

# Pathways to Resilience Among Children in Child Welfare, Corrections, Mental Health and Educational settings: Navigation and Negotiation

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**ABSTRACT:** In this paper I explore how social service delivery systems influence the pathways children travel to resilience. In particular, I look at children's *navigation* to the health resources that are available through service delivery systems and their *negotiation* with service providers for service once under a provider's mandate. Two case examples are used to illustrate health-enhancing and health-challenging patterns of service provision and utilization among high-risk youth. I then address two questions that are critical to understanding children's pathways to resilience: "What services do children say they need to achieve resilience?" and "How does the structure of services affect children's access to the health resources required to nurture and sustain resilience?"

**KEY WORDS:** health resources; navigation; negotiation; youth-in-care.

A large and varied literature has examined resilience in at-risk children and youth from the perspective of their behaviour and psychosocial characteristics. Less developed is our understanding of the structural conditions that support the healthy development of children who lack individual, family, community, and sociopolitical resources to sustain health when faced with the multiple adversities of lives lived at-risk. Furthermore, we know little about children's pathways through the different systems that are mandated to provide for their needs. In particular we have little theory to explain how children manage to survive and thrive with or without these services.

In this paper I explore how the social service delivery systems that most influence the day-to-day lives of at-risk children in Western

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democracies either support children along pathways to resilience or contribute further to the risks they face. Four systems will be examined: Child Welfare, the cluster of mandated services that protect children from abuse; Mental Health, publicly funded services that support psychiatric, psychological and social work interventions to alleviate mental distress; Corrections, the system of discipline and control of children who break the law; and Education, the public system of learning and socialization. Together these four systems influence the pathways children travel when confronted by adversity. Other systems like Public Health, Political and Legislative systems, Spiritual communities and informal peer networks, could equally be examined for their part influencing children's growth trajectories. My choice to focus on Child Welfare, Mental Health, Corrections and Education is intended to narrow this discussion to four systems that are ubiquitous in the lives of the most disadvantaged children in Canada, the United States and other similar minority world countries. It is to be shown that if children are to survive threats to their wellbeing, they require a complex weave of health resources that is best provided by multiple service providers working in a seamless continuum of care.

To accomplish this, I will examine the dual aspects of children's *navigation* to the health resources that are available through service delivery systems and children's *negotiations* with service providers for service once under the mandate of one or more systems. I use two lengthy case examples to illustrate health-enhancing and health-challenging patterns of service provision and utilization. I then move on to look at two questions that are critical to understanding children's pathways to resilience when children become involved with mandated services: "What services do children say they need to achieve resilience?" and "How does the structure of services affect children's access to the health resources required to nurture and sustain resilience?"

### Navigation and Negotiation

Children's experiences of formal service delivery systems can be described as a dual process of *navigation* and *negotiation* to locate and make use of the resources they need to sustain themselves when challenged by adversity. These health resources include *services* like shelter, clothing and counselling for children and their families, socio-political *structures* that ensure safety, access and social justice, as well as the *relationships* that allow children to be seen by others as powerful, competent and gifted through attachments to peers, families and

others in their communities. Children first navigate their way to health resources, either by purposefully seeking out what they need physically, psychologically, socially and spiritually, or as is just as often the case, allowing life to serendipitously present opportunities through chance encounters (Ungar, 2004). A number of qualitative studies have shown that at-risk children manipulate service providers to some degree in order to create opportunities to access the health resources that sustain wellbeing (de Antoni & Koller, 2000; Felsman, 1989; Hauser, 1999; Klevens & Roca, 1999; Todis, Bullis, Waintrup, Schultz & d'Ambrosio, 2001; Tyler, Tyler, Tommasello, & Connolly, 1992; Schofield, 2000; Rak, 2002; Ungar, 2001; Ungar, Teram, & Picketts, 2001). Having successfully navigated their way into the role as client/resident/patient/student of one system or the other, children argue they then become actively engaged in negotiating with service providers for the health resources that fit best for them. At-risk children who are deprived of the resources to sustain health (and resilience) find creative ways to successfully engage with caregivers to get what they need.

### *Case Study 1: Greg*

When Greg, a 19-year-old African Nova Scotian youth was 11, and his 16-year-old sister Fiona was 8, they were both placed in foster care as a result of their mother, Tami's, violence and neglect. Tami's sister brought the family to the attention of Child Welfare because of concerns over Tami's drug use, lack of compliance taking medication to control a severe bi-polar disorder, inappropriate discipline of the children and violent outbursts. Greg's father had left the family when he was five and though he lived nearby and had remarried, there was little contact between Greg and Fiona and their father.

Greg was part of a study of Atlantic Canadian youth in their late teens and early twenties who had extensive involvement with multiple service delivery systems (Ungar, Karabanow, & MacDonald, 2002). All were identified by Child Welfare staff or staff at a Centre for residential and outreach programs for street youth. Through interviews and file reviews, children's own accounts of the services they were provided were contrasted with official records and case recordings. Though participants were chosen for their variable responses to coping with multiple challenges, Greg was seen by workers who knew him as doing exceptionally well considering what he had experienced.

Once placed, Greg and his sister moved back and forth between foster homes, relatives and his parents' homes. Table 1 details these moves. He and his sister were eventually separated when Fiona's

**Table 1**  
**Greg's Service History**

| Dates                         | Type of Placement                      | Length  | Reason for Change   |
|-------------------------------|--|---|---|
| January 14–20, 1994<br>Age 11 | Foster Home 1                          | Ten days after removal from mother<br>One month | Temporary placement unsuitable for longer-term placement of two children.<br>Permanent placement found.   |
| January 21–February 17, 1994  | Unaccounted for in placement record    |   |   |
| February 18–July 24, 1994     | Foster Home 2                          | Five months                                     | Placement breakdown due to sister's angry outbursts.  |
| July 25, 1994–March 10, 1995  | Back to Foster Home 1                  | Eight months                                    | Returned to mother's home for trail period.   |
| March 11, 1995–March 5, 1996  | Back with mother                       | One year  | Services provided are not adequate to the mother's challenges and children are removed permanently.   |
| March 6, 1996–May 13, 1997    | Foster Home 3<br>(placement with aunt) | 14 months                                       | Conflict with aunt over household chores and comments about Greg's mother escalates to the point where blows are exchanged. Charges laid, then dropped. Aunt and Uncle insist children leave. |

|                                   |   |  |
|-----------------------------------|---|--|
| May 14, 1997–May 12, 1998         | Placed with Father and One year step-mother | Conflict with father and stepmother leading to a physical altercation with Father  |
| May 13–November 4, 1998           | Foster Home 4                               | Greg placed without his sister but asked to be moved as the home was very far from his school and it was impossible for him to participate in after school sports. Foster parents finally request he be removed due to his “attitude”. |
| November 5–16, 1998               | Group home                                  | Temporary placement while waiting for foster placement.  |
| November 17, 1998–August 28, 2001 | Foster Home 5                               | Settled in home—Only leaves to attend university.  |
| August 29, 2001–April 24, 2002    | University                                  | Returns to foster home at end of each school year.   |

violent behaviour prevented them being placed together in their fourth foster home. Greg's behaviour, though, had frequently been the cause of earlier moves and at one point had resulted in him being charged for assaulting his aunt, their third foster care provider, when Greg was 13. Charges were eventually dismissed, but Greg was left on probation and aware that he was close to being placed in custody if he continued to be abusive. It was shortly after that episode that he and his sister were moved for a short time to their father and step-mother's. This placement lasted one year before Greg's father asked that the children be again placed in foster care due to his inability to manage them. At that point, placement became permanent.

Once separated from his sister at age 15, Greg was put in two different foster homes. The first, he complained, was too far from his community and school. He resisted living anywhere that would mean he couldn't continue to attend his same school in his old neighbourhood. Finally, with his fifth foster placement, he found stability and remained there for three years. Though he and his foster mother fought over chores and cleanliness, Greg did nothing to sabotage the placement. Remarkably, though this home was in a predominantly White middle-class neighbourhood a distance from where he had grown up, Greg insisted he travel daily by public transit back to his community to continue his education. At school, he did reasonably well and excelled in sports such as American football and basketball.

Greg found through his school many natural supports which were supplemented with a Big Brother when he was 14. Greg also received mental health counselling to deal with his own anger and to look for ways of helping him return home. Eventually, sessions focussed exclusively on helping him adapt to being permanently in care.

At the time Greg was referred to the study, he was in his second year of university studying recreation and outdoor education. He had left his foster mother's home to move in with friends but still maintained contact not only with her, but also his natural mother and sister. His workers say they admire Greg's tenacious desire to succeed in life, to look after his body and his athleticism.

### **Surviving and Thriving**

A child like Greg reminds us that despite many problem behaviours early on, many children survive and even thrive. If we look at the many moves Greg experienced, it is remarkable that he did as well as he has done. Interestingly, Greg explains his success as resulting from his decision to not be moved from his community and his school.

Though the Child Welfare and Education systems were willing to see this move take place, Greg's determination and successful negotiation with workers may have been what saved him. Of course, it was more than just *his* ability to negotiate. Greg's workers also had to provide the financial means for him to travel to his school and be willing to be flexible in allowing Greg to travel the distances he did without adult supervision.

For children like Greg, *resilience results from their successfully navigating their way to the services, structures and relationships (health resources) and their negotiations to have services provided in child-focussed ways that sustain their wellbeing.* Understanding resilience this way moves us beyond studies of how individual children overcome problem behaviours and psychopathology. Instead, resilience is understood as dependent upon the service ecologies of service providers and children's communities (Armstrong, Stroul, & Boothroyd, 2005; Barter, 2005). It is the interaction between what is provided to at-risk children, children's access to health resources on their own terms, and how well the resources that are provided address children's unique constellations of problem behaviours and psychopathology, that contribute most to growth in children who experience themselves as resilient (see, for example, Dupree, Spencer & Bell, 1997). Children's resilience is as dependent on what is built inside them as what is built around them.

Navigation and negotiation are not commonly how we think of children's behaviour when under the mandate of social and educational services. Yet, as Miles (2000) has argued, congruent with the above definition of resilience: "young people's lives are an outward expression or negotiation of the relationship between structure and agency" (p. 36). We cannot understand health as simply the outcome of individual characteristics or mass-produced interventions. At-risk children are active participants in fashioning their case plans.

Masten (2001) defines resilience as a "class of phenomena characterized by *good outcomes in spite of serious threats to adaptation or development*" (emphasis in original, p. 228). This definition, though useful within a paradigm that views health as an individual experience, needs to be broadened if we are to understand how systems enhance or threaten wellbeing. A different understanding of resilience would emphasize the *adequate provision of health resources necessary to achieve good outcomes in spite of serious threats to adaptation or development.* This shift in focus forces us to look first at the social context upon which resilience depends, and second makes health dependent on access to resources. As we begin to see resilience as dependent on access, we are made to consider two sides of an equation.

Systems that deliver services must be designed to provide health resources that are reasonably accessible and available in a timely manner (Lawson & Anderson-Butcher, 2001). However, those who use what the system provides must have some say in how and when they get (and take) what they need (Ungar, 2001).

### *Case Study 2: Fiona*

Fiona, Greg's younger sister, was also part of the study of youth's experiences with multiple service providers in Atlantic Canada. At 16, Fiona is now living in a shelter for street youth preferring their rules to those of her last foster placement (See Table 2). While it was noted in Greg's file that Child Welfare became involved after concerns were expressed by the children's aunt, leading to their voluntary placement by their mother, Tami, Fiona's records also note that around this same time the children's school had notified Child Welfare workers of their concerns. They reported that Tami would frequently abandon the children for days and was suspected of prostitution and drug abuse.

By the time of her placement, Fiona was already having problems at school with violent outbursts that included hitting and biting. Her behaviour made it difficult for her to get an education though she was bright and able to handle age appropriate work. During her first placements with her brother, she went to a special educational program that was more structured and where she did very well, eventually returning to the public school system. However, by Grade Seven, her behaviour deteriorated again. She was found to have a learning disability related to math and was performing below her grade level. By Grade Ten, she was attending sporadically a community school, working on obtaining school credits one at a time in a flexible learning environment.

Her mental health history is just as chaotic. She was assessed at age 8 following disclosure of sexual abuse. Her outbursts were assessed by a psychiatrist as having no biological basis such as Attention Deficit Hyperactivity Disorder (ADHD) or epilepsy. She was labelled as aggressive, oppositional and defiant. Three years later, after being followed by a number of counsellors, she was again assessed. This time features of ADHD were found. She was prescribed Ritalin and sent for anger management. At age 14 she spent a year in an adolescent psychiatric in-patient program but following that, no appropriate community placement could be found that could cope with a girl with her level of need. She was sent unwillingly to a residential treatment program in Western Canada, 4,000 miles from her home. There she was assessed with Post-traumatic Stress Disorder (PTSD) but again

**Table 2**  
**Fiona's Service History**

| Dates                           | Type of Placement                   | Length                                  | Reason for Change   |
|---------------------------------|-------------------------------------|---|---|
| January 14–20, 1994<br>Age 8    | Foster Home 1                       | Ten days only after removal from mother | Temporary foster care placement.  |
| January 21–February 17, 1994    | Unaccounted for in placement record | 1 month                                 | Permanent placement found.  |
| February 18–July 12, 1994       | Foster Home 2                       | 5 months                                | Placement breakdown due to Fiona's angry outbursts.   |
| July 13, 1994–September 2, 1994 | Back to Foster Home 1               | 6 weeks                                 | Removed for psychiatric assessment and to be returned to mother.  |
| September 3, 1994–March 5, 1996 | Back with mother                    | 18 months                               | A wide range of support services were in place to try to give the family the skills they needed to stay together. Towards the end of this time, Child Welfare found the children were living with an aunt most of the time and their mother was disappearing for days at a time. The decision was made to bring the children into permanent care. |

Table 2 (Continued)

| Dates                            | Type of Placement           | Length    | Reason for Change?   |
|----------------------------------|-----------------------------|-----------|--|
| March 6, 1996–January 6, 1997    | Foster Home 3<br>(an aunt)  | 10 months | Fiona is removed from her aunt's home at her aunt's request due to her violent behaviour.    |
| January 7–April 13, 1997         | Back to Foster Home 1       | 10 weeks  | Temporary placement while a more permanent arrangement can be made.                          |
| April 19–June 4, 1997            | Group Home 1                | 7 weeks   | Home closed down.  |
| June 5–22, 1997                  | Group Home 2                | 3 weeks   | Temporary placement while waiting for a space in the therapeutic Children's Response Program |
| June 23, 1997–August 28, 1998    | Children's Response Program | 14 months | Discharged from the program after she is assessed as having reached the goals set for her.   |
| August 29, 1998–January 17, 1999 | Foster Home 4               | 5 months  | Removed from the home after threatening to harm herself and her foster mother.               |
| January 18–March 3, 1999         | Group Home 3                | 7 weeks   | Moved from home to home due to her violence and aggression.                                  |
| March 4–April 5, 1999            | Group Home 4                | 1 month   | Moved from home to home due to her violence and aggression.                                  |

|                                  |   |           |   |
|----------------------------------|---|-----------|---|
| April 6–May 3, 1999              | Group Home 5                                | 1 month   | Continual escalation in violent behaviour culminating in the physical assault of a staff person and property damage which resulted in charges being laid.                                 |
| May 4–14, 1999                   | Children's Response Program                 | 10 days   | Temporary placement.  |
| May 15, 1999–November 29, 2000   | Residential Treatment Home (Western Canada) | 18 months | Planned transfer due to Fiona's unhappiness at being so far from home and desire to be closer to family members. Facility in Central Canada found that is closer to one of her relatives. |
| November 30, 2000–April 14, 2002 | Secure Treatment Centre (Central Canada)    | 17 months | Fiona turns 16 and stops participating in her treatment or using the program's resources. Staff felt that they were no longer meeting her needs and recommended that she be discharged.   |
| April 17–August 5, 2002          | Residence for Homeless Youth                | 4 months  | No information available.   |
| August 6–9, 2002                 | With mother                                 | 3 days    | No information available.   |
| August 10–18, 2002               | Group Home 6                                | 10 days   | No information available.   |
| August 19–September 12, 2002     | Residence for Homeless Youth                | 1 month   | No information available.   |
| September 13–December 5, 2002    | Group Home 6                                | 3 months  | No information available.   |
| December 6–present               | Residence for Homeless Youth                | Ongoing   | No information available.   |

organic disorders such as Fetal Alcohol Effect (FAE) were ruled out. She was subsequently moved to another secure treatment facility in Central Canada.

During her Western placement she was charged with attacking a group home employee. The charges were dealt with through a restorative justice process in which she and her victim decided on her punishment as an alternative to incarceration. She was also caught for shoplifting at age 13 and put on probation for a year.

It's important to note that Fiona never believed there was any legitimate reason to have her and her brother removed from her mother's home and she insists she was never in any danger. Not surprisingly, staff at numerous facilities report that Fiona's behaviour would escalate after visits with her mother. As one psychologist wrote: "we question whether Fiona will respond to treatment interventions in any lasting fashion as long as she believes that the Agency and the other professionals involved are the enemy who is keeping her from her mother's side."

Fiona is now stable, residing in a shelter for homeless youth and participating in several community activities, including church and a choir. She sees her mother infrequently and continues to be bitter about how she was treated by service providers.

Even when research captures people's own accounts of service, there remains a danger in oversimplifying and decontextualizing relationships between systems and outcomes. We must suspend our bias that too quickly locates the etiology for problem behaviours within individuals rather than how service delivery systems are designed, administered, and most importantly of all, integrated. Though Greg and Fiona share much in common in terms of service histories, they exercised vastly different amounts of say over what happened to them. Filtered through their belief systems about their initial apprehension from their mother, it is not surprising that Fiona has remained so angry with her caregivers and required more secure treatment to deal with that anger. Greg on the other hand has managed to negotiate much better for what he needs. Sadly, the one thing that Fiona sought for many years, her return to her mother, was never seen as possible by those who supervised her.

By introducing the idea that child consumers of services actively negotiate for what they need from what is available, we make clients/residents/patients/students back into individuals who cope as best they can with what they have (Ungar, 2002, 2003). As Rutter, Giller, and Hagell (1998) note in regard to children's placement in out-of-home care and later antisocial behaviour, we must recognize children's "heterogeneity in responses to serious adversity" (pp. 211–212).

## Pathways to Health

Though the concept of pathways children travel to health is common in our Western vernacular, the pathways of consumers of social services carries a very specific meaning to health researchers. Those like Rogler and Cortes (1993) who have studied the pathways through and around mental health care systems of clinical and nonclinical populations of Latinos in the United States define the term pathways as follows: "By 'pathways,' we mean the sequence of contacts with individuals and organizations prompted by the distressed person's efforts, and those of his or her significant others, to seek help as well as the help that is supplied in response to such efforts" (p. 555). Rogler and Cortes demonstrate the dynamic interplay between service systems, culture and people's needs. There is an emphasis on both the individual's efforts to seek help and the *response-ability* of systems to provide service. Too much emphasis on the capacity of individuals to seek service can result in victim-blaming, the expression of a neo-conservative ideology that places the responsibility for survival on the shoulders of those most disadvantaged. A more balanced understanding of pathways pays equal attention to the way systems coordinate services to address the collective expressions of need found among those seeking service.

Ironically, service systems are not designed to provide resources to resilient children. We expect these children to survive and grow with minimal intervention. It is only those who are nonresilient, who carry with them labels that define them as clients of each system (dangerous, delinquent, deviant, disordered and disadvantaged) that are provided service. This dichotomous thinking overlooks the immensely helpful role all four delivery systems play in nurturing wellbeing in at-risk children. It also ignores the hidden resilience that children themselves discover and nurture as they navigate their way through, and negotiate with, these systems (Ungar, 2004).

The process of navigating and negotiating, as discussed here, is known to be relevant to some Western populations, but may or may not be relevant globally. As Rogler and Cortes caution: "Broadly conceived, the pathway concept serves as an incessant reminder that coping with mental health distress [and other threats to wellbeing] in a culturally pluralistic, highly differentiated, and bureaucratized society such as that of the United States involves a vast range of helping institutional structures in addition to professionally developed mental health services" (p. 555). In higher context societies where social support, education and aspects of social control are expressed through less formal means of service provision, it is to be expected that

the pathways children travel and how they navigate their way toward service providers and negotiate for health resources will also be different (see Ungar, 2005, for a more detailed discussion of this point).

### Understanding Service Use

In order to understand children's pathways through systems of care and control, we must explore their definitions of resilience, whether the services they say they need are provided, and whether the structure of the services that are provided nurture and sustain resilience?

#### 1) *"What services do children say they need to achieve resilience?"*

By most assessments, Fiona does not show much competence overcoming the challenges she faces. Child Welfare, Mental Health, Corrections and Education have all tried to provide the services necessary for her to remain safe and meet her physical and psychological needs. What is frequently missing from accounts like the one above is Fiona's own expression of personal agency. While it was easier to find data that spoke to Greg's choices, Fiona's file documented more often episodes of resistance to her treatment. Little is made of her own assessment of what would be in her best interest.

Each system, as is typical in case studies of cross-over children (Finlay, 2004) like Fiona and Greg, appears to contribute something to the child's pathway to health. Evidently, while Greg later in his life fits with what we imagine a resilient child looks like, Fiona appears to be more vulnerable. While this may appear to outsiders to the children's lives to be so, this biased view reflects the position of helping professionals more than the children's experience of the service systems.

#### *Architects of Their own Experience*

A more agentic account of Fiona's life would see how her disordered angry behaviour has secured for herself a sense of commitment to her family of origin and marked her resistance to what she perceives as the wrongful removal of her and her brother from her mother's home. Greg is defiant as well, though his pattern of resistance makes it easier for the system to accommodate his needs. He may not be able to return home, but they are willing to change his placement so that he can continue to be educated in his home community. Fiona appears to be using her anger as her best tool for resistance. The professionals around her keep trying to psychopathologize her and her behaviour

but fail over and over again to find a diagnosis that sticks. There is little sign that there is any organic basis for her resistance. Her label as oppositional and defiant is likely a misnomer, the myopia of people who look at children without an appreciation for how the child is looking at them and experiencing their care as intrusive, or worse, iatrogenic.

One can learn from the lack of coordination between services experienced by both Fiona and Greg. Mental health counseling was provided but as a separate service to Child Welfare. When corrections became involved Child Welfare and Mental Health played little or no part in treatment plans. And while Greg's school did accommodate his many changes in residence, their tolerance for Fiona was far less. She required programs in the community to create a learning environment structured to meet her needs. Her school instead took the position that she could only come back if her disruptive behaviour stopped. Thus, we see that multiple systems have intervened sequentially and episodically to address Fiona and Greg's problems but that little cross-system coordination and communication has occurred, resulting in seemingly random and partialized services. Ironically, the 'all-inclusive' service package Fiona experienced in secure treatment half a continent from her home provided more comprehensive access to professionally based health-sustaining resources though failed to provide the community and family supports vital to Fiona's conception of health. Given the relatively minor nature of her offences and the reasonableness of her anger, it is disheartening that Fiona was not listened to more. Children like Fiona and Greg emphasize they do what they do to survive, their chaotic behaviour an accommodation to the threats they perceive from others. They navigate towards whatever success they can achieve by engaging with or resisting services as part of an elaborate dance to have their needs met.

There is evidence that children are the architects of their experiences in each system. A negative placement experience in one system such as Child Welfare has been found to be directly related to a difficult placement history in another such as Mental Health. Haapasalo (2000), in his look at file data on 78 adult offenders in Finland, found strong correlations indicative of this pattern. The offenders' life histories demonstrated links between offending patterns, the neglect and abuse they experienced as children and the intensity of Child Protective Services interventions. A negative placement experience in one system was found to predict a difficult placement history in another. Seen from the point of view of the child, such patterns make sense as children repeat patterns of behaviour that are effective at maintaining

a cohesive sense of who they are while also making known their resistance to the imposition of care and treatment upon them.

### *Using Problem Behaviours to Secure Health Resources*

It is often counterintuitive for professionals to imagine that children manipulate systems of care to provide what they need. Even problem behaviour that brings with it restrictions on the child's freedom can be a way a child maneuvers systems to become more responsive to his or her needs. Typically, children learn one way to get what they want or to be heard and repeat this behaviour until it is no longer effective.

For example, it is predictable that children who learn to adapt in one way in one placement will continue with the same coping strategies in placement after placement until a viable alternative is found. This negative pattern of navigation and negotiation for care and service that results in children having to be moved frequently can mask the hidden resilience found in these children. We have tended to think of health only in terms of children leaving systems, ending treatment. While stereotypically resilient children receive few services, remaining invisible because of their conventional expressions of health, other children take advantage of service systems and modify behaviour in ways that elicit help. It is as if they are shouting louder and louder that something is wrong. In studies with young offenders and children in Child Welfare and Mental Health institutions, children say they get themselves placed as often as others place them (Ungar, 2001, 2004). They are frequently motivated to be in care and under an adult's protection as a way of meeting basic needs, or signaling that they or their families require professional interventions. Unfortunately, their health-seeking behaviours remain hidden behind their more overt psychopathology and behavioural problems. It is difficult for care providers and parents to appreciate the adaptability of their children's chaotic and dangerous behaviour.

Researchers like Loeber and Farrington (2000), in their longitudinal work, have found that "some children engage in minor delinquent acts for excitement, adventure, or other emotions common among children. For these children, offending may be considered as part of the context of child development in which youngsters learn prosocial behaviors by trial and error" (p. 742). Only for some will "early status offences [be] stepping stones in pathways to serious, violent, and chronic offending" (p. 743). We know that for most, as high as 95% according to Moffitt (1997), these patterns desist as children narrow the maturity gap, gaining access to whatever their troubling behaviours brought them as children. Arguably, the older the child, the greater his or her capacity to navigate along pathways to health negotiating more

successfully for health resources to support socially acceptable expressions of health.

### *Cultural Specificity*

Of course, these pathways and the negotiations that take place along the way must be viewed through the lens of culture and context. In another setting, such as in an urban slum in a less economically developed country, Fiona's experiences of neglect may not have demanded such intrusive interventions. Her aggressive behaviour, too, may have fit better in other contexts where street violence or war is part of children's daily lives. Though no one would wish this life on Fiona, one cannot overlook that Fiona was removed from her parent and provided treatment in ways that said more about the cultural biases of those intervening than the self-appraisal by the girl of her own needs. As Guerra (1998) writes with regard to understanding what protects children from the risks they face, "A notable advance in this literature would be to enumerate protective factors vis-a-vis specific risk profiles and contexts... It is ... important to study further how risk and protective factors and accompanying developmental processes vary as a function of other key characteristics such as gender, culture, and social class. This requires a more sophisticated operationalization of "sociocultural context" that goes beyond a checklist of ethnicity, a 5-point social class rating index, or a simple contrast of males versus females" (pp. 398–400). Sadly, despite calls for such diversity there have been few studies that put these ideas into practice (for one example, see McCubbin et al., 1998).

### *2) How does the structure of services affect children's access to the health resources needed to nurture and sustain resilience?*

There has been remarkably little study of how at-risk children interact with the multiple service providers in systems of care specifically mandated to mitigate risk and promote children's optimal development. The resilience literature has instead focussed on the study of interventions and outcomes from *one service system* or another, often with little attention paid to the issues of power, access, marginalization or personal agency on the part of clients, residents, patients or students. Even the most well-respected longitudinal studies of resilience such as those by Werner and Smith (1982, 2001) which have produced exhaustive examinations of individual, family and community variables related to resilience have done little more than note which services were provided to at-risk children.

A separate body of literature on systems of care (SOC) has provided extensive data on children's developmental trajectories when provided services. A SOC is defined by Stroul and Friedman (1986) as a "comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families" (p. 3). The bulk of the literature on systems of care, however, continues to focus on interventions that prevent psychopathology and antisocial behaviour rather than discerning the way systems can promote resilience (for example, Stuck, Small, & Ainsworth, 2000). The difference is more than semantic. Resilience researchers look specifically at the behaviours and internalized capacities of children who overcome adversity in order to inform good program and policy design (Fraser, 1997; Greene, 2002; Walsh, 1998). Zimmerman, Ramirez-Valles and Maton (1999) note we know much more about what causes pathology in at-risk populations of children and youth than why or how some become well-functioning citizens. This is a common refrain among resilience investigators, especially those concerned with marginalized populations whose psychopathology has been exaggerated because of a lack of cultural and racial sensitivity (Batey, 1999; Cross, 1998; Sharma & Sharma, 1999).

Though it is obvious that the provision of services has significant impact on resilience in children, professional myopia has resulted in researchers assuming the provision of interventions is controlled by providers, that the effect of programs is either positive or at worst benign, and that at-risk populations lack family and community capacities to achieve healthy developmental outcomes. In other words, *we have forgotten the children*. We have neglected to look at service utilization from their perspective as agentic consumers of service.

A number of authors have shown that clients, residents, patients and students (the people who are worked with in each of the four service systems) exercise some say over the services they attach to, that association with service providers may have iatrogenic effects in terms of identity construction, support and course of illness, and that families and communities have greater capacity to mitigate risk than is observable by outsiders to those communities (Fontan & Shragge 1996; Rains & Teram, 1992). To date, however, there has been no research that has accessed data from all four of the service systems under discussion here in order to discern the patterns in service utilization among resilient and nonresilient children. Outcome studies have typically limited themselves to examining the impact of only one or two services using cross-sectional, quasi-experimental designs that fail to account for the multiple service context in which interventions

occur. Services negotiate among themselves to decide who owns a client. Services operate with cultural blinders. And services collaborate more or less well in the provision of a continuum of care. These are the hidden factors that affect program outcomes every bit as much as individual risk factors and participation in specific programming. We do not yet know what constellation of interventions and protective processes positively influence children's development while under the care and/or supervision of formal and/or informal service providers.

What we are coming to understand is that the systems themselves are a large part of the equation when we examine the health of children. To illustrate, Black (2003) has shown that dyslexia may be more of a problem "located in the institutions of education and in the policies these institutions follow to assist students with dyslexia to successful graduation" than an individual problem of children who are disadvantaged in their learning. A growing wave of innovative researchers like Black are forcing us to question whether systems are properly organized to accommodate the learning needs of children at-risk.

Work by Cross (2003), for example, has examined poor educational attainment among African-American children. In Cross' analysis he dismisses the impact that slavery has had on educational attainment, arguing this focus has served to blame individual Blacks for a problem which is really more about resources than internalization of a racial identity. He documents convincingly the abundant evidence that African-Americans after slavery sought out educational opportunities and valued reading and writing, but that it was the White population that limited access to education, shutting down high schools, or physically and socially isolating or threatening African-Americans who advanced. Though the level of oppression children with dyslexia and an entire population of African-Americans have experienced is vastly different, both examples help to show that service utilization is as much about the barriers service providers create as it is about giving people access to what they need. Understood in this way, resilience is embedded in the complex weave of social and political relationships.

## Conclusion

Children who need help have the capacity to navigate their way to health resources, whether that navigation places them in contact with service systems or leads them to nonconventional forms of behaviour that bring equal benefits. Either way, we would do better helping children if we spent more time asking them to tell us what they need

and understood how they go about finding health resources with or without interventions. Arguably, we may never be able to distinguish between the children who need services and those who do not because the logic of the question is fundamentally flawed. We have forgotten the personal agency of the very people being served. In so doing, we have neglected to ensure that the design and integration of our services are tailored to those we serve in ways meaningful to them.

If we are to understand the way young people and families navigate their way to health resources and negotiate for their use, we will need the tools and commitment to investigate the lives of children lived in close contact with mandated and nonmandated services. Such research will be useful in designing interventions that fit well with the needs of those served. The barriers we face to understanding and enhancing the pathways children travel through Child Welfare, Mental Health, Correctional and Educational systems can be overcome.

## References

- Armstrong, M.I., Stroul, B.A., & Boothroyd, R.A. (2005). Intercepts of resilience and systems of care. In Ungar, M. (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 387–404). Thousand Oaks, CA: Sage.
- Barter, K. (2005). Alternative approaches to promoting the health and wellbeing of children: Accessing community resources to support resilience. In Ungar, M. (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 343–356). Thousand Oaks, CA: Sage.
- Batey, S. R. (1999). A case study of adolescent African American males and factors in resiliency that have contributed to their development and school success. Doctoral Thesis, Educational Leadership and Innovation, University of Minnesota (unpublished).
- Black, R. (2003). The invisible intellectuals: Dyslexic students getting behind with AHEAD. Poster presentation at the Fourth International conference Advances in Qualitative Research. Alberta, Canada: International Institute of Qualitative Methods University of Alberta Banff.
- Cross, T. L. (1998). Understanding family resiliency from a relational world view. In McCubbin, H. I., Thompson, E. A., Thompson, A. I., & Fromer, J. E. (Eds.), *Resiliency in Native American and immigrant families* (pp. 143–157). Thousand Oaks, CA: Sage.
- Cross, W. E. (2003). Tracing historical origins of youth delinquency & violence: Myths & realities about black culture. *Journal of Social Issues*, 59(1), 67–82.
- de Antoni, C., & Koller, S. (2000). Vulnerability and resilience. A study with adolescents who had suffered intrafamilial maltreatment. *PSICO*, 31(1), 39–66.
- Dupree, D., Spencer, M. B., & Bell, S. (1997). African American children. In Johnson-Powell, G., & Yamamoto, J. (Eds.), *Transcultural child development: Psychological assessment and treatment* (pp. 237–268). New York: John Wiley & Sons.

- Felsman, J. K. (1989). Risk and resiliency in childhood: The lives of street children. In Dugan, T. F., & Coles, R. (Eds.), *The child in our times: Studies in the development of resiliency* (pp. 56–80). New York: Brunner/Mazel.
- Finlay, J. (2004). Cross-over children. Presentation to the Sparrow Lake Alliance on behalf of the Child Advocates Association of Canada Toronto.
- Fontan, J. M., & Shragge, E. (1996). Chic Resto-Pop: New community practice in Quebec. *Community Development Journal*, 31(4), 291–301.
- Fraser, M. (Ed.) (1997). *Risk and resilience in childhood: An ecological perspective*. Washington, DC: NASW Press.
- Greene, R. R. (Ed.) (2002). *Resiliency: An integrated approach to practice, policy, and research*. Washington, DC: NASW Press.
- Guerra, N. G. (1998). Serious and violent juvenile offenders: Gaps in knowledge and research priorities. In Loeber, R., & Farrington, D. P. (Eds.), *Serious and violent juvenile offenders: risk factors and successful interventions* (pp. 389–404). Thousand Oaks, CA: Sage Publications.
- Haapasalo, J. (2000). Young offenders' experiences of child protection services. *Journal of Youth and Adolescence*, 29(3), 355–371.
- Hauser, S. T. (1999). Understanding resilient outcomes: Adolescent lives across time and generations. *Journal of Research on Adolescence*, 9(1), 1–24.
- Klevens, J., & Roca, J. (1999). Nonviolent youth in a violent society: Resilience and vulnerability in the country of Colombia. *Violence and Victims*, 14, 311–322.
- Lawson, H. A., & Anderson-Butcher, D. (2001). In the best interest of the child: Youth development as child welfare support and resource. In Sallee, A. L., Lawson, H. A., & Briar-Lawson, K. (Eds.), *Innovative practices with vulnerable children and families* (pp. 291–321). Dubuque, Iowa: Eddie Bower.
- Loeber, R., & Farrington, D. P. (2000). Young children who commit crime: Epidemiology, developmental origins, risk factors, early interventions, and policy implications. *Development and Psychopathology*, 12(4), 737–762.
- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56(3), 227–238.
- McCubbin, H. I., Fleming, W. M., Thompson, A. I., Neitman, P., Elver, K. M., & Savas, S.A. (1998). Resiliency and coping in "at risk" African-American youth and their families. In McCubbin, H. I., Thompson, E. A., Thompson, A. I., & Futrell, J. A. (Eds.), *Resiliency in African-American families* (pp. 287–328). Thousand Oaks, CA: Sage.
- Miles, S. (2000). *Youth Lifestyles in a Changing World*. Buckingham, UK: Open University Press.
- Moffitt, T. E. (1997). Adolescents-limited and life-course-persistent offending: A complimentary pair of developmental theories. In Thornberry, T. P. (Ed.), *Developmental theories of crime and delinquency* (pp. 11–54). New Brunswick, NJ: Transaction Publishers.
- Rains, P., & Teram, E. (1992). *Normal bad boys: public policies, institutions, and the politics of client recruitment*. Montreal: McGill-Queen's University Press.
- Rak, C. F. (2002). Heroes in the nursery: Three case studies in resilience. *Journal of Clinical Psychology*, 58(3), 247–260.
- Rogler, L. H., & Cortes, D. E. (1993). Help-seeking pathways: A unifying concept in mental health care. *American Journal of Psychiatry*, 150(4), 554–561.
- Rutter, M., Giller, H., & Hagell, A. (1998). *Antisocial behavior by young people*. New York: Cambridge University Press.
- Schofield, G. (2000). Resilience and family placement: A lifespan perspective. *Adoption and Fostering*, 25(1), 6–19.
- Sharma, N., & Sharma, B. (1999). Children in difficult circumstances: Familial correlates of advantage while at risk. In Saraswathi, T. S. (Ed.), *Culture, socialization and human development: Theory, research and applications in India* (pp. 398–418). Thousand Oaks, CA: Sage.
- Stroul, B., & Friedman, R. (1986). *A system of care children and youth with severe emotional disturbances (rev. ed.)*. Washington, DC: Georgetown University Child Development Center.

- Stuck, E. N., Smith, R. W., & Ainsworth, F. (2000). Questioning the continuum of care: Towards a reconceptualization of child welfare services. *Residential Treatment for Children and Youth, 17*(3), 79–92.
- Todis, B., Bullis, M., Waintrup Schultz, M. R., & D'Ambrosio, R. (2001). Overcoming the odds: Qualitative examination of resilience among formerly incarcerated adolescents. *Exceptional Children, 68*(1), 119–139.
- Tyler, F. B., Tyler, S. L., Tommasello, A., & Connolly, M. R. (1992). Huckleberry Finn and street youth everywhere: An approach to primary prevention. In Albee, G. W., Bond, L. A., & Cook Monsey, T. V. (Eds.), *Improving children's lives: Global perspectives on prevention* (pp. 200–212). Newbury Park, CA: Sage.
- Ungar, M. (2001). The social construction of resilience among “problem” youth in out-of-home placement: A study of health-enhancing deviance. *Child and Youth Care Forum, 30*(3), 137–154.
- Ungar M. (2002). *Playing at being Bad: The resilience of troubled teens*. Pottersfield Press.
- Ungar, M. (2003). Resilience, resources and relationships: Making integrated services more family-like. *Relational Child and Youth Care Practice, 16*(3), 45–57.
- Ungar, M. (2004). *Nurturing hidden resilience in troubled youth*. Toronto: University of Toronto Press.
- Ungar, M. (2005). Introduction: Resilience across cultures and contexts. In Ungar, M. (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 15–39). Thousand Oaks, CA: Sage.
- Ungar, M., Karabanow J., & MacDonald N. (2002). Pathways to resilience: A study of high-risk youth and their involvement with human service providers. Grant submission to Dalhousie University, Faculty of Health Professions.
- Ungar, M., Teram, E., & Picketts, J. (2001). Young offenders and their communities: Reframing the institution as an extension of the community. *Canadian Journal of Community Mental Health, 20*(2), 29–42.
- Walsh, F. (1998). *Strengthening family resilience*. New York: Guilford.
- Werner, E. E., & Smith, R. S. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth*. New York: McGraw-Hill.
- Werner, E. E., & Smith, R. S. (2001). *Journeys from childhood to midlife: Risk, resilience, and recovery*. Ithaca, NY: Cornell University Press.
- Zimmerman, M. A., Ramirez-Valles, J., & Maton, K. I. (1999). Resilience among urban African American male adolescents: A study of the protective effects of sociopolitical control on their mental health. *American Journal of Community Psychology, 27*(6), 733–751.

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