberts 1970, p. 310). Moreover, variations in service district boundaries can frequently provide an easy out or an excuse "for

administrative confusion, for lack of cooperation or for failure to provide services" (Lazure & Roberts 1970, p. 310).

1.3 Trends in Special Service Delivery in the U.S.

The shortcomings in the present delivery of services in Canada also exist "in varying degrees in other countries, throughout the world" (Perkins 1975, p. 19). In the U.S., education, social service, and health service agencies share common mandates and common clients. A broad range of services are duplicated. Services lack coordination, and are provided by "... scarce personnel which compete for their employment" (Lacour 1982, p. 265). Hagebak (1982) indicates that some state governments in response are attempting consolidation of local delivery systems "in the interest of cost effectiveness, to assure that those in greatest need continue to receive adequate care" (p. 73).

In the U.S., Public Law 94-142 mandates the nationwide provision of assessment and individualized education plans(IEP's). School boards must provide comprehensive, nondiscriminatory and multidisciplinary evaluations of exceptional needs; provide programs and develop education plans for these needs; provide services, personnel and facilities to identify, plan and program for exceptional needs (Posno 1981, p. 16). In Ontario the issue appears to be not so much whether

assessment and individualized education is called an IEP or a PEP (Personalized Education Plan), rather it is that such a plan must be provided.

1.4 Trends in Ontario: Bill 82

In Canada, organizations such as The Association for Children with Learning Disabilities, The Canadian Association for the Mentally Retarded, The Council for Exceptional Children, and various others, not only created public awareness but also began to lobby and to exert sufficient political pressure to set a legislative process into motion for the protection and extension of the rights of children in need (Korteweg 1983, p. 4).

In Ontario The Education Act (1974) contained only permissive legislation for Special Education. A school board could, if it wished, provide special education programs and special education services for its exceptional pupils. Although most boards provided some programs, the passage of Bill 82 (1980) recognized that the development of a child with special needs is best promoted when treatment and education programs are viewed as interdependent and planned together. It removed the "optional" status of special education and made it the definite responsibility of school boards to offer services which were not offered or were offered by other agencies. School boards in Ontario must now:

(a) identify children with exceptional needs

in the areas of behavioural, communicational, intellectual (including the gifted), physical or multiple exceptionalities;

(b) provide a special education program that is based on and modified by the results of continuous assessment and evaluation and that includes a plan containing specific (learning) objectives and an outline of educational services that meets the needs of the exceptional pupil;

(c) provide special education services, meaning facilities and resources and including support personnel and equipment necessary for developing and implementing a special education program (Posno 1981, p. 15-16).

1.5 Trends toward Cooperation/Collaboration in Canada

In Canada, where human services are primarily a provincial responsibility, several provinces have introduced various forms of reorganization of services in an effort to assure greater rationalization and coordination (An Experiment in Progress ..., 1977, p. 6).

1.5.1 The Atlantic Provinces

The interest and support from the Ministers of Education of the Atlantic provinces resulted in a comprehensive study of the needs of children with low-incidence handicaps and led to expanded programing and services and increased cooperation among the four provincial governments. Through the creation of a new administrative structure in 1975, the APSEA (Atlantic Provinces Special Education Authority), cooperative efforts on behalf of low-incidence handicaps (visual, hearing, multiple handicapped) were ensured. With relatively small populations in the Maritimes, this type of cooperation has 'greatly benefited the handicapped population and at the same time has permitted more fiscally efficient programing' (Gearheart 1980, p. 88).

1.5.2 Quebec

In 1969 an Interministerial committee was formed which included the ministries that were most directly concerned with children in difficulty (Education, Social Affairs, Health, Justice and Labour). The Committee defined and described the responsibilities of the various governmental agencies as they related to such children. Developments in Quebec parallel those in Ontario.

> Since 1975, school boards have gradually expanded their services so that today they are accepting a number of students with more severe handicaps who might have earlier been the responsibility of the Ministry of Social Affairs or specialized private institutions (Gearheart 1980, p. 93).

With the increasing responsibility of the schools to provide direct services to the more severely handicapped population, many school districts could not effectively or efficiently provide services within their local schools and, therefore, have entered into agreement with other school districts or private institutions to provide appropriate schooling (Karagianis and Nesbit 1980, p. 7). Educational provisions for the handicapped student have become an

educational responsibility, not a social or welfare responsibility even though the Ministry of Social Affairs "is the agency other than education with major involvement with handicapped students" (Gearheart 1980, p. 93).

The Office of the Minister of Education in 1978 issued a document entitled "Quebec Schools; Children with Adjustment and Learning Difficulties. Statement of Policy and Plan of Action" (Morin 1979).

The government's official position is that children who had previously been described as exceptional or maladjusted now be referred to as "children with difficulties in learning and adaptation". The province of Quebec saw this as a "positive" change in the perception of children with learning and adjustment difficulties (Karagianis and Nesbit 1980, p. 7). Implementation of the program is presently underway with both financial and program planning support from the provincial level. Gearheart (1980) cautiously warned that how well the local school districts carry out the intent of the provincial government "remains to be seen", although an expanded and improved program is "certainly under way" (p. 94).

1.5.3 Saskatchewan

Saskatchewan, has seen certain pilot projects underway with a growing number of cooperative programs within departments of the government being contemplated (Gearheart 1980, p. 98).

1.5.4 British Columbia

In B.C., a number of special education programs other than the residential programs receive joint support from various ministries, and therefore require coordinated planning at the provincial, regional, and local levels. Such planning has taken place for some time. In 1978 an Interministry Children's Committee (IMCC) was formed, linking the ministries of the Attorney General, Education, Health and Human Resources. These four ministries have attempted to provide additional assistance and guidance in determining how needs may best be met. They appear to have been of most assistance to the severely handicapped, and in planning services in sparsely populated areas. Procedures have been established whereby in problem situations attempts are first made at the local level, then if necessary, at the regional level. If the regional IMCC cannot arrange for the

needed resources, the provincial IMCC is consulted (Gearheart 1980, p. 101).

> The Inter-Ministry Children's Committee system may prove to serve an advocacy role for students who are not being appropriately educated (Gearheart 1980, p. 101).

Gearheart (1980) however cautioned that in B.C., certain of its programs are relatively new and the effectiveness of the IMCC has yet to be fully established (p. 101).

1.5.5 Alberta

The activities of the Institutional (Educational) Services Divisions of the Edmonton and Calgary public school boards provide an excellent example of cooperative effort.

> In this cooperative model, interdisciplinary divisions (health, psychology/psychiatry, social welfare, justice and education) have devised a plan through which they jointly serve the needs of individuals in regional or provincial sheltered settings, treatment centers, or detention homes, with appropriate authority and responsibility delegated to planners of the various program components (Gearheart 1980, p. 102).

1.5.6 Summary

Provincial statements supporting the idea of interministerial cooperation and the existence of effective cooperative programs have illustrated the current trend in Canada. In many places throughout all provinces, local and provincial governmental agencies have made an additional effort to work together to be of service to children with special needs. These programs may in the future provide models for those who need guidance in planning or reshaping their own programs. An investigation of the trends and practices in Canada led Gearheart (1980) to conclude that:

> Much improvement is needed in certain areas of the nation. Nevertheless, it appears that there may be more deliberate planning and cooperation between agencies serving handicapped students in Canada than has sometimes been the case in the United States (p. 103-104).

1.6 Regional Self Sufficiency

The literature has strongly favoured regional self-sufficiency in the delivery of services to communities. The Warnock Committee realized that many severely handicapped youths might be ignored given the sparse geographic distribution of such children in some areas. The Celdic Report indicated that only when a problem is so complex that it requires a combination of expert resources from outside the community, should "it be necessary for a child to be referred out of the normal stream of his home community" (p. 316).

While provincial governments have exercised and should continue to exercise their role in establishing controls and setting standards, services operated by governments remote from the scene cannot quickly, effectively and efficiently be responsive to the changing needs of a local community (Lazure & Roberts 1970, p. 303).

1.7 Incidence of Disabilities

Incidence estimates vary considerably. Accordingly, most writers carefully acknowledge the limitations of their methodology in reporting incidence rates. There are variations in estimates because of a failure to either include or exclude certain types of conditions. "The major source of variation in the estimates in the literature is the narrowness or breadth of the defining criteria" (Rawlyk 1977, p. 45). Those groups generally referred to as "learning disabled" and "emotionally disturbed" tend to be the most contentious because there is little agreement over definitions which can be quantified.

> In general, there is fairly consistent agreement on the incidence of sensory impairments (e.g. blindness and deafness) compared to the functional disorders (e.g. learning disabilities, emotional disturbance) since the latter are frequently based on the judgment of the estimator (p. 45).
>
> Overall, there is a paucity of research in the area concerning incidence rates in Canada. Few systematic incidence studies have been conducted in Canada, and estimates of need in the Canadian population at present tend to be based on

rates established in the United States (Rawlyk 1977, p. 45).

The Celdic Report (1970) estimated "that one child in eight has an emotional or learning disorder that will prevent optimal development unless some intervention takes place" (p. 5); the Warnock Report (1978) suggests that services for children and young people be based on the assumption that:

> One in six children at any one time, and as many as one in five at some time during their school career, will have difficulty to the extent that will need some type of Special Education provision (p. 41).

Karagianis and Nesbit (1980) point out that "the implication for such an increase in the accepted number is profound in terms of both manpower, and cost" (p. 7). Instead of 12½ per cent of our school age population requiring special help, they estimate that 16½ per cent fit into this category (p. 7).

Rawlyk (1977) raised the question of variation in incidence of handicapping conditions in different areas of geographic responsibility. For some school districts, the provision of services (particularly for

more severe handicapping conditions), can actually raise the incidence level in that district (p. 45).

> The lower the prevalence of the condition in the school population, and the higher the costs of an appropriate program, the more likely that families with such handicapped children will move to school districts with established programs thus raising the incidence rate for the ... jurisdiction. If these variations are indeed valid, some way of allowing for them needs to be incorporated into a funding formula (p. 45).

1.8 Services to Minority Groups

A number of writers have discussed the problem of providing special services to minority status children. Professionals can no longer ignore the demand for special services to minority groups since legislation and the greater assertion of rights by minority groups have made the provision of special services to meet the needs of children, a "societal expectation"' (Korteweg 1983, p. 9). Minority or low socioeconomic status children may, in practice, present unusual problems in assessment. The provision of services to children in a culturally and linguistically appropriate manner may have considerable significance for children in those areas with special needs, according to Warnock (1978, p. 69). Special care must be taken where this may be a factor (Gearheart 1980, p. 58). Writing about the ethnic diversity in the U.K., Warnock (1978) recommended that:

> Wherever a child's first language is not English, at least one of the professionals involved in assessing his needs must be able to understand and speak his language. The assessment of the needs and the placement of children from ethnic

> minorities may be a matter of special sensitivity (p. 69).
>
> In short, the danger is equating "different" with "deficient" (Korteweg 1983, p. 5).
>
> Indeed, any tendency for educational difficulties to be assessed without proper reference to a child's cultural and ethnic background and its effect on his education can result in a category of handicap becoming correlated with a particular group in society (Warnock 1978, p. 69).

In this regard, Korteweg (1983) asserted that minorities in Canada, whether for economic or for cultural differences, "have reason to believe that their children do not get a fair deal from the school to which they send them" (p. 5).

Section 2 - Coordination, Collaboration and Organizational Change

2.1 Introduction

This section reviews, condenses and synthesizes the literature on coordination and collaboration, limiting itself to some of the characteristics, issues, problems, factors, guidelines and practices that are worthy of consideration when planning and implementing a collaborative model for coordinated delivery of services. An understanding of the factors revealed in the literature is important to successful local service integration and sound management practice.

2.1.1 Definitions: Collaboration and Coordination

The body of the literature associated with the collaborative school of thought tends to support certain generalizations about the process of collaboration, which may occur between agencies or within a single organizational unit such as an agency (Roberts 1980, p. 1). Surprisingly, there is no clear consensus on the definition of the term "cooperation" in the literature. A collaborative framework is often called a "network", "consortium", or "coalition".

In the broad sense the definitions of parity, cooperation, problem solving, bargaining, shared

> decision making, consortia, cooperatives and collaboration, as they are used interchangeably in (the various) disciplines, are remarkably similar (Reed 1977, p. V).

I do not propose to develop a specific definition of collaboration, but rather to summarize some of the definitions as presented in the literature.

Croan and Lees (1979) define a collaborative framework as 'a formalized association of not-for-profit organizations with the stated purpose of furthering common goals and objectives through combined resources, and leverage' (p. 2). Similarly, Reed (1977) defines collaboration as:

> An active process practiced by voluntary associates who would not normally choose to work together except in situations where mutual benefit can be expected through the collaborative association. The associates represent organizations working toward objectives which benefit the new collaboration, but more importantly benefit each of the component organizations. Each component part views each other component part as a necessary entity in reaching the mutually held objective (p. 1).

On the other hand, coordination is defined by Mulford et al. (1979) 'as a process of decision rules to deal collectively with a shared environment' (p. III). Various elements may be coordinated at various levels of an organization and these may include information, clients, program development, and resources (p. II). Decision rules 'can be mandated by a third party or be created by the participants' themselves (p. 8-9). In the latter case, collaborative efforts usually result from organizational stress caused internally or externally. The decision to coordinate is made either to maximize resources, or to respond to mandates from superordinate organizations (Mulford et al. 1979, p. 12). Commitment to such a change results from inside stimulus such as mutual desire of individuals or local groups, or by outside stimulus such as official or governmental bodies, or changes of mandate as a condition of funding (Croan & Lees 1979, p. 5).

2.2 Coordination

Those sources that address the problem of fragmentation of services emphasize the need for rational coordination, both for continuity of care and for accountability in programs for children in need. The concern for finding models of coordinated service delivery for meeting children's needs has grown at an accelerated pace in recent years (Reed 1977, p IV).

2.2.1 Advantages of Coordinated Approaches

Coalitions increasingly are viewed as a cost-effective means to help agencies offer comprehensive services in a more coordinated manner (Croan & Lees 1979, p. 1).

The cooperative and coordinated approach is recommended as the management tool, and the answer to problems of maximizing services while minimizing costs in these times, which are characterized by limited funds and resources. By working cooperatively, 'community agencies, or organizations are also able to share information, skills and resources to make their own programing more responsive to the needs of youth' (Croan & Lees 1979, p. iii). Although our society as a whole looks with favour on consensus, compatability, and unity, it was however disconcerting to Mulford et

al. (1979) that "very little systematic work is available that demonstrates the actual outcomes or consequences of coordination" (p. 16). The literature on collaboration has been dominated by assumptions favoring the notion, although research that provides hard data on the positive benefits of coordination is difficult to find" (p. 1).

Regardless of whether special services are mandated or whether they are provided within the framework of enabling legislation, many of the issues which legislators and administrative staffs face concerning the allocation of resources remain the same (Rawlyk 1977, p. 44). Fragmented delivery of services creates duplication and gaps in service for those to whom it is directed, besides dissipating money and manpower (p. 44). According to Cash (1970), increased "personnel alone may not provide solutions to malfunctioning issues as well as not being a viable alternative under current fiscal restrictions" (p. 580).

Evidence has been provided regarding the advantages of collaboration and coordination to both service providers and to recipients. Possible benefits are:

- A potential for expanded scope and range of service delivery in a cost effective, efficient way (Croan & Lees 1979, p. i; Brolin 1982, p. 10; Tindall et al 1981, p. 13).
- A systematic reduction of service duplication and the maximizing of available resources (Croan & Lees 1979, p. 4; Tindall et al. 1981, p. 13; Cranley 1981, p. 7).
- A potential for simplified referral and intake procedures which ensures better transition of children into agencies or service streams (Croan & Lees 1979, p. 4; Tindall et al. 1981, p. 13).
- Greater awareness of other agencies' role, commitment, problems and solutions which enhances staff awareness concerning linkages and improves relationships among agencies (Tindall et al. 1981, p. 13).
- "Availability of additional and improved physical facilities, staff, and funding resources" depending on political circumstances (Croan & Lees 1979, p. 4).

In sum, there is general agreement that the process of collaboration is the most efficient means to meet service needs without adding personnel and

financial resources. Although the benefits of coordination are thought to be many, the collaborative processes for developing and maintaining coordination are, on the other hand, more difficult (Croan & Lees 1979, p. iii). Lacour (1982) concluded:

> The process of interagency agreement is neither easy nor a sure fix: it does enhance the opportunity for more profound discussion of goals and functions. It promotes cooperation instead of competition: it broadens our understanding of the ecology of human service systems: it encourages rational responses to conditions most noted for irrationality ... (p. 266).

2.3 Collaboration

2.3.1 Inhibitors or Barriers

While cooperative approaches have gained wide acceptance, unforeseen difficulties may inhibit them from developing as planned (Cash 1978, p. 580). Cooperative agreements with affiliates are often difficult to plan, implement and maintain. There are many reasons for their ineffectual operation or collapse (Croan & Lees 1979, p. 24). The history of the coordination issue briefly overviewed in An Experiment in Progress ... (1977) suggested that coordination cannot be achieved either quickly or painlessly (p. 7). Anticipated barriers may involve external and internal pressures and/or individual motivation and support. These barriers can be overcome, and the intended outcomes enhanced, if facilitating factors and strategies are present or utilized.

Interorganizational linkages and collaborative ventures are inhibited by:

. Differences in participant characteristics such as image, history, values, resources, mission, organizational and staffing patterns, operations and management styles (Croan & Lees 1979).

- Differences in service population and definitions (Tindall et al. 1981, p. 37).
- Inconsistent service standards (Lacour 1982, p. 266).
- Differing agency regulations that complicate the process of coordination (Brolin et al. 1982, p. 8).
- Differing agency priorities (Lacour 1982, p. 266).
- Lack of awareness of policy or priorities (Croan & Lees 1979, p. 24).
- Negative attitudes among agencies cooperating (Tindall et al. 1981, p.12).
- Lack of belief in new collaborative efforts or preference for the status quo (Roberts 1981, p. 15).
- Failure to establish operating procedures that ensure equal power and participation, leading to "top down" imposition and coercion (Roberts 1981, p. 15).
- Fear of domination by another agency (Croan & Lees 1979, p. 29).
- An unwillingness by participants to relinquish power in shared decision making (resulting in subtle sabotage such as postponed decisions,

withheld information, failure to invest staff with adequate authority and responsibility) (Croan & Lees 1979, p. 25).

- Overlapping geopolitical designations (Mulford et al. 1979, p. 15).
- Confused and conflicting loyalties (Croan & Lees 1979, p. 24).
- Unclear lines of accountability (Mulford et al. 1979, p. 15).
- Responsibility without authority (Roberts 1981, p. 12).
- A lack of realistic expectations about roles and responsibilities (Croan & Lees 1979, p. 24).
- A lack of clarity of job descriptions (Tindall et al. 1981, p. 12).
- Failure to recognize that coordination involves costs and some degree of internal disruption during an initial period of adjustment (Mulford et al. 1979, p. 13).
- Prior unsuccessful efforts to promote linkages (Mulford et al. 1979, p. 15).
- Problems relating to the status of standing agreements (Tindall et al. 1981, p. 39).

- The expectation of agency personnel that wholesale disruption of organizational functioning will occur (Mulford et al. 1979, p. 15).
- Attempting to achieve too many purposes and a lack of adequate purpose (Croan & Lees 1979, p. 24).
- Contradictory mandates or lack of mandates (Tindall et al. 1981, p. 38).
- Failure to coordinate budgets with service mandates (Lacour 1982, p. 265).
- Lack of clarity on "first dollar responsibility" (Lacour 1982, p. 265).
- Lack of funding or perceived lack of funds (Tindall et al. 1981, p. 36; Croan & Lees 1979, p. 111).
- Difficulty in reaching an agreement to share resources (Tindall et al. 1981, p. 38).
- Inadequate appraisal of the amount of time and energy required by participants for development and maintenance (Tindall et al. 1981, p. 39).
- Overloads on existing staff (Tindall et al. 1981, p. 12).
- Lengthy delays in the publication of guidelines for implementing legislation and delays in

receiving funds for program development (Tindall et al. 1981, p. 36).

- Lack of return for time and resources invested (Croan & Lees 1979, p. 25).
- Lack of visible successes, rewards or results (Croan & Lees 1979, p. 25).
- The unfavourable reputations (for dependability, reliability) of those involved (Mulford et al. 1979, p. 15).
- Linkage attempts that substantially reduce the independence or visibility of an organization (Brolin et al. 1982, p. 8).
- Political conflicts over "turf" or territory (Brolin et al. 1982, p. 8).
- The presence of vested interests (Croan & Lees 1979, p. 24).
- Poor or limited interagency communication among cooperating agencies (Tindall et al. 1981, p. 38).
- Conflicting views of the constraints on confidentiality of information (Lacour 1982, p. 266).
- Lack of knowledge of legislative trends (Croan & Lees 1979, p. 24).

- Vague language used in regulations, making it difficult to clarify and understand intent, and inconsistencies and confusion in regulations (Tindall et al. 1981, p. 36).
- Lack of knowledge about implementing interagency cooperation (Brolin et al. 1982, p. 8).
- Mistrust among individual agencies who view other agencies as competitors (Croan & Lees 1979, p. 10).
- Personnel turnover (Tindall et al. 1981, p. 38).
- Midstream changes in personnel and policy (Roberts 1981, p. 12).
- Lack of strong central leadership, organizational and management skills (Croan & Lees 1979, p. 24).
- Lack of cooperation among advocacy and consumer organizations (Brolin et al. 1982, p. 8).
- An overemphasis on existing systems (e.g. time and effort spent on inventories) and the postponement of future-looking activities (Croan & Lees 1979, p. 10).

2.3.2 Facilitators and Postulates for Successful Collaboration: Introduction

Many authors have sought to offer constructive advice on how to overcome the barriers to cooperation

or collaboration. Literature suggests a set of key conditions and strategies that enhance the probability of successful interagency collaboration.

If successful coordination of services is the objective, effective interorganizational groups need to be established. Schermerhorn, Hunt and Osborn (1982) list characteristics associated with highly effective work groups:

1. The members of the group are attracted to it and are loyal to each other, including the leader.

2. The members and leaders have a high degree of confidence and trust in each other.

3. The values and goals of the group are an integration and expression of the relevant values and needs of its members.

4. All the interaction, problem-solving, decision-making activities of the group occur in a supportive atmosphere. Suggestions, comments, ideas, information, criticisms are all offered with a helpful orientation.

5. The group is eager to help members develop to their full potential.

6. The group knows the value of constructive conformity and knows when to use it and for what purposes.

7. There is strong motivation on the part of each member to communicate fully and frankly to the group all the information which is relevant and of value to the group's activity.

8. Members feel secure in making decisions which seem appropriate to them (p. 242).

2.3.3 Characteristics of Participating Organizations

It has been speculated "that rural projects are more likely to be successful than are projects attempted in urban communities" (Cranley 1981, p. 7). However, research by Tindall et al. (1981) showed that of eight factors that had a bearing on linkage efforts, locality was last in summed rank order in terms of importance (p. 8). The explanation put forward was that locality may not be considered critical when developing linkages since such concerns as the needs of clients and the identification of appropriate services would be more pressing (p. 10). In any case physical proximity is an important factor facilitating collaboration (p. 40).

Before the participating components become involved in a collaborative endeavor, they should be clear about their own goals or organizational role definition. A clear perception of their own objectives will enable them to better meet their own mission. The greater the similarity of purpose, the easier the task at hand. There should be a focus on external issues since participating administrations must understand the weaknesses of their own programs (Reed 1977). These organizations should enjoy a level of stability since 'interorganizational arrangements cannot be formed or broken on a rapid basis' (Yin & Gwaltney 1981, p. 104).

Collaboration takes place in the context of an organized social system and traditions. Standard operating procedures, organizational rituals or customs, and the avoidance of role changes ought not dominate a participating agency (Reed 1977, p. 14). The required historical patterns include cooperation and broad participative goal setting because collaboration is accomplished through responsiveness to the older settings or suprasystems in the environment. While similar administrative structure facilitates linkages (Tindall et al. 1981, p. 40), bureaucratized

organizations are less likely to successfully coordinate (Mulford et al. 1979, p. 15).

One other point is also important: Organizations should have some slack in their resource base if any cooperative venture is undertaken, as a portion of the current resources (financial base and administrative time) of each must be devoted to the learning of new roles and new methods of working together. Resources must be reallocated to allow for:

> information sharing; the learning of new roles; freedom from legal, political, or financial constraints; devotion of sufficient administrative time; adequate financial base; cooperative funding; start-up funds; involvement of all components in proposal writing; and new rewards and penalties (Reed 1977, p. 17).

Section 3 - Needs, Assessment/Evaluation

3.1 Introduction

Special service programs which serve children with special needs can be conceptualized at three levels:

> (a) an individual program designed for one pupil (e.g. an IEP...);
>
> (b) a group program designed for more than one pupil (e.g. a remedial-reading class); and
>
> (c) an organizational program, considered as a service delivery system ... (Maher & Barbrack 1979, p. 415).

The last concept is the focus of discussion.

The following, based on the above-mentioned organizational programs, outlines some of the considerations in selecting a methodology and reviews the strategies seen as helpful in conducting needs assessment in a service delivery system. It is a discussion of special-service program evaluation as a means for providing an objective and rational basis for making decisions about program design and delivery.

3.2 Rationale

The climate of austerity existing at all levels of government has forced a re-examination of many activities, programs, and policies (Bozeman 1982, p. 264). The past decade has witnessed an increased demand from legislators, taxpayers, and funding agencies for effective and efficient programs (Maher & Barbrack 1979, p. 413). Evaluation of social welfare programs has in recent years received priority attention (Johnson, Nutter, Callan and Ramsey 1976, p. 279). Special service programs are no exception to this phenomenon (Maher & Barbrack 1979, p. 413). The rationale for program evaluation is twofold: first, professionals in the field 'have an obligation to assess effectiveness of service'; secondly, taxpayers have a right to know whether the funds they invest in programs are producing the desired results efficiently (Johnson, Nutter, Callan and Ramsey 1976, p. 280). Indeed, interrelating needs assessment strategies with program planning and evaluative efforts is seen in the literature as aiding organizations in meeting demands for accountability (Marrs & Helge 1978, p. 143).

3.3 Definitions: Program Evaluation and Needs Assessment

Fundamental to program evaluation is a clear definition of what it is. Special-service program evaluation is described by Maher (1979) as "... a process of obtaining and reporting information on a program's adequacy, process, efficiency, and impact" (p. 413). Whelan (1979) defines evaluation as "... a set of observable, sequential procedures which are used to determine if a planned program is functioning below, at, or above expectations" (p. 349). It enables "detection of gaps between what is and what should be" (p. 349).

According to Johnson, Nutter, Callan and Ramsey (1976), program evaluation is the study of programs to ascertain effectiveness in fulfillment of defined goals. It provides evidence and information to the practitioners, administrators, clients and policy makers who must decide "whether what a program has accomplished is 'good' or 'bad', and what steps should be taken to improve its level of 'success'"(p. 280).

The major purposes for evaluation proposed by Brinkernoff (1979) are:

1. To clarify and communicate the

expectations, or standards, for the program;

2. To document operation of the program, particularly those phases of operation requiring legal compliance;

3. To assess impact of the program on its intended recipients; and

4. To provide information to revise and improve the program (p. 356).

According to Marrs and Helge (1978) a perceived need is typically the stimulus for such an enterprise (p. 144). A need can be defined as 'a situation which occurs when what is actually happening is below that which is expected' (p. 144).

Section 4 - Assessment

4.1 Introduction

The abundant research and literature dealing with the assessment of children is purposely circumscribed. For example, this section will not concern itself with the many technical measurement issues, the validity of assessment instruments, nor the plethora of tests that can be used in assessing children with learning or emotional difficulties. Rather, the following will attempt to identify the basic elements of the assessment process which can be found in actual practice and to describe a framework for assessment which is congruent with the philosophy and mandate of the various servicing ministries in Ontario.

The discussion deals with a broad definition of assessment and related issues and brings together the elements in the process which are seen to be essential from both an academic and a pragmatic viewpoint.

4.2 Definitions: Assessment

Dictionary definitions of "assessment" indicate that for centuries the term has been used in the estimation of taxable property, of possessions, or "any useful quality". It would seem to follow that when the term is applied to examination of an individual's personality and behaviour it refers to an accounting of particular qualities, including both assets and liabilities, strengths and weaknesses, achievements and failures (Hood & Anglin 1979, p. 9).

Assessment is broadly defined by Ysseldyke (1983) 'as a process of collecting data for the purpose of making decisions about individuals' (p. 226). Data are used to help make decisions about eligibility for special services, to help plan intervention, and finally to monitor the progress of those receiving special services (p. 226).

Harbin (1977) defines assessment as

> the systematic process of (1) collecting information both on a child's level of functioning in specific areas of development ... and (2) carefully interpreting the information which is collected (p. 35).

The various definitions clearly indicate that assessment is above all a process. In this regard Hood and Anglin (1979) comment that

> unfortunately, there is a common tendency to attempt to identify it concretely as a thing, and the assessment process is often confused with the assessment report. As a result, a few sheets of paper can take on magical symbolic significance and, in being separated from the assessment process, can be used inappropriately in making important decisions for a child (p. 11).

Assessment can either be formal or informal in nature. Formal assessment involves the use of standardized assessment instruments. '"Assessment" is often used to refer to a discrete, standardized and clear routine procedure or entity that has a generally understood form and purpose' (Hood & Anglin 1979, p. 5). Informal assessments, on the other hand, are activities which may involve a set of procedures, but unlike formal assessment, these cannot be validated and the results cannot be measured against established norms.

4.3 Characteristics of the Assessment Process

Assessment refers to a process involving:

- collecting information
- making direct observations
- weighing the facts and developing hypotheses about the problems
- understanding the individual's needs and deficits
- estimating the nature and the degree of assistance which can promote healthy functioning and continuing development
- arranging for the provision of such assistance (Hood & Anglin 1979, p. 10).

4.4 Areas of Assessment Inquiry

Developmental areas when assessing needs include:

- Physical development and health
- Sensorimotor development and skills
- Communication development and skills
- Emotional development and social skills
- Educational/vocational skills
- Independent living skills
- Recreation/leisure (Annual Review... 1984, p. 52-53).

Gearheart (1980) identified the following facets: 'assessment of auditory and visual abilities, educational (achievement) level, adaptive behaviour level, speech and language development, level of intellectual functioning, and general development level'.

While it will not be necessary to have all this information in all cases, Gearheart (1980) noted that these types of assessment data are the most commonly used (p. 58).

4.5 Types of Assessment

Three general types of assessment were distinguished:

1. Screening assessments which are usually done when a child first comes in contact with the service system. They are used to establish eligibility for a program or service.

2. Functional assessments are carried out on a continuing basis as a part of training and habilitation. The individual's progress towards specific objectives is monitored, and results determine whether a change in either objectives or approaches is required.

3. Specialized assessments are conducted when a screening or functional assessment has identified particular areas of concern. They are typically carried out by professionally trained staff (e.g. medical specialists, speech therapists etc.). They are directed at providing specific and detailed information (p. 52) (Annual Review... 1984, p. 52).

4.6 Purposes and Factors Leading to the Assessment Process

Hood and Anglin (1979) listed some purposes and factors leading to the initiation of the assessment process:

- to gain a fuller understanding of a child and family
- to help a child and family obtain an appropriate service
- to enable an agency to decide how to help
- to address the complicated issues perplexing the service providers
- to comply with the administrative demands of an organization
- to ensure that "no stone has been left unturned"
- to obtain further opinions as alternatives to those already considered
- to enable a service to accept or reject referred children
- to delay making a decision
- to pass on or share responsibility for decision-making
- to determine if a child's situation has altered since a previous contact

- to determine the degree of structure or security needed for a child (p. 5).

4.7 Stages

There are many alternative ways of conceptualizing the assessment process. The literature clearly demonstrates that assessment ideally constitutes a graduated range of operations. The stages or steps described are often very closely related and, in some cases, overlapping. In Ontario, the overall process of assessment has varied considerably in different ministries, social, institutions and disciplines. There are many reasons for this: 'differing legislated mandates, differing target population, differing nature of service provided, differing professional orientations and traditions' (Hood & Anglin 1979, p. 1).

Hood and Anglin (1979) view the assessment process as

> 'problem identification, information gathering, integration of information, ranking of possible solutions, and planning of assistance' (p. 19).

The levels identified by Illerbrun and Greenough (1983) are: identification, diagnosis, management, and follow-up (p. 25). This "interactive diagnostic model" is seen by the authors as a most useful approach for all children suspected of having a disability or

disabilities (p. 27). Interaction would include follow-up consultation, observations, program evaluation and possibly modification (p. 27).

A particularly useful format was developed by The Annual Review ... (1984), consisting of six basic steps proceeding in a logical flow.

1. Identification of assessment needs
2. Assessment referral
3. Conducting the assessment
4. Synthesis and Formulation
5. Reporting
6. Follow-up (p. 21).

4.7.1 Identifying Assessment Needs

At this initial stage, decisions are usually made regarding whether assessments are required to provide information for:

- a placement decision;
- planning training or habilitation goals and approaches
- program and placement change (Gearheart 1980, p. 53).

While such a preliminary review is not a substitute for assessment, it may prevent further unnecessary efforts. Assessment is the next logical step when preliminary

review indicates that a definable handicap may exist (Gearheart 1980, pp. 56, 57).

Casefinding and screening can both be included in this initial phase. Information resulting from casefinding simplifies the screening process (Cross 1977, p. 4). There are numerous benefits to screening. Screening indicates the possible presence of an impairment although intervention should not be determined or planned without diagnostic study. Therefore, screening should provide information about a child to decide if he or she should undergo a thorough diagnostic study. Information gained in screening should help facilitate the diagnostic process to follow by indicating the strengths and weaknesses of a child (Cross 1977, p. 6). Screening also avoids expensive and time-consuming diagnostic procedures "for those who will not benefit from early intervention". In addition,

> The purpose of the screening program and the procedures to be used therein should be explained to the parents, as should the results of the screening and their implications for further testing. In the case where a child fails the screening, the parents should be made aware that

the child needs further diagnosis before any conclusive decisions can be made about his suspected condition (Cross 1977, p. 6).

4.8 Issues of Concern

Having discussed assessment in general process terms, a series of specific and interrelated issues dealing with the topic of assessment is the focus of the discussion to follow. Their existence thus far has either been inferred or summarily discussed. Although these issues were seen as highly interrelated, they are considered at this point separately. These issues are now considered since they have for some time been the topic of heated debate.

4.8.1 Three Conceptual Approaches

The present focus is a brief discussion of the three main conceptual approaches or frameworks by which professionals carry out their practice in dealing with children in need.

4.8.1.1 The Medical Model

The medical model (sometimes called the "clinical" model because it is often carried out by professionals other than physicians) is essentially a disease model where "deviance defines the disease" (Miller 1981, p. 92). It assumes that for each disability there is a specific cause and specific cure (MacIntyre 1980, p. 117). This conceptual approach is a biologically derived model of etiology and pathogenesis with the

notable tendency to "blame the victim" (Miller 1981, p. 92). The emphasis is focussed on the deficits inherent in the child while giving little consideration to his environmental context (MacIntyre 1980, p. 117).

> If a placement decision is the only goal of the assessment process, the medical or clinical diagnostic approach may appear to work, since it provides a label for the child which can be used to group him with similarly labelled children (MacIntyre 1980, p. 118).

According to Miller (1981) difficulties accrue when such an approach is applied to problems involving human behaviors

> since the etiology is frequently vague and largely unknown and the cures (drugs, hospitalization, psychotherapy) are utilized rather freely with relatively little consideration for the many variables operating in a particular situation (p. 92).

Frequently, a diagnosis is based on only partial data and "creates particular perplexity when the problem is lifestyle or behavioral deviance, since the latter are contextual and defined socially" (p. 92). The author further noted that the medical model often complicates,

and is complicated by, the organizational structure and the roles occupied within health and mental health services. For example, it conceals the many differences between medicine and psychiatry and "... provides the psychiatrist the protection and support of the same community attitudes that protect the physician" (p. 92).

> (The) model disguises education, moral guidance, personal consultation, social control, and other forms of guidance disguised as medical intervention (p. 92).

The medical model has been extensively used in the mental health establishment, and in health and welfare agencies (Miller 1981, p. 93). It has generally created criticism 'not only from scholars in psychology and sociology, but also from within the mental health establishment itself' (Miller 1981, p. 93). At present, medical and psychiatric viewpoints are considered to be obsolete by most professionals in the field (Epstein 1977, p. 424). Miller (1981) noted that the personality theories that are most consistent with the clinical approach are "... psycho-biological, psychoanalytic, ego-psychology, and some of the

self-theories, particularly those of Rogers and Maslow" (Miller 1981, p. 93).

4.8.1.2 The Learning Model

The learning model, the second approach to be discussed, emerged from "the application of learning theory to intervention with individuals, groups, and institutions" (Miller 1981, p. 94). The learning model was largely derived from contemporary behaviorism and Skinnerian learning theory and has been influenced "by social learning theorists who emphasize modelling, developmental psychologists - especially those who emphasize socialization and expectancy theories" (Miller 1981, p. 94). According to Miller (1981) the model assumes that both adaptive and non-adaptive behaviour is learned and can be unlearned (p. 94). "Reinforcers" and "contingencies" vary, and it is hypothesized that behaviour "is acquired and mediated as a result of stimuli from the environment" (p. 94). Among some of the social institutions that would appear to find learning theories highly acceptable and consistent with their values are public schools, prisons, mental hospitals, and schools for the mentally retarded (p. 94).

4.8.1.3 The Ecological Model

Advocacy of this approach is in no short supply as the need for an ecological "total child" perspective in assessment is well documented. In this regard the Celdic Report (1970) expressed the following concern:

> Our present point of disagreement with the present pattern of delivery of services, however, is that it fragments the child. He is viewed as student, patient, ward, or offender depending upon the department or service system through which he is receiving help. No one sees or is concerned with the whole child as he interacts with his environment. We diagnose and treat and sometimes label for life, on the basis of a small segment, the problem part of the total child. When attention is concentrated on only that part of the child that isn't functioning, that is on the negatives, the pathology, the illness; citizen's groups, parents and all too often the professional, develop a vested interest in the child's disability. Understandably, in this situation where no one has an investment in the child as a whole with his strengths as well as his

> weaknesses the child frequently cannot afford to get better (p. 296).

Gearheart (1980) noted that the ecological model is neither as systematized nor organized as other models since it has been the focus of research for a relatively short period of time (p. 304).

Knowledge of epidemiology, both as a knowledge base and as a practical model is central to this approach. Another major concept is that of prevention, "which is elaborated by the subconcepts of primary, secondary, and tertiary prevention" (Miller 1981, p. 93). An important basic tenet is that the root of the problem is not perceived to be within 'the individual alone or the environment alone but rather in the interaction of the two, since the theory recognizes that each individual is an integral part of separate yet interrelated ecosystems' (Gearheart 1980, p. 304).

> Thus, assessments and intervention focus on the exchanges between the child, the settings in which he participates, and the significant individuals who interact with him (Hobbs 1975, p. 114).

Accordingly, assessment must be flexible, broadly based, and ongoing. Assessment should tap information from all possible sources (Gearheart 1980, p. 53).

Assessment should therefore provide a rich, descriptive data base (Heron & Heward 1982, p. 118). Areas of ecological inquiry include 'family development, personal development, social adjustment, and school achievements' (Hood & Anglin 1979, p. 16). Sources of data include student records, interviews, formal and informal tests, daily observation (Heron & Heward 1982, p. 123).

A comprehensive, integrated ecological assessment considers not only the child's weaknesses, but also strengths, and the areas of satisfactory functioning (Walkenshaw & Fine 1979, p. 15).

> Each child is unique, the center of a unique life space. To design a plan to help him grow and learn requires much specific information about him and about his immediate world. The best way we have discovered to get information needed for a good program planning is to construct a profile of assets and liabilities of the child in a particular setting and at a particular time (Hobbs 1975, p. 104).

The relatedness and interdependence of helping agencies in the total service delivery system, as well as continuity of care within that system, are

conditions inherent in the ecological model (Miller 1981, p. 93). The ecological framework avoids the simplistic and negative labelling process (Hood & Anglin 1979, p. 15). This holistic service-based approach avoids two severe limitations of other schemes: the fixed diagnosis with diagnosis being an end in itself, and the separation of diagnosis and treatment, often to the neglect of treatment. The ecological model does not propose abandonment of classification, but rather it clarifies and takes into account the many variables for the purpose of improving service delivery. The ecological approach takes into account the situational, developmental and transactional character of demands on a service delivery system. Individuals are classified on the basis of the services required to achieve specific goals at a particular period in the life of the individual. The services required are specified to ensure that the individual will be able to function adequately.

Systems analysis is relevant to and consistent with this model (Miller 1981, p. 93). Similarly Hobbs (1975) remarked that the ecological model belongs to no one discipline.

> Its use requires someone who can move freely among and communicate with diverse disciplines in the performance of a liaison function-linking up all the individuals concerned about the child and coordinating the planning and programing on his behalf (p. 121).

Since the model places a heavy emphasis on the importance of environmental conditions, and does not "blame the victim"; it would therefore appear to be highly consistent with the philosophy of the social work profession.

> Social workers have had a major input in the community mental health movement and have, through their understanding of crisis intervention and systems analyses, contributed greatly to the operationalization of the ecological model in the community mental health movement (Miller 1981, p. 93).

Primarily social-work influenced agencies have attempted to deliver services based on the ecological model (Miller 1981, p. 93). The ecological approach would appear to be consistent with the fundamental principles adopted by the Children's Services Division of the Ministry of Community and Social Services (Hood

& Anglin 1979, p. 1). The ecological perspective has also entered educational practice for exceptional children (Heron & Heward 1982, p. 117).

In sum, a rather extensive literature has documented the importance of this approach in assessment, as the management information system and the way of conceptualizing the problem of delivering services. While the system makes use of traditional assessment procedures, it is not limited to them.

4.8.2 Assessment Teams

Effective interagency teams need to be established to ensure interministerial cooperation. Teamwork has become valued and well established in children's services. It has frequently been assumed or implied in the literature that effective assessment requires the services of interdisciplinary teams. At this point, it is necessary to give a cursory consideration to aspects of the teamwork approach.

Korteweg (1983) commented that past and even recent practices have fallen short of societal expectations. "Only a concerted, coordinated team effort will regain the public trust " (p. 9).

In the past twenty-five years the field of our concern has been divided up between a variety of

> specialists and professions giving each its own area of responsibility and competence. Unfortunately the child and his family do not divide into the same neat compartments. In an effort to 'put Humpty-Dumpty together again' the concept of teamwork has developed (Lazure & Roberts 1970, p. 401).

It has been suggested that interdisciplinary understanding and cooperation enriches the services offered to children with emotional and learning disorders, but much that is described in current literature as teamwork dealt with teachers and support personnel and had little relationship to the achievement of interdisciplinary team practice among servicing agencies or ministries.

4.8.3 Early Identification

A persistent theme in the literature on assessment was the adage "a stitch in time saves nine", or the notion of early identification and prevention.

> "Paralleling the educational movement for early screening, assessment, and programming is a similar movement at the community mental health level for early screening, diagnosis and treatment" (Barr & DelFava 1980, p. 1).

The Warnock Report (1978) in England cited as a major recommendation the provision for children under five with special educational needs. The report suggested that age not be a factor in providing appropriate services for children; in fact, education should start as early as possible with no minimum age limit (p. 73). It was pointed out that for some children educational help should be required below the age of two.

4.8.3.1 Legislation

Perkins (1979) critically commented that in Canada, far too many pre-school handicapped children were not receiving any kind of intervention program, while in the U.S.,

> Early intervention is considered so important for handicapped children ... that Public Law 91-142 includes an incentive to states which do not have a pre-school program for handicapped children. Such states are being encouraged to start pre-school programs for three-to-five year-old handicapped children (p. 36).

Public Law 94-142 sets educational age levels at five to eighteen years, but makes provisions for school boards to begin services for special students at age three (Karagianis 1980, p. 8). Nesbit and Karagianis

(1980) on a more optimistic note, commented that in Canada the need to begin programs with the pre-school handicapped child has been recognized.

According to Wanczycki (1983), in the initial years in Ontario, a kindergarten and pre-kindergarten identification program was "innocuous ..." (p. 25). It may also have been beneficial in many instances, as certain children may have, for example, benefitted from early intervention for speech and hearing problems (p. 25). At present, the Kindergarten Early Identification Program (KEIP) has now become mandatory throughout the province and has become part of Bill 82. However, research by Davidson (1981) would seem to indicate that "early identification tends to be conceptualized more as an "extra", than an attachment to the education system ..." (p. 66).

4.8.3.2 Justification

Fossey (1973) suggested that the earlier the child's needs are identified, the greater the return for energy spent. Since problems in early development can multiply upon one another and create even more serious problems in the future (p. 102). With early identification and intervention, needs eventually require less extensive special services (p. 102).

> Communities should be aware that an investment in a child's educational program at an early stage can often alleviate the necessity of tremendous financial commitment at a later stage - to say nothing of the lost potential which results from lack of adequate, early intervention. Positive attitudes toward exceptionality fostered in communities can result in savings - both in lives and in money. "An ounce of prevention ..." In many instances, prevention of maladjustment must commence long before a child reaches school age. Health services and educational services must work co-operatively with parents to ensure that information and assistance is provided at the appropriate time (p. 102).

Prevention where it is pursued is said to require cooperative efforts with other agencies to collect health, education and social data in a multidisciplinary assessment (Gearheart 1980, p. 53). According to Mittler (1978), "the needs of under fives cannot be parcelled up among different government departments simply because it is administratively convenient" (p. 11). In other words, services for pre-school children should not be planned from any

single departmental or professional perspective. Rather it should be planned from a 'genuinely multidisciplinary sharing of skills and resources' (p. 13).

While early intervention is highly desirable, 'the disadvantages of misidentification and labelling must be considered (Gearheart 1980, p. 53). The difficulty in identifying accurately "exceptional" children is compounded at the pre-school and kindergarten level "due to developmental lag, language and cultural background, and other factors" (Wanczycki 1983, p. 25).

> Early identification can be successful only if it adopts the position that a broad range of factors are involved ... and that any one of these factors or any small clustering of them is unlikely to account for or be predictive of a subsequent general (problem)... (O'Bryan 1976, p. 1).

According to O'Bryan (1976), early identification is most desirable when it is directed towards "a general assessment of the child's <u>current</u> capabilities, performance, behaviour patterns, prior experience and ability ..." (p. 2).

> In fact it is arguable that early identification should not be used to predict future problems but to discover the child's current difficulties, strengths, deficits and needs - the better to provide for a program beginning at the level of his available competence (p. 2).

4.8.3.3 Suggestions

Perkins (1979) suggested that provincial governments need to establish well organized programs of "periodic developmental surveillance" for all children between birth and date of entering school. As soon as a child is diagnosed as having a developmental disability, an appropriate program to meet the child's needs should be implemented (p. 36). The Warnock Committee recommended that a "named" person (a health visitor should assume the functions of the "named" person) be the point of contact for the parents of pre-school children (p. 79).

In sum, we have witnessed in Ontario a shift in the early identification process to one of prevention rather than confirmation of a particular handicapping condition. This necessitates increased and more efficient delivery of assessment resources. With the increase in mental health and educational mandates to

service the young child, new expansions are imminent. Without a sufficient funding base, "services to these young children will most effectively be drawn together through interagency cooperation" (Barr & DelFava 1980, p. 1).

Section 5 - Summary

Conceptually, the proposed model for service delivery is based on, and supported by, the accumulated knowledge, attitudes, general theory and empirical research found in the literature. The literature survey provides the project with an information/experiential base from which to draw and gives the project a conceptual framework in regards to process, method and structure.

The review of the literature deals with the following aspects: the problems and trends in special service delivery, selected aspects of assessment, collaboration and organizational change, needs assessment, and other issues tangentially related to our objectives. The purpose is to simplify, summarize and organize the main aspects of the project as found in the literature. No claim is made to present a complete or exhaustive perspective of relevant issues and schools of thought. Specific theories are not extensively critiqued and analyzed in order that the focus be kept on understanding conceptual guidelines. Moreover, the final recommendations do not negate the need to look further for ways to more effectively and efficiently serve the needs of children in Northern

Ontario. Searching the literature for model programs (frequently quoted) which seemed promising in terms of structure and outcomes proved most disappointing, because, as mentioned at the very beginning, documentation is not readily available. Although simplified for the sake of brevity, this review should adequately serve to frame the remaining components of this study. The literature clearly indicates the need for coordination and buttresses the recommendations and guidelines in the chapters to follow. With a coherent theoretical foundation and general framework, a conceptual system against which to build a model is now available.

CHAPTER III - THE MODEL

Introduction

The purpose of the study is to develop an Interministerial Model for the delivery of assessment services for children and families in Northern Ontario. It is felt that children's needs in the North could be served effectively by a coordinated approach using a delivery system that was cooperatively designed, closely coordinated, refined and easily accessed.

The model was developed using the work plan presented in Table 1.

TABLE 1

WORK PLAN

Overall Goal - To implement an interministerial model for the delivery of assessment services in the northern regions.

1. COMPONENT - To collect data on assessment activities, capabilities and needs from MCSS and education agencies.

ACTIVITIES	TASKS
1.1 Develop a (common) data collection tool.	1.11 Identify factors to be measured. 1.12 Establish (common) terms of reference for measurement. i.e. - for categories - operating definitions 1.13 Develop formats for data collection. 1.14 Review approval by Steering Committee.
1.2 Establish implementation plan for data collection exercise.	1.21 Identify agencies to be surveyed. 1.22 Establish process for bilingual duplication and

TABLE 1 (cont'd.)

		distribution of data collection tool.
		1.23 Establish mechanism for providing resourcing to agencies as may be necessary and deliver questionnaires.
		1.24 Establish process for monitoring return of questionnaires.
1.3	To analyse data from questionnaires.	1.31 Identify components to be analysed.
		1.32 Complete initial analysis as per components identified in number one.
		1.33 Integrate data from MCSS and EDUCATION - initial analysis.
		1.34 Summarize major findings from initial analysis.
		1.35 Validate data through random sampling on an individual board/agency/child basis.

TABLE 1 (cont'd.)

1.351	Identify gaps in data collected between MCSS and EDUCATION.
1.352	Establish criteria for identifying random sample selection.
1.353	Develop format for analysis.
1.354	Identify resources to perform analysis.
1.355	Do analysis.
1.356	Summary analysis of data.
1.36	Review of data collection procedures used by Steering Committee.
1.37	Establish hypothesis based on findings.
1.38	Test hypothesis against data.
1.39	Modify hypothesis as necessary.
1.310	Summarize major findings.

TABLE 1 (cont'd.)

		1.311 Presentation of major findings to Steering Committee.
		1.312 Identify areas for improvement in questionnaire for subsequent years.
		1.313 Develop plan for integrating changes into the data collection tool.
		1.314 Approval of plan by Steering Committee.
2.	COMPONENT - To develop joint positions on operational policy issues.	
2.1	Develop draft policy statements.	2.11 Identify policy issues.
		2.12 Priorize policy issues.
		2.13 Establish set of principles for policy resolution.
		2.14 Identify linkages between issues.
		2.15 Establish format for policy presentation.

TABLE 1 (cont'd.)

2.16	Establish responsibility centre for specific policies.
2.17	Prepare initial policy drafts with all options provided.
2.18	Establish consultation process.
2.19	Conduct consultation process.
2.110	Review and determine preferred options based on consultation.
2.111	Draft position paper.
2.112	Present position paper to Steering Committee for decision.
2.113	Revisions as necessary and preparation of final paper.

TABLE 1 (cont'd.)

2.2	Joint acceptance of operational policy positions.	2.21	Identify individual Ministry review processes.
		2.22	Review feedback and revise.
		2.23	Establish mechanism for integration of feedback from individual Ministries.
		2.24	Review of revised policies.
		2.25	Approval by respective Ministries.
		2.26	Notify all relevant agencies of operational policy positions.
3.	COMPONENT - To develop an integrated interministerial model for the delivery of assessment services in Northern Ontario.		
3.1	To establish options for models.	3.11	To determine and priorize basic parameters of the model - i.e. terms of reference.
		3.12	Review of literature for possible options.

TABLE 1 (cont'd.)

3.13	Develop potential models.
3.14	Integrate data findings and policy directions with options.
3.15	Review options from financial perspective.
3.16	Identify impact on existing resources and need for future resources.
3.17	Identify preferred option.
3.18	Review and approval from Steering Committee.
3.19	Determine consultation process.
3.110	Do consultation.
3.111	Integrate feedback from consultation process into final document.
3.112	Review and approval of final document by Steering Committee.

TABLE 1 (cont'd.)

4.	COMPONENT - To implement integrated model.		
4.1	To implement preferred model.	4.11	Establish criteria for selection of pilot area (if pilot project to be done).
		4.12	Develop plan for introduction of model.
		4.13	Establish process for monitoring.
		4.14	Implement plan.
		4.15	Review feedback and identify areas for adjustment.
		4.16	Adjust model as necessary.
		4.17	Review and approval by Steering Committee.

Design Considerations

The delivery of assessment services does not take place haphazardly. Delivery is structured and organized. At the present time, there is a tendency for the delivery system to be structured and organized by individual ministries in isolation. The particular approach taken by this study is that the assessment delivery systems in Northern Ontario can be improved by inter-ministerial and inter-agency collaboration. In attempting to clarify the innovation, it is fair to say that it involves relationships between Ministries and between service stream agencies. It is apparent, then, that the innovation is collaboration in the delivery of assessment services. The developed model addresses these facts.

According to the literature, collaborative organizations exhibit the following characteristics:

- They are a result of shared power and responsibility.
- They involve a high degree of participative decision-making.
- They are non-hierarchial in nature.

- They focus less on roles and more on functions.
- They involve decisions by function rather than role.
- They foster decisions being made by those who must implement them.
- They are operated as open systems.
- They recognize the uniquely ordered perceptual field of each individual.
- They have built-in mechanisms for self-renewal, both individual and organizational.
- They recognize the need for continual ongoing processes of feedback, evaluation, and modification, both individual and organizational.
- They recognize the importance of process as well as input and output.
- They foster mechanisms for building and supporting interdependence.
- They utilize conflict resolutions strategies based on problem solving methodologies rather than arbitrary resolution or political methodologies.

- They foster a high degree of individual control over the immediate decision-making and work environments.
- They function with a common value base that influences organizational and individual behaviour.
- They share a common frame of reference with regard to appropriateness and utility of a collaborative mode of operating.

Project Team

The model was developed by the researcher as an integral part of the study, and was revised by representatives of the Ministry of Education, Health, and Community and Social Services, members of the Project team. Each member reflected the interest and concerns of his respective ministry. The model was again reviewed and approved by the Steering Committee which was Interministerial by composition. Finally it was forwarded to the Deputy Minister's Ad Hoc Committee, and approved for implementation.

Model

Model Assumptions

In developing the model, there were specific assumptions made about the basic characteristics that it should contain. These are:

1. All three Ministries will use common terminology for classification and level of severity of problem which will relate to the level of service provision.

2. Each Ministry will assume the responsibility for ensuring that their agencies fulfill their assessment mandate.

3. Each Ministry will provide assessment services either directly or indirectly, for those areas of agreed-upon responsibility.

4. There will be a sharing of information among the agencies of various service streams providing assessment services to a child and his/her family.

5. The model will have an evaluation/feedback component.

6. The model will have identified decision points in the process, requiring a coordinated approach to assessment provision.

Model Objectives

1. To ensure efficient use of existing assessment resources.

2. To ensure that each child and his/her family has access to a range of assessment services to identify his total needs.

3. To provide a coordinated approach to assessment with a clearly outlined centre of accountability.

4. To provide a mechanism for the identification and resolution of service gap issues.

5. To provide for coordination at the local level.

6. To ensure that assessment systems remain sensitive to changes in assessment strategies and technologies.

Model Principles

The model will also function according to the following principles.

1. Assessments will be conducted focussing on a whole child approach.

2. Assessments will be conducted within the local area as much as possible.

3. The family will be an active partner in the process.

4. The outcome of an assessment will be a clearly defined course of action with responsibility for follow through assigned.

5. Services will be provided, as much as possible, in a linguistic and culturally appropriate manner.

6. Given an adequate level of staffing, the model assumes that assessment will be completed within 30 days of identification of needs.

Statement of Assessment Responsibility

The following have been agreed to by each Ministry.

1. That Education conduct relevant assessments of children for purposes of diagnosing children's learning problems/defining children's learning needs and providing programs to meet these needs.

2. That Community and Social Services ensure provision of relevant assessments of children for purposes of diagnosing children's social, emotional and children's mental health problems, defining children's psychosocial needs, and providing programs and/or services to respond to these needs.

3. That Health ensure provision of assessments for purposes of diagnosing children's health problems, defining children's health needs, and providing programs and/or services to meet these needs.

Procedures for Provision of Services

Assessment services will either be provided directly through agencies of the responsible Ministry or through a purchase-of-service approach. This purchase of service will be between agencies of the same Ministry or from agencies of another Ministry.

Psychosocial assessment of mild and moderate level difficulty will be handled by the agency or board involved with the child and will not be referred to an M.C.S.S. agency of the Ministry of Community and Social Services for assessment.

The local boards of education must provide all the necessary documentation verifying the need for assessment by an outside agency when a referral is made. This will usually entail providing details of standardized assessments completed by appropriate educational personnel confirming that the cause of the child's difficulties in the classroom is not educational in nature.

These same principles of providing all the documentation verifying the need for an assessment by an outside agency will also apply to Ministry of Community and Social Services and Ministry of Health agencies when a referral is made.

Provincial policy positions acceptable to Education, Health and Community and Social Services have been developed around the ability of Boards of Education to purchase programs and services from agencies of other Ministries.

It is not economically feasible or efficient for all Ministries to have the capacity within themselves or through their funded agencies to meet all their assessment needs. The pooling and sharing of resources is the most appropriate path to follow.

Points of Coordination

Each agency within the various service streams has a role to play in case review and coordination as part of their basic operation. In order to ensure the most efficient use of resources as well as the appropriate use of a broader range of assessment resources, this case coordination role must be used effectively, and within an established operational framework.

There must be clearly defined decision points during an internal assessment process when outside agencies, still at the local level, should be involved in a coordinated process to develop a plan of action for certain children.

Since Boards of Education are responsible for education of all children they are as a consequence involved in any assessment used in determining an appropriate placement. Assessment may be provided by other agencies of other ministries or properly fall within their mandate. Because of the large number of assessments used for identification and placement, the focus has been to identify those decision points where resources of other ministries should be involved.

During the Identification, Placement and Review Committee, (I.P.R.C. process) initial activity will focus on determining if the difficulties that a child is experiencing are educational in nature or are, for example, psychosocial in nature, and to such an extent that the specialized assessment resources of a children's mental health program will be needed. A need would be for further assessment to determine the exact nature and extent of the difficulty as well as to

identify the potential need for support services to maintain the child in the school system.

If the I.P.R.C. has documentation to indicate a psychosocial basis for the difficulty as just described, then a referral should be made to the appropriate M.C.S.S. agency for assessment and consultation in determining the most appropriate course of action to meet the child's needs. If, through further assessment, it is determined that the child's problem is basically educational in nature and not psychosocial, then the Board making the referral may be charged for the assessments done by the M.C.S.S. agency. Similarly, the same principle would apply in terms of an identified physical need, and the charge from a health agency.

For the most part, children who are being considered for placement in a self-contained classroom would be the type who require a broader multi-disciplinary approach to assessment, although, depending upon the service approach of any particular board, a resource withdrawal program may also be under consideration as a placement. The common element would be the considered psychosocial or physical nature of the child's difficulties and the potential need for

M.C.S.S. or Health resources to maintain the child in an educational situation.

In addition, the child who is being considered for the category of unable-to-profit would also require a coordinated approach to assessment. Once the principal has determined that a child is unable to profit, a referral should be sent to the I.M.A.P.T. (Inter Ministerial Assessment and Planning Team). The role and function of this group will be discussed separately. This referral would be in addition to the referral to Section 34 as required under the Education Act.

In the assessment process undertaken by an M.C.S.S. or Health agency, difficulties that are identified as basically educational in nature would be referred to the local board of education for assessment and consultation in developing a plan. If the psychosocial or health assessment indicated a treatment approach that would impact on education, joint consultation and assessment would take place in order to determine the most appropriate course of action.

In summary, a coordinated approach to assessment involving agencies in the community would be used when:

1. Through the I.P.R.C. process documentation indicates that the child's difficulties are primarily psychosocial or physical and that the resources of an M.C.S.S. or Health agency may be needed to maintain the child in the classroom.

2. Through the I.P.R.C. process, there is an indication that a child will be identified as unable to profit.

3. Through an M.C.S.S. assessment, the plan to meet the child's psychosocial needs will have impact on his educational program, for instance his residential placement.

4. Through M.C.S.S. assessment, documentation gathered indicates that the nature of the child's difficulties are basically educational or physical.

5. Through Health assessment, the plan to meet the child's health needs will have impact on his educational program (e.g. residential placement).

6. Through Health assessment, documentation gathered indicates that the nature of the child's difficulties are basically educational or psychosocial.

In addition, the use of community resources in an informal way for consultation would also be encouraged. Although not involving the formality of a referral

because the nature of the difficulty is not severe enough to warrant that level of involvement, early consultation ought to assist in preventing the escalation of difficulties to a more severe level.

Conflict Resolution and Service Gaps - I.M.A.P.T.

This body is the major link-up with all components in the system to resolve major service conflicts and gaps. In the procedures just described, situations may arise where the agencies at the local level are unable to come to an agreement on the needs of a child. There also may be situations where there is agreement on what the child needs but there is nothing available to meet the needs. Then I.M.A.P.T. will play a major role in attempting to solve the problem. An interministerial decision making paradigm is included at the end of this section.

Within the M.C.S.S. process, the Unsually Difficult Service Situations Committee (U.D.S.S.) will have been involved in service gap issues related to M.C.S.S. services both in situations involving only M.C.S.S. agencies and in situations involving agencies from other service streams. This group will provide information to I.M.A.P.T. on M.C.S.S. service gap issues involving agencies from other Ministries.

Within Education, the I.P.R.C. will provide information to the Regional Office on service gaps in situations involving agencies from other Ministries. If this does not bring resolution, it will be referred to I.M.A.P.T. The agency performing the case manager role will notify I.M.A.P.T. of service conflict issues.

Since I.M.A.P.T. is composed of upper management people, it has the authority and impact to effect change in the system. For education, it will be officially designated as the Province of Ontario for all cases of Hard to Serve and will play a major role in developing a plan of action for these children.

I.M.A.P.T., as the focus for data, will also play a major planning role in ensuring that assessment resources are available and utilized in the most efficient and effective manner possible.

Responsibilities of I.M.A.P.T.

1. To ensure that consistency is maintained regarding agreed upon areas of assessment responsibility.

2. To ensure that all children receive assessment services as needed.

3. To resolve conflict issues in the service delivery system.

4. To develop an Interministerial planning mechanism for developing new services and or realignment of existing services.

5. To act as the Province of Ontario in Hard-to-Serve cases as designated by the Section 34 Tribunal.

Role of I.M.A.P.T.

1. To review cases and direct agency activities as may be necessary to meet the needs of specific children and their families.

2. To monitor the overall functioning of the assessment model.

3. To develop a plan to be followed to remediate service gaps, duplication, etc.

4. To provide advice and direction to the Section 34 Tribunal and to the U.D.S.S. Committee.

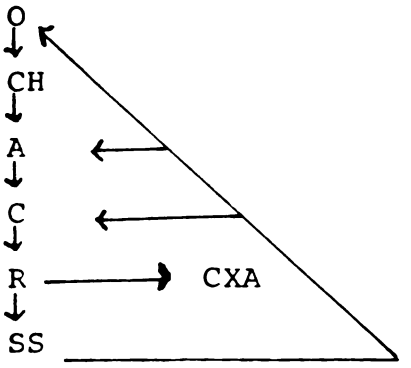
5. To develop a plan of action for Hard-to-Serve cases from Boards of Education.

Inter-ministerial Assessment Service Decision-Making

Steps in rational decision-making and their symbols.

1.	Ask an open-ended question regarding the service gap or conflict issue referred to I.M.A.P.T.	O
2.	Make a two dimensional chart	CH
3.	Generate alternatives	A
4.	Generate criteria	C
5.	Rank the alternatives	R
6.	Make a summary statement	SS

The basic decision-making model



Example of a Possible Referral and Application of the Decision-Making Model by I.M.A.P.T.

Scenario:

A superintendent of education informs I.M.A.P.T. that an I.P.R.C. has established the need for resources potentially available from agency B for student X who is having severe emotional problems.

Question: What service agency is going to provide resources required by student.

	Alternatives			
Criteria	A	B	C	D
A.				
B.				
C.				
D.				
E.				
F.				
G.				
Total				

Alternatives: Ministry of Education, Ministry of Health, Ministry of Community & Social Services, private practice ...

Criteria: Policy, practice, funding, availability of service, responsibility ...

Ranking: Once the alternatives and criteria have been placed on the chart - the alternatives are ranked by applying the criteria against the alternatives and assigning the lowest number to the preferred alternative, then adding them up.

	Alternatives			
CRITERIA	Ministry of Education	Ministry of COMSOC	Ministry of Health	Private Practice
Responsibility	1	3	2	4
Practice	3	2	4	1
Funding	2	3	1	4
Policy	3	1	2	4
Availability	3	4	2	1
Total	12	13	11	14
Ranking	2nd	3rd	1st	4th

Summary: Having considered various alternatives in the context of relevant criteria - I.M.A.P.T. recommends that the required services be provided by the Ministry of Health. Note - Having arrived at its decision, I.M.A.P.T. would refer the case to the appropriate agency for action.

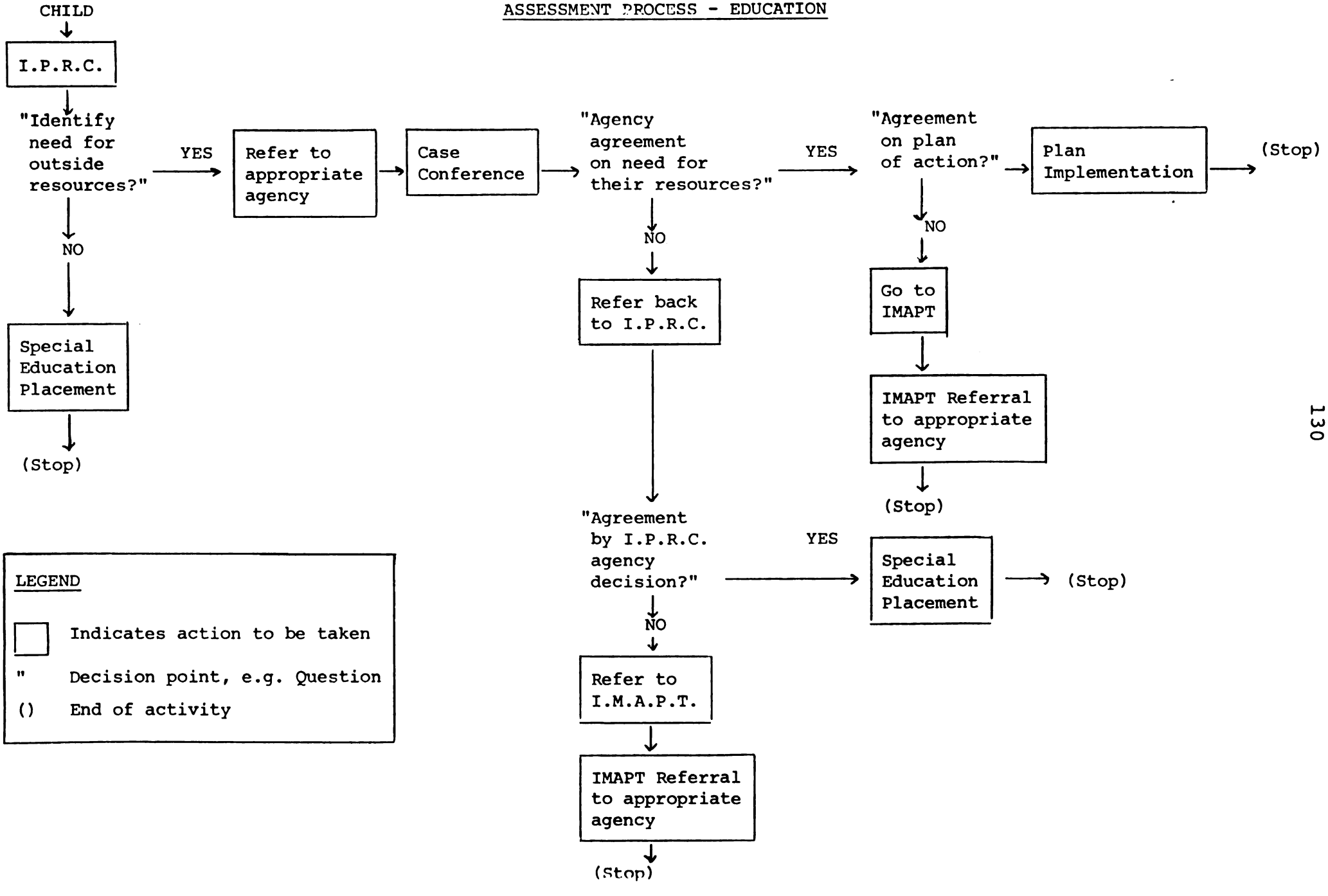
FLOW CHART

ASSESSMENT PROCESS - EDUCATION

CHILD

FLOW CHART

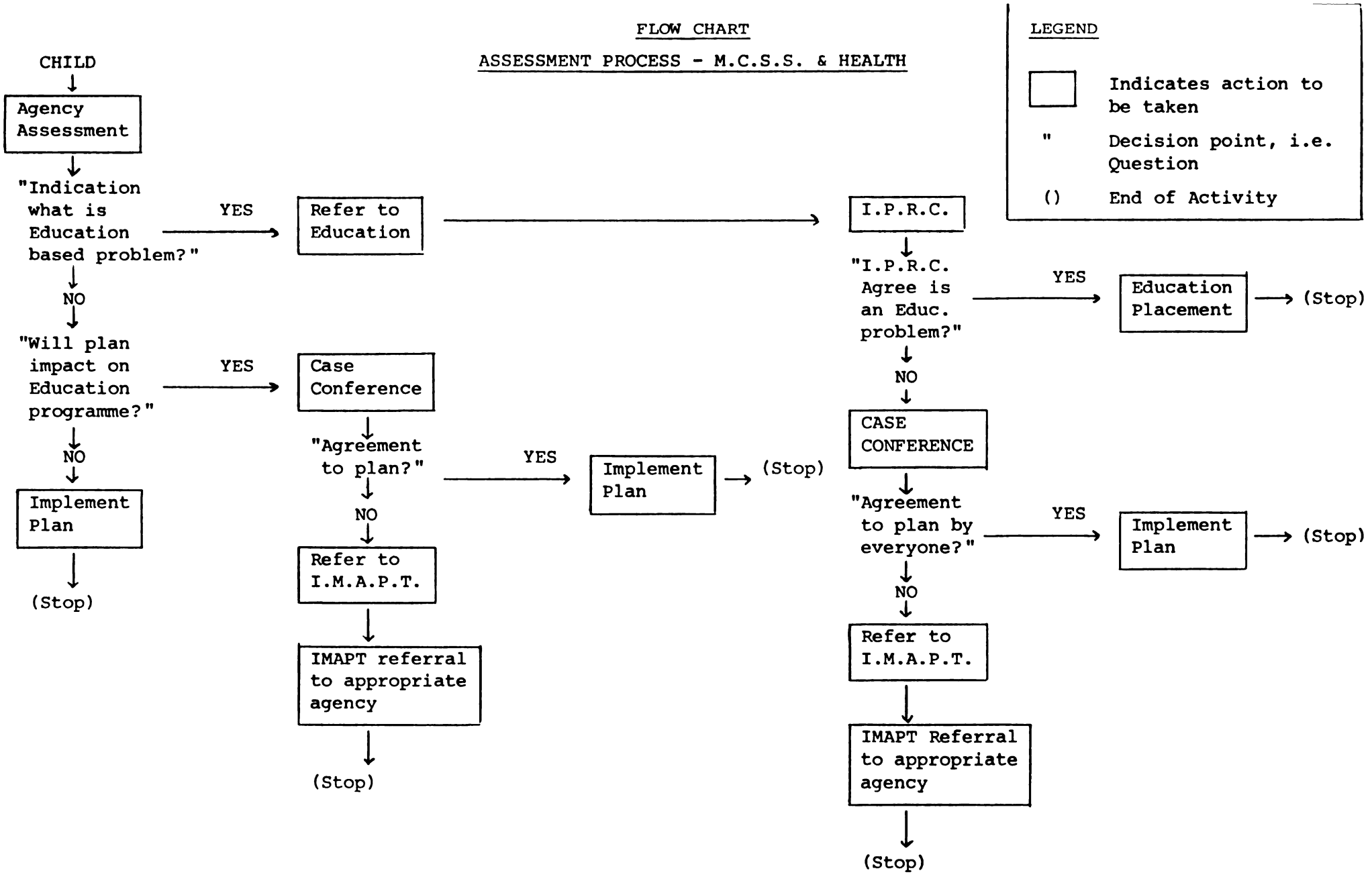
ASSESSMENT PROCESS - EDUCATION




CHILD
Agency Assessment
Indication action to be taken
Decision point, i.e. Question
End of Activity

FLOW CHART

ASSESSMENT PROCESS - M.C.S.S. & HEALTH



Co-ordinating Procedures

This section is a guide to the innovative process of inter-agency collaboration in co-ordinating the delivery of assessment services at the local level. It is intended as an easy reference in the planning and day-to-day management of this innovation. This section is designed to be helpful in a number of ways:

- It sets out expectations for agencies.
- It provides criteria for referrals across Ministries.
- It clarifies agency responsibilities relating to inter-ministerial referrals.
- It describes agreed upon areas of assessment responsibilities.
- It presents options for the provider of the assessment.
- It provides guidelines for the purchase of assessment services from another agency.

However, the section does not give all one needs to know about the innovation. It will not replace experience and the detailed understanding of inter-agency collaboration in co-ordinating the delivery of assessment services; these come from years of experience with many people in many situations.

There is an expectation that the procedures will become increasingly refined as individuals gain experience in operationalizing them. It is sufficient to point out here that the literature and the experience of others during the pilot phase of the current project suggest the following approaches:

Expectations of Agencies

- Each agency will be responsible for co-ordinating the services needed by its clients.
- All agencies will adopt a holistic approach to service.
- Each agency will provide for the needs of its clients with mild psychosocial difficulties.
- Each agency will work co-operatively with other agencies of all Ministries at the local level to ensure that the assessment needs of children and their families are met in an effective and efficient manner.
- Each agency will assume responsibility for providing assessment services that fall within its mandate either directly or through a purchase of service approach.

- Each agency will ensure that the assessment process results in the development of a clearly defined course of action with responsibility for follow-through assigned.

Criteria for Referrals Across Ministries

Although not all children will require assessments inter-ministerial, inter-agency collaboration should take place in cases of the following nature.

(1) Initial assessment activity by one agency indicates difficulties present in areas beyond its mandate. The following are presented as examples of these types of difficulties.

- M.C.S.S. agency during assessment of a child uncovers indicators of intellectual functioning either below or above the norm or indications of a potential physical basis for present difficulties. Case records do not make any mention of these possibilities.
- Educational assessment for learning disabilities uncovers the presence of significant psychosocial dysfunctioning which is having an impact at home and school.
- Physical assessment uncovers indicators of at least a moderate level of psychosocial dysfunctioning or intellectual exceptionality.

(2) Assessment of multi-handicapped children:

- Because of the nature of their difficulties, these children should be assessed by agents from all three Ministries to ensure that a complete picture of strengths and weaknesses is available.

(3) All children being considered by a school board for the Education designation unable to profit.

Agency Responsibilities in Cases of Inter-Ministerial Referral

The referring agency assumes responsibility for information gathering and case co-ordination.

By information gathering, we mean the compiling of the necessary documentation required for making a referral. This documentation would include the following.

- Formal results from assessments to date.
- The identification of factors which indicate the need for the referral.
- A statement of expected outcomes.

By case co-ordination, we mean the referring agency will assume responsibility for case management which covers such areas as service plan development, brokerage and follow through. This function can be transferred to another agency if the final assessment

results indicate a more appropriate focus of primary responsibility. An inter-agency case conference will be the vehicle through which the appropriate focus for case management responsibility will be determined.

The receiving agency, on the other hand, assumes responsibility for analyzing information carrying out assessment functions and ensuring confidentiality of records. The following provides a fuller description of these responsibilities.

Information analysis includes the review of all documentation provided to determine the appropriateness of the referral. The assessment function is carried out on the assumption that the referral is appropriate. As well, the required assessment should be conducted on the basis of the specific needs identified by the referring agency. The case planning function results in the development of a plan of action by the receiving agency through participation in a case conference. On occasion, there may be a need for the receiving agency to carry out the case management function. This, of course, will depend on the outcome of the assessment.

Finally, it is the responsibility of each agency to ensure that the privacy of the client and his family are safeguarded to the fullest extent possible. When

reviewing records to determine which information to send with the referral, decisions should be based on its relevance to the specific situation which prompted the referral. In all cases of an inter-ministry referral, a signed consent form specific to the referral must be obtained. The original should be retained on file and a copy should accompany the referral. If the referral material does not include a consent form, it must be provided prior to the receiving agency involving itself with the case.

Management of the Assessment Process

Each ministry has agreed to a set of clearly defined assessment responsibilities.

- Education will conduct relevant assessments of children for purposes of diagnosing children's learning problems, defining children's learning needs and providing programs to meet these needs.
- Community and Social Services ensure provision of relevant assessments of children for purposes of diagnosing their social, emotional and their mental health problems, defining their psychosocial needs, and

providing programs and/or services to respond to these needs.

- Health will conduct relevant assessments for purposes of diagnosing children's health problems, defining their health needs and providing programs and/or services to meet these needs.

While the above statements are useful for establishing the basic parameters of assessment responsibility, there is a need for some specific statements on areas where definition of responsibility has been somewhat problematic.

Basic Implementation Tasks

The implementation of the inter-ministerial approach to co-ordinating the delivery of assessment services in Northern Ontario, including the I.M.A.P.T. functions, entails a process not to be construed as a product or an event. One can agree with the literature that informs us that the science of implementation still needs to be developed. The basic problem still remains the formulating of a theory of change linked with changing practices. Notwithstanding these limitations, this section will focus on a four-phase process leading to the implementation of the inter-ministerial approach to co-ordinating the delivery of assessment services in the Northwestern, Midnorthern and Northeastern regions of the province.

Pilot Phase

- Conduct a pilot study to determine the efficacy of the model.

Adoption Phase

- Provide feedback on the overall project including the findings of the pilot to participating agencies (e.g. executive report).

- Disseminate information regarding the finalized approach to inter-agency collaboration in co-ordinating assessment services.
- Decide to proceed with the implementation of the interministerial model at the local level.

Implementation Phase

- Monitor implementation, for instance by soliciting feedback from agencies on problems of implementation.
- Interact with directors of agencies and service stream personnel.

Improvement Phase

- Gear strategies to ongoing problems of implementation.
- Change policy as required (if any).
- Assess implementation and its effectiveness.
- Improve implementation as required.

An Agency Procedures Manual was developed to assist in implementation (see Appendix C).

Instrument Development

It was determined that a questionnaire would be the most effective manner for gathering needs assessment data. The format of the questionnaire would be directed toward retrieving individual student data. This determination provides the following advantages:

i) it keeps the number of items to a minimum,

ii) it eliminates the need for the agencies to provide aggregate data,

iii) it links the child directly to the amount of assessment he/she received in the various categories,

iv) it clarifies the picture and expands the information received.

The individual child format was also selected because of its ability to facilitate the collecting of large volumes of information. The individual child identifiers were used in order to track a child from agency to agency, and across service streams.

The survey instrument comprised thirty-five questions (see Appendix B). The following are the leading topics addressed by the questionnaire. The headings for the different clusters of data are as follows:

i) Demographics

ii) Language of Instruction and Assessment

iii) Referrals, Reasons and Placements

iv) Assessment Relations

v) Degree of Severity

vi) Intellectual/Academic Assessment

vii) Sociocultural Assessment

viii) Physical Assessment

ix) Communication Assessment

Problems of long standing in survey research have to do with language usage. As a result of this, a common terminology for classifying assessment problems and their degree of severity has evolved. This common usage strengthened the reliability of responses.

The questionnaire was validated by a panel of judges comprising members of the Steering Committee. The Steering Committee was made up of three Regional Directors of Education for Northern Ontario, the Regional Director for Northern Ontario, Ministry of Community & Social Services, and the three area managers for M.C.S.S. The Ministry of Health was represented by a Northern Ontario planning officer.

This panel of judges had access to the resources of their ministries prior to approving the

questionnaire. The questionnaire was also vetted by representatives of the Ministry of Education's Special Education Branch prior to final approval being given by the Steering Committee.

Results of field work indicated that most school boards preferred the data collection time frame to cover a period from September 1, 1982 to November 30, 1982. This time frame took into account the boards' greatest number of referrals and ensuing assessments. The revised questionnaire was to be hand-delivered in all cases between March and June 1983. The deadline for completion by all school boards was June 30, 1983. The return deadline for M.C.S.S. agencies was extended to August 5, 1983. Analysis of the data took place during the following spring and summer.

Validity of the Instrument

The decision to conduct a survey was made after having taken into consideration various alternatives. According to Orlich (1978), in far too many cases, persons conduct a survey to obtain data which could have been collected or abstracted from primary source reports, forms submitted to coordinated agencies or other available records.

As mentioned in Chapter I, an initial review of assessment data available from M.C.S.S. and Education indicated that data collection formats varied greatly. As a result, an alternative data collection process (a survey) was required to accurately document the status of assessment services currently functioning within Northern Ontario.

The merits of conducting personal interviews and telephone interviews as alternatives to carrying out survey research were considered. However, since the size of the representative sample group was comparatively large and since the sample population was scattered throughout the vast region of Northern Ontario, both the personal interview technique and the telephone interview were deemed inappropriate. Many writers have commented on the advantages of the survey questionnaire as an information-collecting technique. Orlich (1978) articulates the general advantage of using written questionnaires of the type administered in this study, in the following way:

- many individuals can be contacted at the same time
- written questionnaires are less expensive than personal interviews

- each selected respondent receives identical questions
- responses can be easily tabulated
- respondents can answer at their own convenience within the alloted time
- persons in remote or distinct areas can be reached
- interviewer biases are avoided
- uniform, measurable data can be gathered which allows for research investigation
- a written questionnaire requires a much shorter time to complete

The disadvantages of this approach have similarly been described by Orlich (1978):

- the investigation is prevented from learning the respondents' motivation for answering questions
- respondents are limited in their free expression of opinions/information
- questions can have different meanings to different people
- there are no assurances that the intended respondent will actually complete the instrument

- the return of all questionnaires is difficult to achieve

Reliability and Validity of Data

To improve the reliability and validity of the data gathered, a decision was made to have Ministry of Education staff visit each school board. The purpose of this was to clarify questions and concerns of respondents. The same personal approach was planned for the Ministry of Community and Social Services, as their personnel were also to conduct workshops for their agencies, hand deliver the questionnaire, and assist in completing the forms. However, time constraints prevented M.C.S.S. from taking an approach similar to that taken by the Ministry of Education. As a result, the M.C.S.S.- related questionnaires were administered by mail. To offset the methodological weakness of simply mailing out the questionnaire, M.C.S.S. personnel were made available to visit their agencies and assist in completing the questionnaires, when possible.

The objectives, purposes and methods of the Northern Assessment Task Force project were initially presented at Regional Education Council

meetings to the Directors of Education of each school board in the three regions in the early spring of 1983. Directors of Education were asked to inform their superintendents, who in turn would inform their special education personnel of the impending data collection exercise. Ministry of Education personnel held work sessions with each board's special education staff, and aided the boards in completing the questionnaires. To ensure that the participants properly completed and returned the questionnaire, personal follow-ups were conducted, and telephone follow-ups were initiated.

Board personnel filling out the questionnaires included only those special education teacher-diagnosticians, psychologists, psychometrists, special education consultants or speech consultants who were directly involved in formal student assessments and who were familiar with case loads and any pertinent information that was required to complete the questionnaires.

Findings

Findings generated by the assessment questionnaire for the period between September 1 and November 30, 1982 within Ministry of Education and Ministry of Community and Social Services agencies in the Northwestern, Midnorthern, and Northeastern regions of Northern Ontario present data and highlight some themes which appear to run through the data. These themes need to be taken into account in considering decision-making, collaboration practices, and realignment of services for service stream agencies in the Timiskaming and Thunder Bay districts. Both quantitative data - reporting frequencies and percentages, and qualitative data are reported. For the purposes of this study, the data are displayed and discussed in the context of each individual district since each of the geographic regions is unique. The data to date, involving the districts of Thunder Bay, and Timiskaming reflects information derived from a total of 745 individual questionnaires. The data reveal that 119 questionnaires were completed in the district of Timiskaming, and 626 in the district of Thunder Bay. There were approximately 164,332 students

enroled in schools in the two districts involved in the survey.

Table 2 presents information on the distribution of referrals by Ministry and agency type, for the districts of Timiskaming and Thunder Bay.

Within these two districts, Ministry of Education referrals represent approximately 69% of all cases. The data reveal that in the district of Timiskaming M.C.S.S. has been involved in 14 of the 119 referrals. This suggests that education referrals represent approximately 89% of the total referrals. In the district of Thunder Bay, the rate of M.C.S.S. referral involvement is 34%. This is considerably higher than in the district of Timiskaming. While education was involved in 406 referrals in the district of Thunder Bay, M.C.S.S. is shown to have been involved in 220 of all cases (n 626).

Information on the respondent population and methodology discussed in the summary section of Chapter V is intended as a perspective to the overall study. It includes the presentation of more detailed information concerning the questionnaire data as they relate to the districts of Timiskaming and Thunder Bay.

TABLE 2

Numerical and percentage distribution of recorded referrals by Ministry and agency type for the districts of Timiskaming and Thunder Bay

Education	District of Timiskaming	
	n	%
Public Boards of Education		
Kirkland Lake	14	11.8
Timiskaming	81	68.0
Column Total	95	79.8
Separate Boards of Education		
Kirkland Lake R.C.S.S.	10	8.4
Column Total	10	8.4
Total Education	105	88.2

TABLE 2 (cont'd.)

M.C.S.S.		
Child and Youth Services of Timiskaming	14	11.8
Column Total	14	11.8
Total All Agencies	119	100

Education	District of Thunder Bay	
	n	%
Public Boards of Education		
Geraldton	4	.6
Lake Superior	19	3.0
Lakehead	257	41.1
Nipigon-Red Rock	20	3.2
Caramat DSA	6	1.0
Connel and Ponsford DSA	2	.3
Kilkenny DSA	3	.5
Nakina DSA	9	1.4

TABLE 2 (cont'd.)

TABLE 2 (cont'd.)

Northern DSA	20	3.2
Upsala DSA	6	1.0
Column Total	346	55.3
Separate Boards of Education		
Geraldton R.C.S.S.	12	1.9
Lakehead R.C.S.S.	48	7.7
Column Total	60	9.6
Total Education	406	65.2

M.C.S.S.	District of Thunder Bay	
	n	%
C.A.S. District of Thunder Bay	114	18.2
North of Superior Community Mental Health Program	22	3.5
Regional Children's Centre Lakehead Psychiatric Hospital	84	13.4
Column Total	220	35.1

TABLE 2 (cont'd.)

TABLE 2 (cont'd.)

Total All Agencies	626	100

Agreed Upon Assessment Responsibility

The data were examined in relation to mandated and agreed-upon assessment responsibility outlined below. This will serve to frame the ensuing discussion.

The assessment responsibilities of each ministry are found in the following statements:

- Education will conduct relevant assessments of children for purposes of diagnosing children's learning problems, defining children's learning needs and providing programs to meet these needs.
- Community and Social Services will conduct relevant assessments of children for purposes of diagnosing children's psychosocial needs and providing programs to meet these needs.
- Health will conduct relevant assessments for purposes of diagnosing children's health problems, defining children's health needs and providing programs and/or services to meet these needs.

It was agreed that psychosocial assessments of mild level difficulty would be handled by the school board involved with the child. A board would not, in

this case, make a referral to an M.C.S.S. agency (i.e. C.M.H.C.) for assessment.

The Ministry of Health's mandate would be to provide assessment services for the entire range of health-related problems regardless of the degree of severity or difficulty,

As was outlined in the survey questionnaire, the categories of assessment activities include the following:

(1) primarily psychosocial;

(2) primarily educational;

(3) primarily physical;

(4) combined educational and psychosocial;

(5) combined educational and physical;

(6) combined psychosocial and physical; and

(7) combined psychosocial, educational and physical.

These categories describe the various activities provided by the Ministry of Education, the Ministry of Health and the Ministry of Community and Social Services either individually or collectively.

While M.C.S.S. can be expected to provide assessment services for psychosocial categories (1), (4), (6) and (7) listed above (as prescribed by

mandate), its responsibility is primarily in relation to cases which are moderate, severe and very severe. The Ministry of Education on the other hand can be expected to provide assessment services for educational categories (2), (4), (6) and (7). When categories (4) and (7) involve psychosocial difficulties beyond the mild level of severity, the Ministry of Education is to receive support from a sister M.C.S.S. agency.

Finally, the Ministry of Health can be expected to provide assessment services in relation to categories (3), (5), (6) and (7). The combined categories (5), (6) and (7) would necessitate the involvement of either the Ministry of Education or Health, or both, depending on the particular problem.

CHAPTER IV - PILOT

Two significant sources of support existed for pilot testing the ideas, assumptions, and activities of the inter-ministerial model for co-ordinating the delivery of assessment services in Northern Ontario. As one would expect, the findings of the survey and the recommendations derived from these findings provide such support. Secondly, support was also provided by members of the Northern Assessment Task Force Steering Committee. After examining the preliminary findings of the survey and considerable consultation, the steering committee was advised of the development of a pilot project proposal. As a result of this, approval was given by the Ministries of Education, Health, and Community and Social Services under the direction of the Deputy Ministers' Ad Hoc Committee on Children's Services to field test the general framework.

The purpose of the pilot was to field test the model and the feasibility and effectiveness of the operational procedures. The inter-ministerial model to which we refer can be viewed as a set of constructs for organizing, co-ordinating, and executing both inter-/intra-ministry and inter-/intra-agency collaboration in the delivery of assessment services

within clearly defined agreed upon areas of assessment responsibility. It also comprises a process to resolve issues where conflict occurs.

Pilot Selection

A modified random selection process was used to determine the districts to be involved in the pilot project. The figure, on this page provides an illustration of the clusters of districts, by region, comprising the total population. Close examination of districts, within regions, revealed the existence of significant differences between regional characteristics.

A Northeastern

Cochrane

Muskoka

Nipissing

Parry Sound

Timiskaming

B Midnorthern

Algoma

Sudbury

Manitoulin

C Northwestern

Kenora

Rainy River

Thunder Bay

As a result, two new clusters were derived by the application of agreed upon criteria to the characteristics of each sample. Factors such as ethnicity, the presence or absence of specific types of M.C.S.S. facilities, both types of boards and schools within districts, linguistic characteristics of schools, and so on served as a basis for reclustering the eleven districts.

Once stratified, two districts (Thunder Bay and Timiskaming) were randomly selected from normal populations.

Pre-Pilot Activities

Prior to conducting the pilot, members of the project team carried out four distinct sets of tasks. Here, we present an inventory of pre-pilot activities by task topic.

Agency Procedures Manual

An agency procedures manual was developed by the researcher in concert with project team members to be used by local agencies throughout the course of the pilot project. The manual (see Appendix C) had five major objectives:

i) To delineate assessment responsibilities for areas of uncertainty.

ii) To identify points in the assessment process where inter-agency co-ordination should take place.

iii) To establish procedures to be followed in making an inter-agency referral.

iv) To establish criteria and procedures for charge back and purchase of service situations.

v) To establish criteria and procedures for referrals to the conflict resolution body (I.M.A.P.T.).

I.M.A.P.T. Procedures

Procedures were developed to provide guidelines for conflict resolution. These procedures discussed in the model have the following objectives:

i) To establish criteria and processes for decision making.

ii) To provide detailed procedures for implementing decisions once decisions have been made.

iii) To establish procedures for monitoring I.M.A.P.T. cases.

iv) To develop procedures for establishing an ongoing data collection mechanism.

v) To establish procedures for joint ministry planning.

Evaluation Instruments

A third task involved developing a set of instruments for evaluating the pilot project and its effectiveness. The instruments included:

i) Checklists of procedures to be followed at the local level relating to inter-agency referrals, charge backs, and purchase of service(s).

ii) Interview schedules for assessing the completeness and usefulness of the procedures manuals, training sessions, and outcomes.

iii) Questionnaires for assessing the impact of the pilot in the context of manpower, case volume, clarification of agency mandate, administrative, and financial issues and concerns.

iv) Financial cost analysis sheets relating to the potential purchasing of services and charge back costs.

v) A checklist to document I.M.A.P.T. procedures, referrals, decision making, manpower needs, and effectiveness.

Information

This aspect of the project involved the development of an information dissemination strategy likely to result in the implementation of the pilot project in the randomly selected districts. The tasks resulted in:

i) A set of criteria for selecting pilot districts.

ii) Procedures for communicating with agencies involved in the pilot.

iii) The development of training session materials.

iv) Plans for organizing and co-ordinating training sessions involving ministry personnel and agency staff.

v) Clarification of the nature and scope of support to be provided to agencies during the pilot period.

vi) The development of a mechanism for the early identification and resolution of problems arising during the pilot.

Training Sessions

The project identified two distinct target populations that required training and orientation prior to piloting the model. These distinct populations comprised agency staff and Ministry personnel who interface with designated service stream agencies.

Ideally, all staff involved with assessment in an agency should attend an orientation training session. This, however, was not always possible. As a result, the focus of the training sessions was agency directors and senior staff members having responsibilities related to the monitoring of activities of their agency and involvement in identifying and reviewing potential cases requiring outside assessment. It was assumed that each agency would conduct an in-house orientation for other personnel involved in assessment and inter-agency collaboration processes.

In each district the focus for agency training was on the model, its purpose and the local level procedures manual. Some discussion also took place around the evaluation process and agency roles in providing required data.

Within each of the two districts, Ministry orientation training involved personnel directly in contact with local service stream agencies. The sessions drew attention to the importance of full support and co-operation. During orientation, members of the training team reinforced the belief that Ministry personnel would likely be the first to experience the reactions of service stream agencies. As such, they would be the link through which operational issues would be identified prior to becoming major issues or concerns.

In keeping with this perspective, the focus for Ministry staff training was on ensuring that personnel had an understanding of the intent of the initiative and the processes to be followed. As well, some time was spent discussing the organization of the project and inter-/intra-agency linkages and communication channels.

Full day training session were held in both districts. All agencies across each Ministry attended the same sessions. Each agency received a procedures manual at the training session. The ideas of the procedures manual were detailed, page by page, by the

researcher and members of the project team. These sessions were designed to clarify issues related to:

i) The background of the project
ii) The pilot mandate
iii) The activities of the project team
iv) The logic and ideas of the model
v) Data collection procedures
vi) Inter-agency collaboration at the local level
vii) Communication linkages
viii) The meaning of implementation
ix) Implementation considerations

Upon completion of the training sessions, participants were provided opportunities to evaluate their appropriateness and effectiveness. Questionnaires were completed by each participant to provide insight into the effectiveness of the training and model, Table 3. This information was important as it provided a basis for improving training sessions for fostering inter-agency collaboration.

Ministry staff training sessions occurred the day following agency related sessions. As a result of this, concerns raised during the training of agency personnel were addressed immediately by Ministry

personnel. This permitted the development of strategies for coping with factors likely to impede implementation.

TABLE 3

EVALUATION OF TRAINING SESSION

	RESPONSES BY PERCENT		
	Yes	No	No Response
1. Was the overall purpose of this project clearly explained to you?	86	14	0
2. Was the model for coordinating the delivery of assessment services fully clarified?	79	21	0
SPECIFIC COMMENTS			
A. Do you feel each of the following components of the process were clearly explained?			
1. Points where cross-Ministry inter-agency referrals would occur.	86	7	7
2. Definitions of general assessment responsibilities for each Ministry	71	22	7

TABLE 3 (cont'd.)

3.	Specific areas of assessment responsibility:			
	A) Psychosocial	64	36	0
	B) Learning disabilities	64	29	7
	C) Speech & Language	64	36	0
	D) Developmental	64	29	7
4.	Documentation needed for local level cross-ministry referral.	93	7	0
5.	Responsibilities of all parties in a cross-ministry local level assessment.	57	36	7
6.	Responsibilities of agencies purchasing assessment services.	86	14	0
7.	Responsibilities of agencies providing a purchased service.	86	7	7
8.	Documentation required for purchase of service agreements.	86	7	7

TABLE 3 (cont'd.)

9. Criteria and documentation for a charge-back situation.	93	0	7
10. Criteria for I.M.A.P.T. referral.	86	7	7
11. Procedures for I.M.A.P.T. referral.	93	0	7
12. Function of I.M.A.P.T. committee.	93	0	7

B. The responses to the open ended question clustered as follows:

	Very Good	Fine	Good	Satisfactory	Adequate	O.K.	Sufficient	No response
i) Length of training session		7	21	7	14	14	7	29
ii) Method of presentation			29	7	14	21		29
iii) Group size/composition			29	7		29	7	29
iv) Resource materials	7		29	7		29		29

Pilot Data

A range of data were required in order to develop an information base for determining the feasibility of the model, the effectiveness of the model, and processes of implementation. In this connection, the pilot project included carrying out the following data related tasks:

i) Data forms were to be developed by the project team, and were to be completed by each agency director. These data forms were then returned to the researcher for analysis. These forms identified the number of cases of an inter-ministerial nature that were serviced. These forms also indicated the type/nature/extent of inter and intra-ministerial purchases of service, and chargebacks.

ii) Agency personnel were to be interviewed in order to determine the strengths and weaknesses of procedural materials provided.

iii) Cases referred to I.M.A.P.T. to determine consistency of decisions, appropriateness of decision making criteria; and the amount of

time involved to resolve conflict situations were to be analyzed.

iv) The impact on manpower, case volume, and so on, as a result of model requirements, were to be analyzed.

v) Financial impact on funding as a result of across ministry purchasing of services, charge backs, etc., and reviewing the legitimacy of costs being charged, will be examined.

vi) Overall agency interaction patterns relating to the development of informal structures, and general interactional patterns, will be noted.

Communication

The method of entry once districts were randomly selected was typically "top down". Immediately following selection, agencies were informed of their involvement in the pilot project through written correspondence. Letters were forwarded to agency personnel by local regional directors of education, the regional director of the Ministry of Community and Social Services, and a Ministry of Health official. These letters identified the respective project staff from each Ministry involved in the pilot project. They also provided information concerning the date, time, location, and purpose of the proposed orientation sessions.

After the training sessions were completed, lines of communication were established between Ministry field staff, local agencies and the project staff with a view to addressing ensuing issues. Although the agencies were requested to contact a particular member of the project staff when requiring further clarification, a general situation developed whereby agency personnel tended to approach Ministry personnel with whom they were familiar.

In order to support Ministry staff in these situations, a set of likely questions and responses was prepared for their use. When a new issue arose which had not yet been addressed, Ministry staff receiving the result notified a member of the project team. It was the responsibility of the project organizers to develop strategies for coping with problems of implementation. Such situations were communicated to all agencies in the two pilot areas as well as Ministry staff. Every attempt was made to attend to factors affecting implementation within five working days.

After the pilot had been operating for approximately three months, a progress meeting of participating agencies and Ministry personnel took place in each of the two districts. The purpose of these meetings was to get feedback on how well the project had been progressing from the perspective of local service stream agencies. This provided opportunities for issues requiring resolution to surface and for agencies to share their collective experiences. These meetings lasted a full day. The expenses of service stream agencies involved in these meetings were handled by agency-related Ministries.

Roles and Dates

The principal role of the project team was to organize and co-ordinate implementation of the pilot and to provide resource support to agency and Ministry personnel throughout the duration of the pilot project. The immediacy of this role proved important to the overall success of the piloting phase of this dimension of the larger project. A second important role involved the systematic collection of data throughout the pilot. This was achieved through the tabulation of forms mailed to the researcher by each agency director or the director's designate. At the completion of the pilot, interviews were conducted with each agency director or the director's designate. This information was important as it provided a basis for evaluating the effectiveness of the model. This field testing was carried out during the period of April/August, 1984.

Results

Training

The leading topics to which members of the pilot project training team devoted their attention include:

i) rationale for study and the pilot;

ii) the model, and its organizing constructs, assumptions, objectives and logic;

iii) survey data; 73 Tables were developed for each of the pilot districts, and are available from the researcher;

iv) local level procedures manual (and I.M.A.P.T. manual where applicable);

v) communication and linkages between service stream agencies;

vi) the meaning of inter-/intra-ministerial/agency collaboration;

vii) implementation considerations;

viii) the operational plan;

ix) data collection procedures; and

x) the activities of the project team.

The following are some of the issues arising from the pilot training sessions:

i) agencies in both districts indicated a need to identify a maximum time frame for children to remain on a waiting list prior to being serviced;

ii) the need for further clarification regarding the manner in which Health related agencies fit into the proposed system of inter-agency collaboration and I.M.A.P.T. processes;

iii) the need for agencies to work out implementation details such as time frames that would be consistent with already established procedures and within operating principles underpinning the model;

iv) the need for operational definitions of terms such as formal assessment, informal assessment, and referral;

v) procedures likely to result in the shifting of activities reflecting agency related responsibilities in the provision of assessment and treatment services;

vi) the need for a universal set of consent forms; and

vii) problems of identified service gaps.

General Findings

The interviews that were held with representatives from agencies involved in the pilot focused on information concerning the acceptability of the assessment responsibilities as assigned, the level of agreement with the procedures developed for coordinating the delivery of assessment as well as a general discussion regarding any changes required prior to implementation of the model across Northern Ontario. Attempts were also made to review selected files of cases identified as inter-ministerial to determine if appropriate documentation was on file and to determine whether established procedures were implemented.

Table 4 and 5 present a summary of data gathered in the pilot project carried out in the district of Thunder Bay, and the district of Timiskaming. Totals for cross-ministry referrals received should be the same as for referrals made. However, the slippage in the system has created a significant discrepancy. This will be dealt with in Chapter V under mandate drift.

Table 6 presents a summary of the data gathered from the Evaluation Form (Appendix E) mailed to the agency director or their designates concerning their experiences with the pilot project.

Although the data from the interviews will be summarized in Chapter V, some of the direct comments from the agency directors or their designates are as follows:

- Even though money is available, some Francophone children are not being served because of a lack of Francophone personnel. (Timiskaming Roman Catholic Separate School Board.)
- We need a trained teacher diagnostician. (Timiskaming Board of Education.)
- Much more interested in meeting needs of the District and filling the gaps in service, than in worrying about Ministry jurisdictional responsibility. (Timiskaming Health Unit.)
- Charge-backs have more or less been shelved because cooperation within the district precludes their necessity. (Kirkland Lake Board of Education.)
- The procedures manual is completely workable, and a good reference in case a problem should develop. (Kirkland Lake Board of Education.)

- I must admit that I was a reluctant participant in this project. However, the close cooperation among the other agencies and ourselves forces me to eat humble-pie.
- The model is an excellent manual to fall back on. (Kirkland Lake Roman Catholic Separate School Board.)
- There are definite gaps in the system even though cooperation is at a high level. (Child & Youth Services District of Timiskaming.)
- Service is now available in the psychological area to serve the District. (Cochrane-Timmins Resource Centre.)
- The delineation of each Ministry's tasks and roles should make accountability easier. (Regional Children's Centre of Thunder Bay.)
- At the local level, people see this as a worthwhile and time-saving enterprise. (Nipigon Red Rock Board of Education.)
- Implementing these procedures has had a positive effect on staff. (Geraldton Board of Education.)

- The inter-agency referral form was good for our use. Our board was not involved in any charge-backs. (Lakehead Board of Education.)
- In our opinion, the definitions of assessment responsibilities for the Ministries of Education, Community and Social Services and Health provided for the project are too vague as operational guidelines, as they pertain to mentally retarded children. (Northwestern Regional Centre.)

Findings of the pilot will be summarized and recommendations generated in Chapter V.

TABLE 4

DISTRICT OF TIMISKAMING

SUMMARY OF PILOT PROJECT DATA

Cross-Ministry referrals received	51
Cross-Ministry referrals made	61
Purchased assessments provided	0
Purchased assessments bought	0
Charge-back assessments made	0
Charge-back assessments received	0

TABLE 5

DISTRICT OF THUNDER BAY

SUMMARY OF PILOT PROJECT DATA

Cross-Ministry referrals received	33
Cross-Ministry referrals made	13
Purchased assessments provided	12
Purchased assessments bought	7
Charge-back assessments made	4
Charge-back assessments received	0

TABLE 6

EVALUATION OF PILOT PROJECT

	RESPONSES BY PERCENT		
	Yes	No	No Response
1. Are the points identified where cross-ministry inter-agency referrals should take place?	91	9	0
2. Are there other situations which should be included for cross-ministry referrals?	9	82	9
3. Were the specific Ministry responsibilities for assessment clear in each of the following areas?			
A. Psychosocial	73	18	9
B. Speech & Language	55	27	18
C. Learning Disabilities	55	27	18
D. Developmental	64	9	27
4. Are there other areas of assessment responsibility that need to be defined?	9	73	18

TABLE 6 (cont'd.)

5. Do you feel there has been a positive effect on staff as a result of implementing these procedures?	36	18	46
6. Is material requested on inter-agency referral forms adequate?	100	0	0
7. Do the procedures for Purchase of Service meet your needs?	64	0	36
8. Do you feel the criteria for charge-backs is adequate?	46	18	36
9. Do you feel that costs other than just for the assessment should be charged back?	27	64	9
10. Have you had experience with an agency unwilling to accept a charge-back?	9	73	18

TABLE 6 (cont'd.)

11. Do you feel the criteria for I.M.A.P.T. referral is adequate?	54		46
12. Do you feel that the I.M.A.P.T. procedures are adequate?	64		36
13. Do you feel that I.M.A.P.T. has been successful in resolving service difficulties?	0	0	100

CHAPTER V - SUMMARY, CONCLUSIONS, RECOMMENDATIONS

Introduction

The purpose of the study was to develop a long range coordinated model for the delivery of assessment services for exceptional children in the northern regions of Ontario.

In this chapter provisions are discussed that provide answers to the research questions cited in Chapter I.

Procedures

Following proven procedures, in the study data have been assembled using the principle of triangulation. This involves assembling multiple data sources and trying to assess consistency of findings across the varying methodological modalities. Types of procedure used to yield data underpinning the study include (1) survey of the literature, (2) assembling of archival data, (3) conducting limited ethnographics, (4) survey data, (5) use of key informants, (6) statistical data and (7) piloting of the model.

Reaching conclusions in interministerial assessment service research is without a doubt a tenuous business. Nevertheless, it is fair to state that the conclusions and final recommendations reflect

the analysis of the questionnaire data, pilot results and general indications of what would likely optimize assessment service offerings in the Northwestern, Midnorthern, and Northeastern regions of the province of Ontario. Thus, the principal conclusions address issues related to both the scarcity and unequal distribution of assessment services in the Regions. In some instances, scarcity and distribution are clearly language related. In other instances, scarcity and distribution are agency related. It is fair to say that the data provide evidence that districts themselves are not equally involved in the provision of assessment services. The data also show that the sophistication of placement services varies by district and by regions within districts.

Method of Entry

The methods of entry can be characterized as a "top down" approach. Permission from the Steering Committee and senior administrators within agencies was solicited prior to any data gathering. A similar process was undertaken in the context of gaining entry to two randomly selected districts involved in the pilot aspects of the project. Both survey and pilot related data are deemed to be sufficiently

representative as to warrant widespread implementation of existing recommendations.

Summary of Findings from the Instrument

To simplify the presentation of findings, the data for the most part have been grouped and organized in accordance with clusters of questions on the survey instrument. This, in turn, has resulted in the tabulation of data under nine distinct headings. The reader is urged to refer back to the questionnaire should difficulties arise.

The purpose of this section is to summarize the findings previously discussed. The last section of this chapter draws implications or recommendations from these results regarding service gaps, mandate drifts, realignment requirements, and general issues.

The following summaries have been extracted from the 73 Tables for the districts of Timiskaming and Thunder Bay, and are available from the researcher.

- In many jurisdictions, referrals and assessments among lower age group children need to be increased.
- No comprehensive provisions are made in some jurisdictions for assessing in French, children whose language of instruction is French.

- The responsibility for providing appropriate placements after assessment is generally considered to be the responsibility of local boards of education. In some jurisdictions, the range of alternative placement possibilities is limited.
- Referrals and assessment activities are expected to result in improved programs and services. In some instances, referrals and assessments do not result in improved programs and services for students.
- Psychosocial assessment is identified as one of the assessment service areas which increases among older group children. The majority of children with psychosocial problems should be referred for assessment at an earlier age level.
- The appropriateness of referrals is contingent on screening processes. The rate of inappropriate referrals tends to suggest that personnel at the present time are insufficiently trained to determine the assessment needs of children.

- There is a widespread need to provide assessment services in French to referral children whose mother tongue is French.
- The rate of "already active cases" stands to increase in the future. Increases will result from the implementation of Bill 82 and IPRC processes. Consequently, additional assessment and placement resources will be needed.
- The findings in this study relating to the nature and scope of assessment services available in different districts suggest a pattern of unequal distribution.
- Public and R.C.S.S. boards are not equally involved in referral and/or assessment processes.
- The findings in this study regarding resource gaps suggest the need for audiologists, speech therapists, psychologists, physio-therapists, French language health care specialists, teacher diagnosticians, and psychiatrists.

Summarizing statements must also be made regarding mandate drift. By mandate drift, we mean that a

ministry or agency within a ministry is providing service in an area related to educational, health, or psychosocial needs where another ministry or service stream agency has jurisdiction. Where drift exists, it is likely to occur as a result of a) lack of knowledge and understanding of jurisdictional responsibility or b) insufficiency of resources within service stream agencies with assigned mandate. It appears to this researcher where drift occurs, this situation could be corrected by a) clarifying mandates b) realigning services or c) purchasing services.

The evidence presented in this chapter suggests the following summarizing statements relating to mandate drift.

- The responsibility for mild and moderate level assessments is typically within the agency having a designated mandate. Interestingly, school boards frequently conduct psychosocial assessments belonging to M.C.S.S., while M.C.S.S. agencies conduct assessments within the realm of the jurisdiction of education.
- The responsibility for physically based speech assessment is typically within the

Ministry of Health. The Ministry of Education is responsible for speech correction. Some M.C.S.S. agencies continue to provide assessment services in this area.

- In some instances, intra-agency referral systems need to be examined. The preferred approach is to institutionalize an inter-agency referral system that is both appropriate and effective. At the time of the study, there was a high rate of biological/physical referrals within the M.C.S.S. referral system which resulted in referrals to other agencies.

Summarizing statements must also be made regarding realignment requirements. Information from the tables suggest the need for realignment is an apparent product of inappropriate referrals. This situation exists when a referral for assessment service is made to one Ministry or service stream agency when the responsibility (agreed-upon mandate) for the provision of assessment service is the responsibility of another Ministry or agency. The data suggest the following realignment issues:

- The rate of psychosocial referrals to M.C.S.S. at the severe and very severe levels should be higher.
- M.C.S.S. involvement in educationally related referrals and assessments in some jurisdictions is inappropriately high.
- Numerous referrals made to M.C.S.S. agencies by school boards result in no assessment being carried out.
- At the time of the study, M.C.S.S. involvement in assessing clients with mild or moderate level problems implies a need for realignment relating to "level of severity".
- From the point of view of the present study, education is underinvolved in intellectual assessments. Actually, what is happening is that educational agencies frequently refer clients requiring an intellectual assessment to an M.C.S.S. agency.
- Another area requiring attention is that having to do with speech assessment. In at least one district, speech assessment is conducted almost wholly by M.C.S.S.

- Examples of the various types of speech activity suggest a need to refine both inter-agency and intra-agency referral systems.
- The data indicate instances of M.C.S.S. carrying out both educational and physical assessments. These situations have implications for education and health related agencies.

In the context of other issues, summarizing statements of a general nature are also in order.

- Local agencies use various informal means rather than formal means of coping with charge backs when fee-for-service conditions exist.
- In many jurisdictions, the number of mild- and moderate-level educational assessments being conducted is noticeably high.
- In most educational jurisdictions integration is the preferred means of servicing exceptional children.
- In some regions, the correlation between request for service and provision of educational, physical or psychosocial

assessment service is directional and positive.

Summary of Findings from Pilot

The following statements are brief summaries of the findings from the pilot:

1. The ideas and logic of the inter-ministerial model for co-ordinating the delivery of assessment services in Northern Ontario result in beneficial change in the assessment field;

2. The statements of assessment responsibility are acceptable to service stream agencies;

3. The operational policies and procedures through which local service stream agencies can meet their agreed-upon assessment responsibilities are both appropriate and effective;

4. Agencies that participated in the pilot phase of the project tended to become increasingly supportive of the notion of the need for inter-agency/ministry collaboration in the delivery of assessment services;

5. The pilot project resulted in an escalation of collaborative efforts geared to the provision of assessment services;

6. The agency procedures manual is viewed as a comprehensive document;

7. The volume of assessment activity of an inter-ministerial nature varies by district and agency type;

8. Timing is important to the potential success of inter-agency innovations;

9. Participants suggested the need for additional in-service geared to ongoing problems of inter-agency collaboration in the provision of assessment services (as opposed to a single one-day front-end training session);

10. When faced with charge back situations agencies are capable of resolving issues without a formal charge back mechanism;

11. The findings in this pilot regarding service gaps suggest that the main problem is in professional resource gaps;

12. The nature of professional resources and the scope of their availability are district related;

13. Continued support is needed in the provision of professional resources in French;

14. In some jurisdictions, a wider spectrum of educational placements is desirable in the longer term.

Finally, the pilot study verified the existence of professional resource gaps, institutional slippage, and

the need for ongoing realignment both within and between agencies.

Conclusions

The conclusions below have been logically derived from the summary of findings of the survey data and the pilot. They convey judgements as to assessment needs in Northern Ontario.

1. That education service stream agencies conduct relevant assessments for purposes of diagnosing children's learning problems, defining children's learning needs, and providing programs and/or services to respond to these needs.
2. That Community and Social Services agencies assume responsibility for the provision of relevant assessments of children for purposes of diagnosing children's social, emotional and children's mental health problems, defining children's psychosocial needs, and for the provision of programs and/or services to respond to these needs.
3. That health related service stream agencies ensure provision of assessments for purposes of diagnosing children's health problems, defining children's health needs, and providing programs and/or services to meet these needs.

4. That the Ministries of Community and Social Services, Education, and Health assume responsibility for ensuring that their service stream agencies fulfill their assessment mandate.
5. That the Ministries of Education, Health, and Community and Social Services use agreed upon terminology and operational definitions relating to types of assessment problems and levels of severity of such problems.
6. That each agency provide for the assessment needs of its clients with psychosocial problems at the mild level.
7. That the provision of assessment services be geared to the linguistic and cultural needs of clients.
8. That once a referral is made, the resultant assessment be conducted within an agreed-upon time frame.
9. That where an agency of a Ministry having responsibility for the provision of assessment service is unable to provide an assessment service, arrangements be made between an agency of the same Ministry or from an agency of another Ministry for the purchase of appropriate services.

10. That local school boards provide all the necessary documentation verifying the need for an assessment by an outside agency.
11. That an in-service training program be implemented to provide classroom teachers with opportunities to develop required diagnostic and programing expertise. Professional expertise in these areas will reduce service gaps and will also have the effect of reducing the nature and scope of inappropriate referrals.
12. That the Ministries of Community and Social Services, Education and Health engage in inter-ministry collaborative practices in the provision of assessment services in Northern Ontario.
13. That service stream agencies within the Ministries of Community and Social Services, Education and Health engage in both intra- and inter-agency collaboration practices at the district level in the delivery of assessment services throughout Northern Ontario.
14. That service stream agencies refine the criteria utilized for referral decision making.

15. That the quantitative and qualitative levels of assessment staffing be assured in Northern Ontario and that such staffing be geared to the nature and scope of assessment needs.
16. That a set of agency-related procedures be developed which provide the basis for inter-agency collaboration in organizing and co-ordinating the delivery of assessment services throughout Northern Ontario.
17. That a set of procedures be developed that will ensure inter-ministry and inter-agency collaboration in the resolving of major service conflicts and/or gaps.

Summary Conclusions

i) both service and realignment gaps exist;

ii) the project has evolved a defensible model which addresses both service gap and realignment issues;

iii) the model and its procedures can be used as a basis for expanding professional resources and improving collaboration practices.

Recommendations

In the context of these conclusions the following recommendations are made.

1. That the inter-ministerial Model for Co-ordinating the Delivery of Assessment Service be implemented in the Northwestern, Midnorthern, and Northeastern Regions of the province, without further delay.
2. Co-ordination cannot be achieved either quickly or painlessly nor will it automatically endure. Strategies will be required to maintain a sense of ownership and fair distribution of responsibility. It is recommended that there be periodic frank discussion and review of the Inhibitors or Barriers, "2.3.2", lest, having been overcome the first time such barriers arise again to the detriment of the co-ordination of the delivery of assessment service.
3. It is recommended that successors to the original participants in the project become oriented by reviewing the documents related to the establishment of the model, so as to be aware of the factors that were considered before this project was successfully launched.

4. Problems in a similar political context may land themselves to similar co-operative solutions. Where populations are sparse, ethnically, linguistically, and culturally diverse, and distances are great, the model may provide an approach that will help to solve the problems.

Reflections

An interministerial study that requires a collaborative effort is fraught with joy and sorrow. To be able to work from a holistic point of view, knowing that the three ministries and their agencies collectively have the access to human and fiscal resources necessary to bring to bear on any particular child's problem is a dream. To make this dream a reality for all types of problems all over Northern Ontario was an onerous task. I have mentioned the achievement of co-terminus boundaries and what a benefit it was; however a problem we never could solve was how to bring the steering committee together for a decision in less than six weeks.

Another problem in a study of this duration was maintaining continuity of participants. The director representing the Ministry of Community and Social Services on the steering committee changed three times, in addition we had one acting director. There were also three different representatives from the Ministry of Community and Social Services on the project team. From the Ministry of Health we had three different planners on the steering committee, and two different representatives on the project team.

The study began with one government and carried on after the election of a new government.

These were factors to be dealt with in the course of the study and did not have any great effect positively or negatively except that it may have lengthened the time frames as the study moved along.

The fact that this study operated without a budget fostered collaboration between the Ministries since cooperation was required every time the project faced a resource requirement. Although I would recommend a budget for a project of this magnitude, the fact that it was financed out of existing revenues of each Ministry did not detract from the project appreciably.

The variance of ministry policy within government policy is worthy of note. The passive involvement of the Ministry of Health initially caused some concern. However as one watched the project develop, the congruence between the policies of each ministry in relation to the project's objectives gradually became a fait accompli.

I knew that the job of creating a change in the assessment services for exceptional children and youth in Northern Ontario would be a long and difficult

process; but it's a job I would start on again tomorrow.

APPENDIX A

DEFINITIONS

ASSESSMENT QUESTIONNAIRE

NORTHERN ASSESSMENT TASK FORCE

CHILD DATA

Please complete the following information on each child referred to your agency/board between the period September 1, 1982 and November 30, 1982. Please read the following instructions before completing this section.

Name Code

Enter the first and last letters of the surname in the first two boxes and the first and last letters of the given name in the next two. Do not use a nickname, a diminutive, or a middle name. Use the legal name which appears on the birth certificate or OHIP form. Note that the two spaces for the code of the given name are not for two initials but for the first and last letters of the first given name. In the case of a hyphenated or two-part name, enter the first character of the first part of the name and the last character of the second part. This applies to given names and to surnames.

Examples

	Surname	Given Name
David Robert Smith	S H	D D

Mary-Ann Armstrong-Jones	A S	M N
Bruce Van Dyck	V K	B E

Birthdate:

Enter the date in the order year/month/day.

Example: June 12, 1964

Y Y	M M	D D
6 4	0 6	1 2

Referral Date:

Enter the actual date that you received a formal request for assessment in the order year, month, day.

Mother Tongue

This refers to the language a person first learned in childhood and still understands. In the case of infants it means the language most often spoken in the home. In this box please enter the number code for the child's mother tongue.

Definitions

Please use the following definitions to assist you in completing the questionnaire.

Referral

A formal request for information to assist in determining an appropriate plan of action for a client. For boards of education, this would mean beyond the regular classroom situation, requiring parental permission to conduct an assessment.

New Referral

This refers to a case that has not been previously involved with the assessment services of your agency/board.

Already Active Case

This refers to a case that has been receiving programing services from your agency/board and a decision has been made to reassess the child.

Previously Active Case

This refers to a case that has been closed and is reopened with a new referral for further assessment.

Assessment

For purposes of this questionnaire, please include information on both formal and informal

assessments that your agency/board may be conducting. For example, observing a child in school or at home should be noted as part of the assessment process which may also include more structured procedures that may require specialized tools or skills.

The following definition of assessment has been included to assist in clarifying for you what is meant by assessment.

Assessment refers to a thoughtful process involving:

- collecting information
- making direct observations
- weighing the facts and developing hypotheses about the problems
- understanding the individuals' needs and deficits
- estimating the nature and the degree of assistance which can promote healthy functioning and continuing development
- arranging for the provision of such assistance.

Note

Within this framework, initial intake activities such as a social history done to establish why the referral has been made to your agency/board would not be included in this exercise. This would include general information on the client, social history data, and any other information collected to determine the appropriateness of the referral prior to deciding on any course of action to be taken. However, any assessment undertaken as a result of this intake activity would be included in the questionnaire.

As well, any ongoing monitoring activities done to determine the impact of effectiveness of programs implemented would not be included in this data collection, as they are evaluative in nature as opposed to assessment oriented.

Formal Assessment

Involves the use of standardized assessment instruments that have been validated and provide results which can be measured against a set of established norms.

Informal Assessment

Activities that may involve a consistent set of procedures but which have not been validated and thus the results cannot be measured against a set of established norms.

Psychosocial Assessment

The psychosocial area refers to those socially learned aspects of one's life which relate to emotional patterns, perception and thought patterns and patterns in interpersonal relationships. A psychosocial assessment is undertaken to determine the psychosocial functioning of a child and to assess the effects that disorders in these areas are having on the child's overall ability to cope with his/her environment. A psychosocial assessment should provide measures of:

1. Intensity of child's disorder - the extent of child's behavioural/emotional difficulty.

2. Duration of child's disorder - length of time child has displayed behavioural/emotional difficulty.

3. Frequency with which child demonstrates behavioural/emotional problem.

4. Reactivity - responsiveness of child to corrective intervention.

Levels of Psychosocial Difficulty

Mild

Intensity - behaviour is annoying or disruptive to the immediate environment.

Frequency - from rare to occasional occurence.

Duration - short term from less than one day to one week.

Reactivity - behaviour either disappears without intervention or by giving some extra attention, i.e. "talking it over".

Moderate

Intensity - behaviour threatens the general ability of the child to benefit from the normal environment, or it threatens the well-functioning of the environment.

Frequency - occurs frequently: relationship between cause and immediate behaviour is difficult to identify.

Duration - semi-permanent; problematic behaviour becomes more regular.

Reactivity - requires a treatment plan focused on specific behaviour change.

Severe

Intensity - inability to benefit from the normal environment even with in-house supports - behaviour may pose significant risk to the environment.

Frequency - has become the typical behaviour pattern for the child.

Duration - behaviour permanently entrenched; occasional problem free periods.

Reactivity - requires a multi-service treatment program.

Very Severe

Intensity - behaviour presents imminent risk to self, others and/or property.

Frequency - apparently permanent.

Duration - behaviour fully integrated into child's personality.

Reactivity - requires a comprehensive residential treatment program.

Educational Assessment

An educational assessment is undertaken to determine the impact of a specific exceptionality on a child as it relates to his ability to learn in the classroom. The assessment should provide some

indication of necessary teaching strategies, specialized techniques required, curriculum modifications, etc.

Levels of Educational Difficulty

Mild - child is in a regular classroom situation.

Moderate - child is on a resource withdrawal program.

Severe - child is in a self-contained special education classroom.

Very Severe - child is in a provincial school or specialized school program. Physical Assessment

A physical assessment is undertaken to determine the impact of a particular medical disorder on a child's physical capabilities.

Level of Physical Difficulty

Mild - Sporadic need for medication/therapy. Generally does not disrupt daily routines and activities.

Moderate - Medication or therapy on a consistent daily basis. Minimal disruption to daily routines and activities.

Severe - Need for specialized health support services/treatment on a daily basis. Significant disruption to daily routines and activities.

Very Severe - Constant medical attention required to maintain child. Primary focus of daily routine.

Assessment Categories

The following definitions are intended to assist your agency/board in determining where to categorize your various assessment activities.

Intellectual Assessment

Those assessment activities, usually of a standardized nature, undertaken to determine an individual's potential or capacity to learn.

Functional Academic Assessment

Those assessment activities undertaken to determine the extent to which a person has mastered the concepts, operations, skills, etc. directly related to the school curriculum. While some of the assessment activities in this area could be of a standardized nature, as defined, the majority is likely to fall into the category of informal assessment. For boards of education, activities in this area would likely be done for all children being considered as exceptional.

Social/Cultural Assessment

A process undertaken to determine the extent to which a person has developed appropriate adaptive behaviours and to identify those environmental factors contributing to the maladaptive behaviours.

Such specific areas as child and family, psychiatric, and behaviour would be the focus for this category. For boards of education, behavioural assessment completed by the board for children thought to be in the category of behavioural exceptionality would be included. Assessing the extent of an emotional or psychosocial basis for speech and language difficulties would also be covered in this category.

Biological/Physical Assessment

A process undertaken to determine the extent to which a person is organically, physically and neurologically sound.

Such specific areas as motor and neurological would be the focus for this category. For boards of education, physical assessment completed by the board for children thought to be in the category of physical exceptionality would be included here. Assessing the physical extent of a speech and language problem would also be covered in this category.

Communication Assessment

A process undertaken to pinpoint the functional difficulties a person may be having in one or more communication modalities.

Such specific areas as assessing speech and language capabilities would be included. For boards of education, communicational assessments completed by the board for children thought to be in the sub-categories of autistic, hearing impaired, learning disabled and speech and language impaired, which fall under the general category of communication exceptionalities, would be included.

Agency/Program Definitions

Use the following set of definitions to assist you in selecting the appropriate response when necessary.

C.M.H.C. - Residential	A Children's Mental Health Centre that in addition to providing mental health services to children on an out-client basis also has a residential component where clients live while receiving mental health services.
C.M.H.C. - Non-Residential	A Children's Mental Health Centre that provides services only on an out-client basis.
Probation and Aftercare	An M.C.S.S. operated service dealing with children placed on

	Probation by the Family Court.
Observation & Detention Service	A short term predispositional service for children who are involved with the courts.
Training School	A post dispositional M.C.S.S. operated residential program for children in conflict with the law with a finding of delinquency made by the courts.
M.R. Schedule I	An M.C.S.S. operated facility for mentally retarded children and adults providing both in patient and out patient services.
M.R. Schedule II	As per Schedule I except that the facility is operated

	by a private board rather than by direct Ministry employees.
M.R. Schedule III	As per Schedule II except that services are offered in various locations in the community rather than in one centralized location.
Developmental Programing & Assessment Services	An M.C.S.S. funded service that provides assessment and program planning services for developmentally handicapped persons.
Regular day nursery	Half-day or full-day program for normal children licensed under the Day Nurseries Act.
Segregated day nursery	Half-day program for mentally retarded or physically handicapped

	children licensed under the Day Nurseries Act.
Integrated day nursery	Half-day or full-day program for normal and mentally retarded or physcially handicapped children licensed under the Day Nurseries Act.
Preschool program for the blind	Half-day program for blind children licensed under the Day Nurseries Act.
Preschool program for the emotionally disturbed	Program offered by Children's Mental Health for children below the age of 6 years. This program would not be licensed under the Day Nurseries Act.
Developmental Centre	A full-day program

	licensed under the Day Nurseries Act for school-aged children who have been assessed as being severely or profoundly retarded.
Regular Classroom	School-age program for normal children operated by a board of education.
Resource or withdrawal	Child is in a regular classroom and withdrawn from the classroom on scheduled basis for remedial assistance. Program is operated by a board of education.
Self-contained	Special education classroom operated by a board of education within the regular school where a child receives a special

	education program for 50% or more of their time.
Section 15	A special education classroom created as a result of a formal agreement between a board of education and a residential facility for the residents of that facility where treatment is the primary need for the pupils.
Special Education Trainable Mentally Retarded	A special education program provided by a board of education for students assessed as being trainable mentally retarded.

APPENDIX B

INDIVIDUAL CHILD

ASSESSMENT QUESTIONNAIRE

NORTHERN ASSESSMENT TASK FORCE

ASSESSMENT QUESTIONNAIRE

Please complete one questionnaire for each child up to and including 21 years of age who was referred to your agency/board for assessment services during the time period September 1, 1982 to November 30, 1982. Refer to the accompanying set of definitions to assist you in choosing the most appropriate response.

Child Data

Agency Code [ ][ ][ ] [3] (1 2 3 4)

Child Number [ ][ ][ ] (5 6 7)

Surname [ ][ ] (8 9)

Given Name [ ][ ] (10 11)

Date of Birth [ ][ ][ ] (12 ... 17)

Sex

1. Male
2. Female [ ] (18)

Mother Tongue (select one)

1. English
2. French
3. German
4. Other [ ] (19)

Agency Code | 3 | Child#

5. Native Indian & Inuit 7. Unknown

6. Italian

Ethnic Group and Status (select one)

1. Caucasian
2. Status Native Indian
3. Non Status Native Indian
4. Metis
5. Asaian
6. Negro
7. Other

[ ] 20

Referral Date

[ ] [ ] [ ] 21 26

General Assessment Information

1. Indicate the appropriate referral category for this child.

   1 New referral

   2 Already active case requiring further assessment

   3 Previously active case reactivated and requiring further assessment

[ ] 27

2. If this child was a new referral or a reactivated case, indicate the source of the referral; i.e. the person or agency that requested the assessment from you.

   01 C.A.S.

   02 C.M.H.C. - Residential

   03 C.M.H.C. - Non-Residential

[ ][ ] 28 29

Agency Code | | | | 3 | | | | Child# | | | |

04 Probation & Aftercare

05 Observation & Detention Service

06 Training School

07 M.R. Schedule I

08 M.R. Schedule II

09 M.R. Schedule III

10 Association for the Mentally Retarded

11 Segregated day nursery

12 Developmental Centre

13 Integrated day nursery

14 Regular day nursery

15 Infant Stimulation Program

16 Developmental Programing & Assessment Services

17 Court

18 Police

19 Crippled Children's Centre

20 General Hospital

21 Parent

22 Physician

23 Public Health Unit

24 School Board

25 Provincial School

26 Private School

Agency Code | | | | 3 | Child# | | |

27 Private Psychologist

28 Private Psychiatrist

29 Private Speech Pathologist

30 Private Speech Therapist

31 Private Physiotherapist

32 Private Occupational Therapist

33 Psychiatric Hopsital

34 Other (please specify) _____

3. (a) For Boards of Education only. Please indicate the status of this pupil. Select one option only.

1 Resident pupil of the board

2 Day pupil in Section 15 classroom

3 Facility pupil in Section 15 classroom

4 Pupil of another board

5 Pupil, the responsibility of the Province of Ontario

6 Pupil, the responsibility of Canada [ ] 30

7 Other (please specify) _____

(b) For M.C.S.S. Agencies only.

Does the child

1 Live within your catchment area

2 Live outside your catchment area [ ] 31

Agency Code | 3 | Child#

4. Please indicate the present educational placement of this child. Use the definitions provided to assist you in selecting the appropriate placement. For boards of education, please indicate the placement after completion of the Identification, Placement and Review Committee process wherever possible.

32 33

01 Regular day nursery
02 Segregated day nursery
03 Integrated day nursery
04 Preschool program for the blind
05 Preschool program for the emotionally disturbed
06 Preschool program for the deaf
07 Developmental Centre
08 Regular classroom
09 Resource or withdrawal program
10 Self-contained classroom
11 Section 15 classroom
12 Special Education for the Trainable Mentally Retarded
13 None
14 Other (please specify) _____

Agency Code | | | | 3 | Child# | | |

5. Please indicate the primary reason for this referral

   1 Psychosocial assessment
   2 Educational assessment [ ] 34
   3 Physical assessment

6. Was the assessment activity that you carried out

   1 Primarily psychosocial
   2 Primarily educational [ ] 35
   3 Primarily physical
   4 Combined educational and psychosocial
   5 Combined educational and physical
   6 Combined psychosocial and physical
   7 Combined psychosocial, educational and physical

7. In terms of the criteria provided with this questionnaire,

   (a) would your assessment findings indicate the child to be a:

      1 Mild psychosocial problem [ ] 36
      2 Moderate psychosocial problem
      3 Severe psychosocial problem
      4 Very severe psychosocial problem
      5 Not applicable

Agency Code | 3 | Child#

(b) would your assessment findings indicate this child to be a:

1 Mild educational problem
2 Moderate educational problem
3 Severe educational problem
4 Very severe educational problem
5 Not applicable

37

(c) would your assessment findings indicate this child to be a:

1 Mild physical problem
2 Moderate physical problem
3 Severe physical problem
4 Very severe physical problem
5 Not applicable

38

8. For M.C.S.S. agencies only, was this assessment requested by a board of education to assist in determining if the child is unable to profit from instruction.

1 yes
2 no
3 unknown

39

Assessment Detail

Please provide the information requested in the following specific areas of assessment. It is not

Agency Code | 3 | Child#

expected that every agency/board will provide assessments in all the areas listed or that every child will require assessments in all areas. Use the definitions provided to assist you in recording your assessment activities.

Intellectual Assessment

If this child was referred for, and/or received an intellectual assessment from your agency/board, please complete this section.

9. Select the appropriate status of the intellectual assessment.

   1 Assessment completed
   2 Assessment partially completed with a referral made to another agency/board
   3 No assessment required in judgement of agency
   4 No assessment was done with a referral to another agency/board
   5 No assessment was done with no referral possible to another agency/board (i.e. service gap)
   6 Assessment in progress by your agency/board
   7 Assessment pending by your agency/board

40

10. Where a further referral was made for intellectual assessment, indicate the reason.

Agency Code | | | | 3 | Child# | | |

1 specialised assessment needed which your agency/board was unable to provide

2 assessment needed that was outside of the mandate of your agency/board

3 child moved away before the assessment was completed

4 other (please specify) _____

41

11. Indicate the agency/board to which you made a further referral.

01 C.A.S.

02 C.M.H.C. - Residential

03 C.M.H.C. - Non-Residential

04 M.R. Schedule I

05 M.R. Schedule II

06 M.R. Schedule III

07 Developmental Centre

08 Association for the Mentally Retarded

09 Segregated day nursery - M.R.

10 Integrated day nursery

11 Regular day nursery

12 Nursery for physically handicapped

13 Preschool program for the emotionally disturbed

14 Preschool program for the blind

42 43

Agency Code | 3 | Child#

15 Infant Stimulation program

16 Developmental Programing & Assessment Services

17 Crippled Children's Centre

18 General Hospital

19 Public Health Unit

20 School Board

21 Provincial School

22 Private School

23 Physician

24 Private Psychologist

25 Private Psychiatrist

26 Private Speech Pathologist

27 Private Speech Therapist

28 Private Physiotherapist

29 Private Occupational Therapist

30 Psychiatric Hospital

31 Other (please specify) _____

12. Please indicate the number of assessment activities completed on this child for each of the following categories.

1 Standardized intellectual assessments [44 45]

2 Informal in-home intellectual assessments [46 47]

3 Informal in-school intellectual assessments [48 49]

Agency Code [ ][ ][ ] [3] Child# [ ][ ][ ]

4 Informal other intellectual assessments [ ][ ] 50 51

13. Please indicate the primary reason for doing this intellectual assessment

1 Educational purposes [ ] 52

2 Psychosocial purposes

3 Physical purposes

Functional Academic Assessment

If the child was referred for and/or received a functional academic assessment from your agency/board, please complete this section.

14. Select the appropriate status of the functional academic assessment.

1 Assessment completed [ ] 53

2 Assessment partially completed with a referral made to another agency/board

3 No assessment required in judgement of agency

4 No assessment was done with a referral to another agency/board

5 No assessment was done with no referral possible to another agency/board (i.e. service gap)

6 Assessment in progress by your agency/board

7 Assessment pending by your agency/board

Agency Code | | | | 3 | Child# | | |

15. Where a further referral was made for functional academic assessment, indicate the reason.

1 Specialized assessment needed which your agency/board was unable to provide

2 Assessment needed that was outside of the mandate of your agency/board

3 Child moved away before the assessment was completed

4 Other (please specify) _____

54

16. Indicate the agency/board to which you made a further referral.

01 C.A.S.

02 C.M.H.C. - Residential

03 C.M.H.C. - Non-Residential

04 M.R. Schedule I

05 M.R. Schedule II

06 M.R. Schedule III

07 Developmental Centre

08 Association for the Mentally Retarded

09 Segregated day nursery - M.R.

10 Integrated day nursery

11 Regular day nursery

12 Nursery for physically handicapped

55 56

Agency Code | | | | 3 | Child# | | |

13 Preschool program for the emotionally distrubed

14 Preschool program for the blind

15 Infant Stimulation program

16 Developmental Programing & Assessment Services

17 Crippled Children's Centre

18 General Hospital

19 Public Health Unit

20 School Board

21 Provincial School

22 Private SChool

23 Physician

24 Private Psychologist

25 Private Psychiatrist

26 Private Speech Pathologist

27 Private Speech Therapist

28 Private Physiotherapist

29 Private Occupational Therapist

30 Psychiatric Hospital

31 Other (please specify) _____

17. Please indicate the number of assessment activities completed on this child for each of the following categories.

Agency Code | | | | 3 | Child# | | |

1 Standardized functional academic assessments [57][58]

2 Informal in-home functional academic assessments [59][60]

3 Informal in-school functional academic assessments [61][62]

4 Informal other functional academic assessments [63][64]

18. Please indicate the primary reason for doing this functional academic assessment.

1 Educational purposes [65]

2 Psychosocial purposes

3 Physical purposes

Social/Cultural Assessment

If this child was referred for and/or received a social/cultural assessment from your agency/board, please complete this section.

19. Select the appropriate status of the social/cultural assessment

1 Assessment completed [66]

2 Assessment partially completed with a referral made to another agency/board

3 No assessment required in judgement of agency

4 No assessment was done with a referral to another agency/board

Agency Code | | | | 3 | Child# | | |

5 No assessment was done with no referral possible to another agency/board (i.e. service gap)

6 Assessment in progress by your agency/board

7 Assessment pending by your agency/board

20. Where a further referral was made for social/cultural assessment, indicate the reason.

1 Specialized assessment needed which your agency/board was unable to provide [ ] 67

2 Assessment needed that was outside of the mandate of your agency/board

3 Child moved away before the assessment was completed

4 Other (please specify) _____

21. Indicate the agency/board to which you made a further referral.

01 C.A.S. [ ][ ] 68 69

02 C.M.H.C. - Residential

03 C.M.H.C. - Non-Residential

04 M.R. Schedule I

05 M.R. Schedule II

06 M.R. Schedule III

07 Developmental Centre

08 Association for the Mentally Retarded

Agency Code | 3 | Child#

09 Segregated day nursery - M.R.

10 Integrated day nursery

11 Regular day nursery

12 Nursery for physically handicapped

13 Preschool program for the emotionally distrubed

14 Preschool program for the blind

15 Infant Stimulation program

16 Developmental Programing & Assessment Services

17 Crippled Children's Centre

18 General Hospital

19 Public Health Unit

20 School Board

21 Provincial School

22 Private School

23 Physician

24 Private Psychologist

25 Private Psychiatrist

26 Private Speech Pathologist

27 Private Speech Therapist

28 Private Physiotherapist

29 Private Occupational Therapist

30 Psychiatric Hospital

Agency Code | | | | 3 | Child# | | |

31 Other (please specify) _____

22. Please indicate the number of assessment activities completed on this child for each of the following categories.

1 Standardized social/cultural assessments [70][71]

2 Informal in-home social/cultural assessments [72][73]

3 Informal in-school social/cultural assessments [74][75]

4 Informal other social/cultural assessments [76][77]

23. Please indicate the primary reason for doing this social/cultural assessment.

1 Psychosocial difficulties in school [78]

2 Psychosocial difficulties in the home

3 Psychosocial difficulties in the community

4 Psychosocial difficulties in school and home

5 Psychosocial difficulties in school and community

6 Psychosocial difficulties in home and community

7 Psychosocial difficulties home, school and community

8 Speech and language difficulties

Agency Code | 4 | Child#

Biological/Physical Assessment

If this child was referred for and/or received a biological/physical assessment from your agency/board, please complete this section.

24. Select the appropriate status of the biological/physical assessment.

1 Assessment completed

2 Assessment partially completed with a referral made to another agency/board

3 No assessment required in judgement of agency

4 No assessment was done with a referral to another agency/board

5 No assessment was done with no referral possible to another agency/board (i.e. service gap)

6 Assessment in progress by your agency/board

7 Assessment pending by your agency/board

[ ] 8

25. Where a further referral was made for biological/physical assessment, indicate the reason.

1 Specialized assessment needed which your agency/board was unable to provide

2 Assessment needed that was outside of the mandate of you agency/board

[ ] 9

Agency Code | 4 | Child#

3 Child moved away before the assessment was completed

4 Other (please specify) _____

26. Indicate the agency/board to which you made a further referral.

10 11

01 C.A.S.

02 C.M.H.C. - Residential

03 C.M.H.C. - Non-Residential

04 M.R. Schedule I

05 M.R. Schedule II

06 M.R. Schedule III

07 Developmental Centre

08 Association for the Mentally Retarded

09 Segregated day nursery - M.R.

10 Integrated day nursery

11 Regular day nursery

12 Nursery for physically handicapped

13 Preschool program for the emotionally disturbed

14 Preschool program for the blind

15 Infant Stimulation program

16 Developmental Programming and Assessment Services

17 Crippled Children's Centre

Agency Code | | | | 4 | Child# | | |

18 General Hospital

19 Public Health Unit

20 School Board

21 Provincial School

22 Private School

23 Physician

24 Private Psychologist

25 Private Psychiatrist

26 Private Speech Pathologist

27 Private Speech Therapist

28 Private Physiotherapist

29 Private Occupational Therapist

30 Psychiatric Hospital

31 Other (please specify) _____

27. Please indicate the number of assessment activities completed on this child for each of the following categories.

1 Standardized biological/physical assessments [12][13]

2 Informal in-home biological/physical assessments [14][15]

3 Informal in school biological/physical assessments [16][17]

4 Informal other biological/physical assessments [18][19]

Agency Code | 4 | Child#

28. Please indicate the primary reason for doing this biological/physical assessment.

1 Vision difficulties

2 Motor difficulties

3 Speech and language difficulties

4 Intellectual difficulties

20

Communication Assessment

If this child was referred for and/or received a communication assessment from your agency/board, please complete this section.

29. Select the appropriate status of the communication assessment.

1 Assessment completed

2 Assessment partially completed with a referral made to another agency/board

3 No assessment required in judgement of agency

4 No assessment was done with a referral to another agency/board

5 No assessment was done with no referral possible to another agency/board (i.e. service gap)

6 Assessment in progress by your agency/board

7 Assessment pending by your agency/board

21

Agency Code | 4 | Child#

30. Where a further referral was made for a communication assessment, indicate the reason.

1 Specialized assessment needed which your agency/board was unable to provide

2 Assessment needed that was outside of the mandate of your agency/board

3 Child moved away before the assessment was completed

4 Other (please specify) _____

22

31. Indicate the agency/board to which you made a further referral.

01 C.A.S.

02 C.M.H.C. -Residential

03 C.M.H.C. - Non-Residential

04 M. R. Schedule I

05 M. R. Schedule II

06 M. R. Schedule III

07 Developmental Centre

08 Association for the Mentally Retarded

09 Segregated day nursery - M.R.

10 Integrated day nursery

11 Regular day nursery

12 Nursery for physically handicapped

23 24

Agency Code | | | | 4 | | | | Child#

13 Preschool program for the emotionally distrubed

14 Preschool program for the blind

15 Infant Stimulation program

16 Developmental Programing and Assessment Services

17 Crippled Children's Centre

18 General Hospital

19 Public Health Unit

20 School Board

21 Provincial School

22 Private School

23 Physician

24 Private Psychologist

25 Private Psychiatrist

26 Private Speech Pathologist

27 Private Speech Therapist

28 Private Physiotherapist

29 Private Occupational Therapist

30 Psychiatric Hospital

31 Other (please specify) _____

32. Please indicate the number of assessment activities completed on this child for each of the following categories.

Agency Code | 4 | Child#

1 Standardized communication assessments [25 26]

2 Informal in-home communication assessments [27 28]

3 Informal in-school communication assessments [29 30]

4 Informal other communication assessments [31 32]

33. Please indicate the primary reason for doing this communication assessment. [33]

1 autism

2 hearing impairment

3 learning disabilities

4 speech and language impairment

34. Language of instruction (select one) [34]

1 English

2 French

3 Both English and French

4 Other

35. Language of assessment (select one) [35]

1 English

2 French

3 Both English and French

4 Other

APPENDIX C

CO-ORDINATING THE DELIVERY OF ASSESSMENTS

AGENCY PROCEDURES MANUAL

Co-ordinating the Delivery of Assessments

Agency Procedures Manual

Purpose

The Ministries of Community and Social Services, Education and Health have agreed to adopt a coordinated procedure for the provision of assessment services to children in Northern Ontario. The model outlines a set of principles, which informs local agencies of the extent of interministerial agreement and a set of procedures which will permit implementation. The model is designed to encourage local cooperation and local decision-making agencies in the provision of assessment services to children.

Objectives

- To ensure efficient use of existing assessment resources.
- To ensure that each child and his/her family has access to a range of assessment services to identify his total needs.
- To provide a coordinated approach to assessment with a clearly outlined centre of accountability.
- To provide a mechanism for the identification and resolution of service gap issues.

- To provide for coordination at the local level.
- To ensure that assessment systems remain sensitive to changes in assessment strategies and methods.

Expectations of Agencies

- Each agency will be responsible for coordinating the services needed by its clients.
- All agencies will adopt a holistic approach to service delivery.
- Each agency will provide for the needs of its clients with mild psychosocial difficulties.
- Each agency will work cooperatively with other agencies of all ministries at the local level to ensure that the assessment needs of children and their families are met in an effective and efficient manner.
- Each agency will assume responsibility for providing assessment services that fall within its mandate either directly or through a purchase of service approach.
- Each agency will ensure that the assessment process results in the development of a

clearly defined course of action with responsibility for follow through assigned.

Management of the Assessment Process

1. Assessment responsibilities

The following have been agreed to by each respective ministry:

- Education will conduct relevant assessments of children for purposes of diagnosing children's learning problems/defining children's learning needs and providing programs to meet these needs.
- Community & Social Services will conduct relevant assessments of children for purposes of diagnosing children's social, emotional and children's mental health problems, defining children's psychosocial needs and providing programs and/or services to respond to these needs.
- Health will conduct relevant assessments for purposes of diagnosing children's health problems/defining children's health needs and providing programs and/or services to meet these needs.

While the above statements are useful for establishing basic parameters of assessment responsibility, the following examples provide further definition:

(a) Psychosocial Assessment. The psychosocial area refers to those socially learned aspects of one's life which relate to emotional patterns, perception and thought patterns and patterns in interpersonal relationships.

A psychosocial assessment is undertaken to determine the psychosocial functioning of a child and to assess the effects that disorders in these areas are having on the child's overall ability to cope with his/her environment.

Within the broad area of psychosocial needs, it is the expectation of the three ministries that referrals will only come to an M.C.S.S. agency when the psychosocial difficulties are at least at the moderate level. The moderate level of psychosocial difficulty is defined using the parameters of intensity, frequency, duration and reactivity as follows:

Intensity: Behaviour threatens the general ability of the child to benefit from the normal environment, or it

threatens the well-functioning of the environment.

Frequency: Occurs frequently: relationship between cause and immediate behaviour is difficult to identify.

Duration: Semi-permanent; problematic behaviour becomes more regular.

Reactivity: Requires a treatment plan focussed on specific behaviour change.

In general, any psychosocial difficulty that consumes large blocks of time resulting in major disruptions in the environment or resulting in the child being unable to continue his involvement in the environment, would be considered a moderate level psychosocial difficulty. Further evidence to support this decision would be that the disruptive incidents are occurring on a regular basis and that the behaviour is extending itself into all aspects of the child's environment.

Any psychosocial difficulties that are less problematic than this should be handled by the agency with the child.

(b) Speech and language assessment. The following guidelines are designed to provide direction to local school boards, health and community agencies in creating sharing arrangements for the provision of speech and language programs for school-aged children.

The guidelines stress the unique advantages of each setting in addressing the needs of children with communication disorders. It is expected that local school boards and agencies will determine the most appropriate service delivery models (withdrawal/integrated/intensity of support, etc.) and will employ appropriately trained staff to provide assessment and programing.

Ministry of Education (School Boards)

School boards will be primarily responsible in the following circumstances:

i) when assessment or programing for the communication disorder requires close cooperation and liaison with the educational team;

ii) when appropriate programing requires the educational context for improvement;

iii) when communication programing can and

should be part of the pupil's educational program;

iv) when communication problems are having, or are likely to have, a significant impact on educational progress or school adjustment; i.e. when educational development will be impeded without communication skill programing;

v) when liaison with a medical management team is not essential.

Ministry of Health

Health agencies will be primarily responsible:

i) when assessment and/or management of the communication disorder requires the involvement of and liaison with a medical management team;

ii) when co-ordinated efforts of other services available within the health setting are required;

iii) when the assessment and/or management plan does not require liaison with an educational team; i.e. the goals of the assessment/treatment plan need not become part of the child's educational program;

iv) when no liaison with an educational team is essential.

Ministry of Community and Social Services

M.C.S.S. treatment facilities will be primarily responsible in the following circumstances:

i) when a child in residential care/treatment does not leave the facility to attend an educational program;

ii) when such services are provided as part of a Section 16 agreement with a school board.

(c) Developmental assessment. Determination of responsibility for assessing mentally retarded children should be made within the following framework.

Education - responsible for both standardized and functional assessments of cognitive comprehension and capacity to learn. This would include such areas as functional motor skills, activities of daily living skills, academic skills and general social/emotional functioning.

Health - responsible for assessments

of a diagnostic nature related to causality and physcial well being. Such areas as physiotherapy because of the direct relationship to improvements in muscle tone circulation, etc., would be viewed as a health responsibility.

M.C.S.S. - responsible for assessments of a phychosocial nature where the presenting social/emotional difficulties are outside of the norm for the functioning level of the child and at least at the moderate level of severity.

(d) Learning disabilities

Education - responsible for both standardized and functional assessments of cognitive comprehension and capacity to learn. This would include a determination of the process used by the child to learn and the modality through which the child learns best.

Health - responsible for assessments of a diagnostic nature related to causality and physical well being.

M.C.S.S. - responsible for assessments of a psychosocial nature where the presenting social/emotional difficulties are at the moderate level or above.

2. Inter-Agency (Interministerial) Referrals

(a) Criteria. Although not all children will require inter-agency referrals for assessments, they should take place in cases of the following nature:

(i) Initial assessment activity by an agency indicates difficulties present in areas beyond their mandate. The following are presented as examples of these types of situations:

. M.C.S.S. agency during assessment uncovers indicators of intellectual functioning either below or above the norm or indications of a potential physical basis for present difficulties.

Case records do not make any mention of these possibilities.

- Educational assessment for learning disabilities uncovers presence of significant psychosocial dysfunctioning which is having impact at home and school.
- Physical assessment that uncovers indicators of at least a moderate level of psychosocial dysfunctioning or intellectual exceptionality.

(ii) Assessment of multi-handicapped children:

- Because of the nature of their difficulties, these children should be assessed by agents from all three ministries to ensure that a complete picture of strengths and weaknesses is available.

(iii) All children being considered for the education designation unable to profit by a school board.

Note: While the predominant focus of these procedures is on school-aged children, all three ministries recognize the importance of early identification/intervention and therefore would support the use of these same procedures for preschool children. This would involve a referral for the younger child who either displays learning patterns characteristic of learning disabilities or other complex learning patterns that require a specialized assessment in order to develop a program to maximize his learning potential.

(b) Referring agency responsibilities

. Documentation referral documentation includes:

- Formal results from assessments to date.
- The identification of factors which indicate the need for the referral.
- A statement of expected outcomes.

. Case coordination:

- The referring agency will retain

responsibility for case management which covers such areas as service plan development, brokerage and follow through. This function can be transferred to another agency if the final assessment results indicate a more appropriate focus of primary responsibility. An interagency case conference will be the vehicle through which the appropriate focus for case management responsibility will be determined.

. Monthly reporting:

- Referring agencies are responsible for completion of the monthly assessment activity sheet (form - appendix VI). These sheets are to be sent to the I.M.A.P.T. representative of the respective ministry to allow for evaluation and monitoring of the model.

(c) Receiving agency responsibility

. Information analysis:

- The referral documentation is reviewed to determine the appropriateness of the referral.

. Assessment function:

- On the assumption that the referral is appropriate, the required assessment should be conducted on the basis of the specific needs identified by the referring agency.

. Case planning function:

- Participation in a case conference is required to assist in the development of plan of action. There may be a need to assume the case management function, depending upon the outcome of the assessment.

(d) Confidentiality of records. It is the responsibility of each agency to ensure that the privacy of the client and his family are safeguarded to the fullest extent possible. When reviewing records to determine which information to send with the referral, decisions should be based on its relevance to the specific situation which prompted the referral. In all

cases of an interministry referral, a signed consent form specific to the referral must be obtained. The original should be retained on your files and a copy should go with the referral. If the referral material does not include a consent form, it must be provided prior to the receiving agency involving itself with the case.

3. Provision of Assessments

(a) Options. While the preceding may assist in determining more easily the locus of assessment responsibility, there are a number of options regarding the actual provider of the assessment. It is recognized by all three ministries that while responsibility may rest with a specific agency, that agency may not have the resources required to carry out the assessment. An agency with the responsibility for the assessment may therefore either provide it directly or purchase the assessment from another agency.

M.C.S.S. agencies may purchase services directly from another agency. Costs are paid directly to the agency providing the assessment.

Boards of Education must purchase services from an individual professional rather than an agency, except in the case of a board purchasing from another board. This is to comply with the Education Act. Where the

individual professional is an employee of another agency, it is expected that the payments will revert to that agency if the assessment was done on agency time. It is expected that the majority of assessments arranged in this manner will be done during regular business hours, rather than on a private fee basis.

Where health assessment services are not locally available, the existing medical referral system to other service centres will continue to be used.

(b) Purchase of service agreements. Purchase of service agreements should address the following:

- Detailed outline of expected outcomes, i.e. questions that are expected to be answered as well as programing suggestions.
- Detailed breakdown of specific activities to be performed by the assessor, including minimum expectation of programing ideas or the development of a full service plan whichever seems more appropriate.
- Cost breakdown related to the activities to be completed.
- Expected completion date.
- Commitment to involvement in one case review - evaluation of progress.

(c) Payment procedures. For agreements between agencies, payment should be made on the basis of an invoice from the providing agency. In situations where an individual professional is completing the assessment an agency time and the payments will revert to the agency, the following procedures must be followed:

(i) The individual should turn over the fee to the agency as soon as it is received.

(ii) The employing agency should provide the employee with a receipt stating that the funds received were for professional activities done on agency time, on behalf of the board of education.

(iii) When filing on income tax form the employee will submit the receipts as a basis for explaining why no income taxes will be paid on these monies.

Note: Any agency that is providing purchased assessment services in excess of twice a month should ensure that their respective ministry personnel are notified. This will assist the ministries in planning to meet service needs.

4. Conflict Resolution/Service Gap Issues

(a) Interministerial assessment and planning team (I.M.A.P.T.). This body is the major link with all components in the system to resolve major assessment service conflicts and gaps. Situations may arise where agencies of different ministries are unable to come to an agreement about the provision of assessment services to a child and his family. There may also be situations where there is agreement on the needs of the child but there is nothing available to meet the need. These are the types of issues that would be referred to an Interministerial Assessment Planning Team. It is stressed that all local attempts to resolve problems have been exhausted prior to a referral to an I.M.A.P.T.

There will be three (3) I.M.A.P.T. groupings in the Northern Ontario, corresponding to the Ministry of Education regions: Northeast (North Bay, Timmins); Midnorthern (Sudbury, Sault Ste. Marie); Northwest (Thunder Bay, Kenora). Each team will be composed of one representative of each of the three ministries.

(b) Criteria for referral to I.M.A.P.T.

. Only cases of an interministerial nature can be referred.

. All local level procedures must be attempted before a referral comes to I.M.A.P.T.

. Referrals to I.M.A.P.T. will involve:

- Resolution of a question of responsibility for provision of a specific type of assessment;

OR

- Resolution of a question regarding the need for a specific type of assessment;

OR

- Request for assistance in the identification of a source of or facilitating access to a specialized assessment resource not available at the local level;

OR

- A child who has been designated unable to profit by a school principal. This referral will be for information only.

(c) Referral procedure

. In a conflict resolution situation, the referral can come from either agency, although if possible, it should be a joint referral from both agencies.

- In a service gap situation, the request for assistance must be a joint referral from the agencies of the ministries involved with the child.
- The referral should be sent to the designated ministry representative on the I.M.A.P.T. team of the ministry responsible for the agency. (See form, Appendix C). In cases of joint referrals, each ministry responsible for an agency making the referral should receive the referral.
- A school board will be expected to refer all children who have been designated unable to profit, for information only.

(d) Referral documentation

Conflict resolution referral:

- Assessment data that supports the need for the assessment that is in conflict.
- Statement with supporting documentation from the non-providing agency that outlines the rationale for not providing the assessment requested.

. Chronological listing of all of the attempts made to resolve the situation locally.

Service gap referral:

. Summary of all assessment activities by involved agencies that support the need for the specialized assessment that is unavailable locally.

. Identification of attempts made to secure the assessment and reasons why they were not successful.

. If possible, the identification of potential source of specialized assessment and costs involved.

Unable to profit referral:

. All assessment documentation from the board of education and other community agencies which were used in the process of arriving at the designation Unable to Profit.

(e) Outcomes

. Designation of a responsible agency for the provision of the assessment in question.

- Direction to agencies to make further attempts to resolve the issues locally.
- Determine that the assessment in question is not necessary.
- Support the Unable to Profit Hard to Serve decision and assist the board in determining an appropriate placement to meet the child's needs.

Follow-up

All cases that are referred to I.M.A.P.T. will have a case manager assigned by I.M.A.P.T. generally on the basis of the agency with the most involvement with the child. Regular reviews of these cases will be done by I.M.A.P.T. to ensure that their recommendations are carried through and that a plan of action for service delivery is developed.

INTERMINISTERIAL

MONTHLY ASSESSMENT REFERRAL ACTIVITY

AGENCY SERVICE

From \ To	Home Care	Public Health Unit	Hospital	Community Mental Health	Children's Treatment Centre	Psychiatric Hospital	Children's Mental Health	Children's Aid	Residential Treatment Centre	Family Counselling	Developmental Delay	Infant Stimulation	Board of Education	Other	Physio	Nursing	OT	Speech	Multi-Handicapped	Developmental Delay	Emotional/ Behavioural	Family	Assessment	Psychological	Educational Assessment
Home Care																									
Public Health Unit																									
Hospital																									
Community Mental Health																									
Children's Treatment Centre																									
Psychiatric Hospital																									
Children's Mental Health																									
Children's Aid																									
Residential Treatment Centre																									
Family Counselling																									
Developmental Delay																									
Infant Stimulation																									
Board of Education																									
Other																									

Inter-agency Referral Form

Referring Agency

Name _____ Date of referral _____

Address _____ Telephone _____

_____ Contact person _____

_____ _____

Child Information

Name _____ Telephone _____

Sex _____ D.O.B. _____

Address _____

_____

Parent's/Guardian's Names:

Father _____

Mother _____

Present School Placement:

Name _____ Telephone _____

Address _____ Contact person _____

_____ _____

_____

Service Request

Please state the assessment activity you would like us to carry out and why. Attach copies of relevant assessment information which supports this request.

_____

Signature Position

I.M.A.P.T. Referral Form

Agency Name _____

Address _____

Telephone _____

Is this a joint referral? Yes ___ No ___

If yes complete section below.

Agency Name _____

Address _____

Contact Person _____

If not a joint referral, please identify agency(ies) of another Ministry(ies) which is/are involved in this case.

Name _____ Name _____

Address _____ Address _____

_____ _____

Telephone _____ Telephone _____

Contact Person _____ Contact Person _____

_____ _____

Is this case being referred to I.M.A.P.T. because of

A. a need for conflict resolution ___

B. a service gap situation ___

C. Unable to Profit (Education) ___ (information only)

Please complete the section below which is most appropriate for this referral.

Conflict resolution referral

1. a) What assessment has been requested that is in dispute?

_____

_____

_____

b) Name of agency that you are requesting assessment from.

_____

_____

c) Outline your rationale for the assessment requested. (Please attach assessment reports).

_____

_____

_____

_____

_____

_____

_____

_____

_____

d) Please attach written response from provider agency that outlines their reason for not providing assessment requested.

_____

Signature

_____

Position

Service Gap Referral

This must be a joint-agency submission.

1. a) Identify assessment needed that is unavailable at the local level.

_____

_____

_____

b) If you have identified a potential provider for the above assessment, please identify below. Indicate costs if known.

_____

_____

_____

_____

2. Outline your rationale for why you feel this assessment is necessary. Please attach supporting documentation.

_____

_____

_____

_____

_____

_____

_____

Signature	Signature
Agency	Agency

Unable to Profit (Education)

1. List outside agencies which have been involved in assessing this child.

_____

_____

_____

2. Outline rationale for why you consider this child to be Hard to Serve. Attach formal assessment reports.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature

_____

Board

APPENDIX D

TRAINING SESSION

EVALUATION FORM

Training Session

Evaluation Form

General Overview

1. Was the overall purpose of this project clearly explained to you?

   Yes _____ No _____

2. Was the model for co-ordinating the delivery of assessment services fully clarified?

   Yes _____ No _____

   If you answered no to either question 1 or 2, please comment on what further clarity you feel is needed.

   _____

   _____

   _____

   _____

   _____

Specific Components

A. Do you feel each of the following components of the process were clearly explained?

   1. Points where cross-Ministry inter-agency referrals would occur.

      Yes _____ No _____

If no, specify where clarity is needed. _____

_____

_____

2. Definitions of general assessment responsibilities for each Ministry.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

3. Specific areas of assessment responsibility:

A) Psychosocial Yes ___ No ___

B) Learning disabilities Yes ___ No ___

C) Speech & Language Yes ___ No ___

D) Developmental Yes ___ No ___

If no to any of the above, please specify where clarity is needed.

_____

_____

_____

_____

4. Documentation needed for local level cross-ministry referral.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

5. Responsibilities of all parties in a cross-ministry local level assessment.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

6. Responsibilities of agencies purchasing assessment services.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

7. Responsibilities of agencies providing a purchased service.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

8. Documentation required for purchase of service agreements.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

9. Criteria and documentation for a charge-back situation.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

10. Criteria for I.M.A.P.T. referral.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

11. Procedures for I.M.A.P.T. referral.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

12. Function of I.M.A.P.T. committee.

Yes _____ No _____

If no, specify where clarity is needed. ____

_____

_____

B. Please identify other topic areas that you feel should have been discussed during the training session.

_____

_____

_____

C. What other areas of assessment responsibility do you feel need to be defined?

_____

_____

_____

D. Please provide your comments on the following:

i) Length of training session

_____

ii) Method of presentation

_____

iii) Group size/composition

_____

iv) Resource materials

_____

v) Other _____

E. Any further comments you may wish to make regarding the training session are most welcome.

_____

_____

_____

_____

_____

_____

_____

Thank you.

APPENDIX E

EVALUATION FORM

IMPLEMENTATION - PILOT PROJECT

Evaluation Form

Implementation - Pilot Project

Co-ordination of the Delivery of Assessment Services

Agency Name _____

Person completing form _____

Telephone Number _____

1. Do you feel the points identified where cross-ministry inter-agency referrals should take place are valid?

_____

_____

_____

2. Are there other situations which should be included for cross-ministry referrals?

_____

_____

_____

3. Specific Ministry responsibilities were determined for each of the following areas of assessment. Were they useful to your agency and did they assist in local level co-ordination efforts?

   A. Psychosocial _____

_____

_____

B. Speech & Language _____

_____

_____

C. Learning Disabilities _____

_____

_____

D. Developmental _____

_____

_____

4. Are there other areas of assessment responsibility that you feel need to be defined?

_____

_____

_____

Impact on Manpower

5. What impact have these procedures had on the workload of your assessment staff i.e.

A. Time for assessments _____

_____

B. Co-ordination tasks _____

_____

C. Case conferences _____

_____

D. Inter-agency contacts _____

6. Generally do you feel there has been a positive or negative effect on staff as a result of implementing these procedures?

_____

_____

_____

_____

_____

_____

_____

Administrative Procedures

7. Is material requested on inter-agency referral form adequate?

_____

_____

_____

8. Do the procedures for Purchase of Service meet your needs?

_____

_____

_____

9. Do you feel the criteria for charge-backs is adequate?

_____

_____

_____

10. Do you feel that costs other than just for the assessment should be charged back?

Yes _____ No _____

If yes, please elaborate _____

_____

_____

11. Have you had experience with an agency unwilling to accept a charge-back?

Yes _____ No _____

If yes, please elaborate _____

_____

_____

12. Do you feel criteria for I.M.A.P.T. referral is adequate?

Yes _____ No _____

Please elaborate _____

_____

_____

13. Do you feel that the I.M.A.P.T. procedures are adequate?

    Yes _____ No _____

    Please elaborate _____

14. Do you feel that I.M.A.P.T. has been successful resolving service difficulties?

    Yes _____ No _____

    Please elaborate _____

    _____

    _____

15. Please feel free to make any further comments about this project that you wish. Since this is a pilot activity, all feedback can be used to help improve our procedures before we implement across the entire Region.

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

Thank you.

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