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Establishing a recovery orientation in first line mental health teams in Québec

Perspectives from social workers and managers

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ABSTRACT

Following the 2005 Mental Health Action Plan most mental health services are offered in primary care teams. This policy called for a paradigm shift away from a biomedical model of care toward a process-focused 'recovery' orientation in mental health. Concurrently, it called for the use of a results-orientation that is outcome-focused in order to ensure efficiency.

The objective of this research project was to explore the development of recovery-oriented practices among social workers in first line mental health teams in Québec. To do this, I investigated the microprocesses of implementing recovery-oriented services and practices alongside results-oriented management techniques. In addition, this project explored the saliency of a recovery orientation specifically for first line mental health social workers.

This qualitative, exploratory study consisted of 11 semi-structured interviews with social workers and managers in first line mental health teams. The results indicate that certain aspects of work organization, such as flexibility, autonomy, reflexivity, training, and interdisciplinarity can foster a practice that is recovery-oriented. In addition, the results show that the foundations of both the recovery orientation and the social work profession share common values. However, social workers face constraints to practice that go beyond their know-how and professional base.

Our exploratory study leads us to contemplate the influence of work organization on changing practice. The results suggest that practicing from a recovery orientation was a shared ideal among the participants but that the meaning and expression of this ideal was profoundly shaped by practice contexts. The implications of these results are that recovery-oriented systems will be difficult to develop in a result-oriented paradigm.

Key words: Recovery, Mental Health Action Plan, mental health social work practice, first line mental health care, results-oriented management

RÉSUMÉ

Le Plan d'action en santé mentale institué en 2005 marque le début d'une période de changements profonds qui auront un impact significatif sur les équipes de première ligne qui assurent la plupart des services au Québec. Le changement se manifestera sur deux fronts distincts. En premier lieu, le passage de services historiquement ancrés dans un modèle biomédical vers des services centrés sur le rétablissement. En second lieu, l'adoption de processus administratifs s'inscrivant dans une philosophie de gestion axée sur les résultats qui ont pour objectif de mesurer et d'assurer l'efficacité des services.

L'objectif de cette étude est d'explorer le statu du développement des pratiques axées sur le rétablissement au niveau des travailleurs sociaux de première ligne dans le contexte administratif mentionné ci-haut. Le travail de recherche qualitatif et exploratoire est construit sur l'analyse de 11 interviews semi structurés avec des travailleurs sociaux et des gestionnaires dans des équipes de première ligne en santé mentale. Les entretiens m'ont non seulement permis d'identifier et d'examiner des actions concrètes s'inscrivant dans l'effort d'implantation du Plan d'action mais aussi de sonder et d'explorer la signification qui est donnée au rétablissement par les travailleurs sociaux de première ligne.

Les résultats indiquent que certains facteurs relatifs à l'organisation du travail tels que la flexibilité, l'autonomie, la réflexivité et l'interdisciplinarité peuvent favoriser une pratique orientée vers le rétablissement. Aussi, les résultats démontrent que le modèle du rétablissement et la profession du travail social partagent des valeurs fondamentales mais que la signification et l'expression du rétablissement ont été profondément influencés par les modèles organisationnels et obligations administratives en vigueur. Il appert que les travailleurs sociaux sont confrontés, dans leur pratique, à des contraintes qui dépassent leur mandat professionnel et, à certains égards, leur savoir-faire.

En somme, les résultats obtenus indiquent que le passage avec succès vers la pratique de services basés sur le rétablissement est compromis par les exigences d'un modèle de gestion axé sur les résultats.

Mots clés : Rétablissement, Plan d'action en santé mentale, interventions en travail social, équipes de première ligne en santé mentale, gestion axée sur les résultats

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LIST OF ABBREVIATIONS

AQRP – Association québécoise de readaptation psychosociale

CASW – Canadian Association of Social Workers

CLSC – Centre local de services communautaires

CSSS – Centre de santé et services sociaux

DSM – Diagnostic and Statistical Manual of Mental Disorders

EBP – Evidence-based practice

IFSW – International Federation of Social Workers

MHAP – Mental Health Action Plan

MSSS – Ministère de la santé et services sociaux

OPTSQ – Ordre Professionnel des travailleurs sociaux du Québec

OTSTCFQ – Ordre des travailleurs sociaux et thérapeutes conjugaux et familiaux du Québec

PII – Plan d'intervention individualisé (Personalised Intervention Plan)

RRASMQ - Regroupement des ressources alternatives en santé mentale du Québec.

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INTRODUCTION

With the release of the 2005-2010 Mental Health Action Plan in 2005, Québec is one of the first non-Anglo-Saxon[1] societies to adopt an official recovery orientation[2] in mental health policy. The Mental Health Action Plan (MHAP) also favours public access to care, continuity of services, quality of life, effectiveness and efficiency of the health care system, and hierarchization of care. The directive of the hierarchisation of care is the impetus for the development of first line mental health teams. These teams, which were developed or expanded in community care agencies, the *Centres locaux de services communautaires or local community services centres* (CLSC), aim to respond to 70% of people seeking mental health services. The MHAP was developed following the reengineering of the Québec Health and Social Services system in which the CLSCs were merged with other territorial agencies to form the larger integrated networks called *Centre de santé et services sociaux* (CSSS). Given the multitude of changes at the strategic level as well as the changes in the mental health care delivery systems it is pertinent to consider the many factors that may be affecting mental health social work practice. In other words, this project is not only contemplating the specific ways in which this new policy is being operationalized in the recently formed first line mental health teams, but also how the microprocesses of the operationalization of the policy is facilitating or hindering recovery-oriented social work practice[3].

In order to better understanding how new policies, tools, and procedures in a transformed mental health service delivery system are affecting recovery-oriented discourse and practice, this exploratory, qualitative study used semi-structured interviews with social workers and their managers in two CSSS. A comparative approach was favoured in order to unveil diverse reactions at the local level to the new mental health policy and its

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[1] The term recovery has been translated as *rétablissement* although native French speakers will often use *rétablissement* and recovery interchangeably.

[2]This approach proposes a radical change in the position of people living with or having lived with mental health problems. The concept will be discussed in detail in Chapter 2 - Recovery.

[3] The recovery process and the field of social work share many common values and theoretical roots. A recovery-oriented practice is one that is perhaps not foreign to most professionals with a social work background. It is focused on more than symptom reduction and deficits. It is focused on engaging the whole person and their strengths (Rapp, 1998), social inclusion, person-centred interventions, and an assertion that an individual in recovery can achieve personal success and experience a valuable life (Anthony, 1993; Deegan, 1998).

overarching recovery orientation. In this way, the recovery orientation and social work mental health practice are placed in relation to particular organizational contexts. The results indicate that although most social workers claim to have always adhered to the values found in the recovery orientation, organizational and structural issues, such as a focus on outcome measures, are more prominent in the discourse of participants than the implementation of a recovery orientation. Moreover, the results indicate how context, such as the unique history of the CSSS, composition of the team, and experience of professionals, mitigates the reaction to the new policy and to the recovery orientation. Despite decades of literature on mental health recovery a consensus on what it actually represents has not been determined. Moreover, there is limited information in the literature that investigates how the organisation of work for front line social workers can foster recovery-oriented practice.

According to Carpenter (2002) the social work profession and the field of mental health have been inextricably intertwined since the early 20th century. A study conducted by Gérin (2002) concerning the roles of social workers in various mental health practice settings revealed that the central strength of the social work profession is its ability to analyse social problems in a multidimensional manner in order to avoid the pitfalls of a purely biological causation of mental health problems. The majority of respondants in that study believed that the future of social work mental health practice is in community mental health care. Nevertheless, Gérin (2002) concludes by stating that social workers in her study were torn between their pragmatic role (read: institutional role) of focusing on social functioning and their 'abstract' role in which they have been trained to provide a larger and more contextualized vision of mental health problems that considers not only the individual but his family and friends (p.96).

Several studies and documents have discussed the development of first line mental health teams and the recent policies changes (Fleury, 2009; Government of Québec, 2008); these documents do not focus on the establishement of a recovery orientation. Although work has been done to outline the essential services needed in a recovery-oriented system (Anthony, 2000) there has been no systematic empirical inquiry assessing barriers to the

development of recovery-oriented interventions. Little is known about specific organisational factors and formalised procedures that promote a renewal of recovery-oriented practice; there is a lack of examples that take into account the professional experiences of social workers and their managers. This study presents a detailed inquiry that assesses how and if organizational contexts have moved beyond policy to foster recovery-oriented practice. This study is based upon the assumption that although recovery-oriented practices at the institutional level are in their infancy, the long-awaited recognition of recovery suggests real prospects for developing mechanisms to deal with the operationalisation of recovery-oriented practice. Rhetoric has changed in policy and the mental health services system in Québec has been transformed. Has this transformation resulted in recovery-oriented interventions by first line mental health social work practitioners?

This study is pertinent because there are gaps in our knowledge related to how to position mental health services and practices, particularly social work practice, in a manner that promotes and supports the recovery process for individuals and their families living with mental health problems. Thus the aim is to analyse the research sites in order to develop links between the recovery approach and social work practice and develop a better understanding of how institutional context affects the establishment of a recovery-oriented approach.

This thesis is divided into seven chapters. The first chapter presents the problematic that is under investigation and is followed by an exhaustive literature review regarding recovery and the Mental Health Action Plan, which is divided into Chapters two and three, respectively. The fourth chapter is dedicated to a discussion of methodological considerations. The fifth and sixth chapters offer an analytical presentation of the results that emerged from the interviews. The final chapter will provide conclusions and discussion points in order to discuss the contributions that this research project can have to furthering our knowledge of social work mental health practice and recovery-oriented practice in the current organizational and political context.

CHAPTER 1 – PROBLEM STATEMENT

There are several levels of change that have taken place in the last decade concerning mental health care. At the macro level, the structure of our health and social services system was completely reorganised with the creation of the CSSS in 2003. Later, in 2005 the MHAP resulted in a reform of the mental health service delivery system. The MHAP paved the way for a change in philosophy toward a recovery orientation[4]; the concept of recovery was thus officially recognised by the Québec government. The first line mental health teams created within the CSSS designated social workers as an essential profession in providing mental health services (Government of Québec, 2011).

I began my graduate studies with an interest in social work practice in specialized psychiatric settings. This included an interest in the meaning(s) that psychiatric social workers gave to recovery and the gaps I observed between practice reality and discussions in the literature. With the shift of mental health care toward the first line[5] the relevance of conducting this research study in the newly formed first line mental health teams instead of a psychiatric institution predominated[6]. I determined that a greater source of information and inspiration concerning recovery-oriented social work practice existed in the first line teams that are presumably less medicalised and more community focused. This initial interest was further developed to question how first line mental health social workers experienced the Québec government reforms and how the change in orientation toward a recovery framework affected their practice. These questions led to the initial identification of key concepts such as recovery-based interventions, social work practice approaches, and service organization[7].

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[4] Other directives of the MHAP include establishing a hierarchy of services and a populational approach aimed to increase accessibility, inclusion, and destigmatisation whilst decreasing costs. The MHAP will be discussed in greater detail in Chapter 3 – Mental Health Policy in Québec

[5] First line denotes a primary care mandate that offers general services that are directly accessible

[6] With the large-scale transfer of funding, staff, and patients to the first line following the MHAP, the bulk of mental health service provision is dispensed in the first line and the psychiatric hospital is no longer meant to be the centre of mental health care

[7] These concepts were used as points of departure to form interview questions for this study. This will be further discussed in Chapter 4 – Methodological Considerations

1.1 Recovery

Recovery is a term that has been discussed and debated in North American mental health literature for almost two decades. Yet a consensus on what recovery actually represents - a model, a philosophy, a paradigm shift, a program, or an intervention strategy - has not emerged; it remains a contested concept. Nora Jacobson (2004) describes her book, *In Recovery: The making of mental health policy* as a "book about the making of definitions" (p.xi) of recovery. From the outset she outlines different meanings of recovery that are held by the various promoters of this new paradigm in mental health. Davidson, O'Connell, Tondora, Styron, & Kangas (2006) report that it is the heterogeneity of the recovery experience that makes it complex to use for policy. However, the heterogeneity of recovery is not inherently negative; a homogenous definition could stifle critical reflection (Corin, Rodriguez, & Guay, 1996; Rodriguez, Corin, & Guay, 2000). My understanding of recovery is based on my initial impetus to practice from an anti-oppressive perspective[8] and awareness that mental health social work approaches have been a factor in supporting the status quo and "fostering relations of dominance" (Dominelli, 2002, p.28). When I was first introduced to the concept of recovery I immediately recognized a fit with my social work values[9] as well as the stated values of other colleagues and professionals. Social work practice has a social justice and social change mission congruent with the values articulated in recovery; values that include the inherent worth of every person, equality, and dignity (Cohen, 1995; Corrigan & McCraken, 2005; Davidson et al., 2006; Jacobson and Greenley, 2001; Manning, 1999). Yet in my practice we continued to be dominated by the centrality of the medical model in our actions that undermined the position of people living with mental health problems and did not consider the effect of structural issues and the environment on their experiences. The emerging literature and accounts by service users

[8] According to Dominelli (2002) anti-oppressive practice moves away from the idea that the professional is an expert and instead "acknowledge[s] power differentials, and recognises client agency, knowledge and skills" (p.185)

[9] According to the Canadian Association of Social Workers (CASW) Code of Ethics (2005), the professional core values and principles include : respect for the inherent dignity and worth of every person ; pursuit of social justice ; service to humanity ; professional integrity ; confidentiality ; competence in professional practice.

has enriched and informed my understanding of recovery; it is more complex than what the anti-oppressive and social justice frameworks offer. The recovery perspective is grounded in the self-determination of the client and his family; active participation; complete access to information and education surrounding the service agency's goals and intentions; and the importance of considering the effects of multiple factors.

Emil Kraeplin (1913), the 'father' of modern psychiatry, posited that chronicity was inevitable and that a progressive downfall course following diagnosis is the only prognosis. The concept of recovery is essentially a paradigm shift in the understanding of a person's lived experience of mental illness. At the crux of my conceptualization of recovery is the positioning of mental health problems as part of an individual's life journey; the experience of suffering need not be reduced by a perspective that defines mental health problems solely as a chronic illness. I regard recovery in the sense of the 'universality of recovery', meaning a more subjective notion of hope, aspirations, rights, and freedoms to reflect the diversity of persons and cultures living with mental health problems. It is not a universal process as it is not homogenous and is not experienced in the same way by everyone.

Science, medicine, and technocratic policies cannot completely answer the needs of people with mental health problems; when we consider the subjective experiences of many people living with mental health problems, they often site poverty, housing, marginalisation, violence, and other personal and sociopolitical conditions as factors in their mental ill-health (Corin et al., 1996; Perron, 2005). Thus, interventions and practice must be scrutinised in order to ensure that they are not hindering an individual's path to recovery. This project seeks to investigate if a recovery-oriented framework is salient to first line mental health social workers; if social work's professional base is congruent with the principles of recovery, to what extent do social work interventions in first line mental health teams match those principles?

1.2 Mental health social work practice

Although an individual will go through the process of recovery, professional intervention can facilitate this process (Anthony, 1993, 2004; Davidson et al., 2006; Rodriguez et al., 2000; Rodriguez, Bourgeois, Landry, Guay & Pinard, 2006). This requires certain "critical values underlying our practices...'people first' values" (Anthony, 2004, p.105) or as stated by Rodriguez et al. (2006)

> *"En santé mentale, certaines pratiques essentielles, au-delà de celles fondées sur la recherche experimentale, font appel à des manières d'être, à des attitudes et à la capacité d'être en relation" (p.149).*

The value-laden orientation of recovery is particularly interesting for social work. Many of the critics of an over-reliance on the medical model in mental health have been social workers themselves. In 2003, the *Ordre Professionel des Travailleurs Sociaux du Québec* (OPTSQ) questioned the pervasive power of the medical model in mental health and questioned how this may affect social work practice:

> *"Le pouvoir médical en santé mentale est encore une réalité omniprésente et il influence indirectement notre pratique, notamment à travers les questionnements suivants : Quelle est l'indépendance des travailleurs sociaux vis-à-vis le modèle médical et les pratiques médicales, qui restent dominantes dans le champ de la santé mentale? Quelle importance réelle devraient avoir les instruments comme le DSM[10] dans la pratique des travailleurs sociaux, notamment en ce qui a trait au remboursement des services par les compagnies d'assurance et les gouvernements?"*
> (OPTSQ, 2003, para. 8)

In the field of social work, a seminal piece of work has influenced social work practice in mental health and in other practice areas. Charles Rapp developed the strengths model and discusses case management with people suffering from severe and persistent mental illness. His conceptualization proposed a radical shift: moving the focus on illness

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[10] The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a manual that is used to diagnose, categorize and then ambiguously guide treatment decisions in psychiatry. The DSM as we know it today is the result of several revisions since it was first published by the American Psychiatric Association (APA) in 1952.

or deficit to the background and instead focusing on strengths or resilience as the most effective path to recovery. Rapp's (1998) book *The Strength's Model: Case Management with People Suffering from Severe and Persistent Mental Illness* is widely considered to be useful as a practice manual and has become increasingly popular in the social work field and beyond. Mental health managers and practitioners are currently using it as a way to bridge the gap between recovery rhetoric and practice. The approach places little or no emphasis on illness or symptoms and proposes a focus on service user's skills and competencies and includes intervening in a normalized setting. It is imperative however to maintain a critical stance of this approach regardless of its current following in modern social work. Unlike the practice potential that a recovery approach offers, the strengths-based model maintains a chronicity of mental illness despite its focus on strengths. Gray (2011) states that the model is actually grounded in neoliberalism with notions such as individual and family responsibility or self help which can mask problems that are due to structural inequalities. Nevertheless, this model, developed by a social worker, is an example of how the social work profession has contributed to the evolution mental health practice. Despite the assertions of the OPTSQ and the influence of the strengths-based model, the literature concerning the role of social workers in creating changes in practice towards recovery approaches is limited.

I am particularly interested by the ways in which institutional contexts and a formal professional base, particularly shared values, influence social workers practice purpose[11]. With a recovery-oriented practice framework and a professional base including respect, self-determination, equality, and promotion of well-being, I experienced conflict in my practice purpose within an agency that was historically authoritarian and hierarchical. However, the MHAP and the recently transformed mental health system have made an open call to transform institutional contexts toward recovery. This project explores if the reforms have resulted in consistencies, or conflict, between the social work professional

[11] Practice purpose refers to the result of the construction of meaning and interventions related to the tasks assigned by the institution. The construction of meaning is determined by social work values and theoretical frameworks (Healy, 2005)

base and institutional context. Carpenter (2002) and Shera (1996) support the idea that social workers would be oriented toward the principles found in the recovery model that move beyond the reductionism of the biomedical model; they argue that the values and beliefs found in the recovery model are closely aligned with those of the profession of social work. Carpenter (2002) posits, "social workers are well-suited to the tasks of answering the mandates of the recovery paradigm" (p.92). If this is valid, then social workers would find the concepts found in the recovery framework to be salient and barriers to the application of recovery in their practice would be due to institutional factors, and not professional factors.

Currently, evidence-based practice[12] is favoured in traditional mental health settings. Evidence-based practice is informed by scientific methods; Anthony, Rogers & Farkas (2003) state that evidence-based practice is not informed by a recovery vision and thus policies and service organisation do not speak to a recovery-oriented system. These authors do believe, however, that a marriage between recovery policy and practice and evidence-based practice is possible. Essentially they argue for an evolving definition of evidence-based practice. Similarly, Davidson, Drake, Schmutte, Dinzeo & Andres-Hyman (2009) and Torrey, Rapp, Van Tosh, McNabb & Ralph (2005) admit to the limits of evidence-based practice but believe that these limitations can be dealt with by "assuming that scientific evidence is only one important component of decision-making" (Guyatt & Rennie, 2002 as cited in Davidson et al., 2009, p. 327). Nevertheless, the strategic intent of evidence-based practice in the context of neoliberal reforms of mental health service delivery cannot be ignored. Evidence-based practice is embedded in a results-oriented management context in which performance outcome measures are strictly controlled. A focus on these quantitative indicators of service quality and outcome measures may lead to a new type of professional accountability and a decrease in professional autonomy (Shera, 1996). This would logically result in certain changes in practice. Can a new orientation

[12] Evidence-based practice (EBP) refers to mental health treatments or interventions that are empirically supported and usually disregard experience-based knowledge. This is further dicussed in Chapter 3 – Mental Health Policy in Québec

toward recovery also lead to a renewal of practice in parallel to increased demands for professionals to prove their efficiency and efficacy?

1.3 Organisational contexts

There is a gap in the literature that investigates a social worker's subjective perspective of her front-line experience in a first line mental health team in Québec with regards to how organisation of work can foster recovery-oriented practice. A social worker's front-line experience is influenced by the organization of her work, which is usually determined by her administrative manager. At the 2010 conference for the *Association québécoise de réadaptation psychosociale (AQRP)*, Louise Marchand and Herman Alexandre spoke about the contribution that the manager, who in our Québec health and social services system is first and foremost a health care professional, can have to the process of recovery for a person living with mental health problems. They cite several values that are at the basis of recovery[13] and explain that the manager's role is to act as a bulldozer clearing the path for the clinical team and the service users so that they may implement creative ideas and interventions. The manager's goal is to give power back to the professionals so that they in turn can give power back to the service users. They explained how prior to the recent reforms in Québec's mental health care landscape, service users were positioned as 'charges of the State'. Now the autonomy and choice of the service users is the new paradigm[14]. They cited several elements in the organization of work that are imperative to fostering recovery-oriented practice. These included: differentiating and integrating the different types of professions in order to create a true interdisciplinary team whilst reinforcing each profession's strengths; work climate that supports mutual aid and solidarity; a strong support system within the team; time given to professionals to reflect on their practice. Evidently, a manager's mandate, directives, and

[13] Rights, needs, potential, hope, active participation, support network, mutual aid and peer support, community action, quality of care

[14] Marchand and Alexandre (2010) posit a new line of questioning that managers and professionals should go through when working with a service user : Am I supporting his autonomy ? Focused on his strengths? Is he well informed of the advantages and inconveniences of his choice? Have I asked him his opinion? Are his choices being respected?

priorities trickle down from a strategic entity in the health and social services system. In addition, the tensions that exist due to the process-oriented recovery model being embedded in a results-oriented healthcare system will no doubt result in contradictions on the field. The way in which managers will interpret and implement the need for outcome measures will affect the way in which first line mental health social work practice is informed. There has not been any literature uncovered that examines the ways in which managers and their professional teams interpret mental health policy and translate it into action in Québec's context.

Promotion of mental well-being is central to the MHAP (Government of Québec, 2005a) and to the first line mental health care approach. Unlike the biomedical model in which psychiatric or mental health care has historically been entrenched, the recovery model is not "individually focused, treatment oriented and expert-driven" (Hill & Harris, 2008, p.311 as cited in Harvey, 2010, p.41). Whilst discussing health promotion in general, Harvey (2010) elaborates, ascertaining that overall health promotion within a primary care setting such as a first line mental health team "emphasizes working collaboratively with groups and communities to identify and address health needs, thus fostering a sense of community ownership of solutions" (Harvey, 2010, p. 41-42). The values and processes involved in these community-oriented, participative approaches that consider a variety of factors and realities are central not only to health promotion but to the recovery model. The MHAP (2005) refers to full social inclusion and active citizenship as the principle mode to promote recovery (p.15) and articulates the first step as including service users and their networks in the decision making process. Is the government's recognition of recovery a true paradigm shift? Is a renewal of practice under way and what role will social workers play in this renewal? Although, the MHAP espouses recovery and places the service user at the centre of care, Davidson et al. (2006) concluded that a recovery-oriented system, which promotes

empowerment[15] and a focus on the person could not exist in parallel to the existing biomedical oriented system that rewards compliance and focus on disorder. The same question can be asked of the operationalization of a recovery-oriented system within a neoliberal framework. In other words, what are the microprocesses of implementing a recovery *ethos* in the current zeitgeist?

[15] Empowerment refers to an individual having control over his life and active participation in the decisions that are made that affect his life. It also refers to the space given to exercise freedom of choice based on informed consent (Government of Québec, 1998 ; Rodriguez et al., 2006)

CHAPTER 2 - RECOVERY

The people from whom the concept of recovery first emerged - those living with or having lived with mental health problems - are the best sources of information in order to understand the process of recovery and the factors that hinder or facilitate this process. However, because many contexts define recovery in different ways, the perspectives of policy makers and practitioners regarding the concept of recovery will also be discussed in this chapter. The following literature review will highlight the recovery model with respect to two key elements in this study: 1) mental health policy and practice and 2) social work theory and practice. A review of the literature will expose the different definitions that exist and unmask the heterogeneity of the recovery orientation. I also will discuss social work theory and practice and the potential relationship it has with the recovery orientation.

In the early 1990's literature and policy in the United States began including recovery as a stated goal (Anthony, 1993; Wisconsin Department of Health Services, 1997). The literature foretold of recovery-oriented systems even in institutional settings and described this new philosophy as one whose values include process-oriented person-centered services, a move away from the disease model of care, service user involvement, shared decision making, development of citizenship and social roles, empowerment, connection with social roles, finding purpose and meaning in life, hope, human rights and a positive culture of healing (Anthony, 2000; Chamberlin, 1998; Deegan, 1997; Farkas, 1996; Jacobson and Greenley, 2001; Jacobson and Curtis, 2000; O'Connell, Tondora, Croog, Evans, & Davidson, 2005). The movement to develop recovery-oriented services systems has not been isolated to the United States. The term recovery is defined and stated in literature and policy from New Zealand, Australia, the United Kingdom, and Canada (Bonney & Stickley, 2008; Mental Health Commission of Canada, 2009; Ramon, Healy, & Renouf, 2007).

As discussed in the previous chapter, in Québec recovery first appeared as a directive in mental health policy in 2005 with the unveiling of the MHAP (Government of Québec, 2005a). This policy transformation was superimposed on a major reengineering of Quebec's health and social services system that called for a strong fiscal imperative of accountability and an emphasis on performance outcome measures. Given the current

neoliberal climate, we might associate cost reduction, based on the idea that a person could recover and therefore no longer needs services, as one reason why recovery may have been included in the policy. However, this neoliberal agenda was not the sole influence for the recognition, development, and imperative for recovery-oriented services. In Québec, the term 'recovery' echoed the practices and approaches that had been previously developed in the community and alternative resources. A long-standing social and political movement involving people living with or having lived with mental health problems, community organizations, and consumer rights activists as well as academic literature contributed significantly to the acknowledgement for a need to transform our mental health service system.

As discussed by Jacobson (2004), the meaning of recovery varies according to the positionality of the individual or group and according to the context. Ralph (2000) and Davidson et al. (2006) reiterate Jacobson's assertion that the definition of recovery is heterogeneous; the context in which it is defined has profound implications for the meaning that it carries. In order to understand the development of recovery in a Québec context, this chapter begins with a review of the origins of recovery – a concept present in the narratives of mental health users since the 1930's (Onken, Dumant, Ridgway, Dornan, & Ralph, 2002, p.7). The concept of recovery originated as a critique to the traditional and inarguably oppressive biomedical model on which mental health care is historically based. The leading voices discussing recovery in the literature in the 1990's were those of survivors (Deegan, 1988, 1997; Chamberlin, 1998) and authors from major psychosocial rehabilitation centres in the Unites States (Anthony, 1993).

2.1 Origins of recovery

The conception of recovery and the paradigm shift toward a recovery orientation at the political and societal level has its origins in four main sources, none of which are mutually exclusive. This section will review each of these sources beginning with a brief overview of the role played by the alternative resources movement in Québec in creating fertile ground for a conception of recovery to grow. I will also discuss how the recovery

paradigm is related to the empowerment and psychosocial (or psychiatric) rehabilitation models. Finally, I will briefly present the longitudinal studies that contributed to the conceptualization of recovery especially from the perspective of the scientific community.

2.1.1 A critique of traditional practice

Literature since the anti-psychiatry movement in the 1960's and survivor's movement starting in the 1970's has promoted, discussed, and researched practices that would serve to empower service users and restore their civil rights by decreasing stigmatization, allowing for subjective constructions of reality, reducing the impact of labeling and inadequate diagnostic criteria, and creating room for social change (Chamberlin, 1978; Deegan, 1988). The anti-psychiatry and survivor's movements discuss the biomedical approach in terms of the practical irrelevance to service users' lives (McCulloch, Ryrie, Williamson, & St-John, 2005, p.10). The 1960's and 1970's provided a fertile ground for these movements, as other historically oppressed groups (people of colour, women, homosexuals) were also fighting to obtain basic civil rights. The political goals of the mental health grass-roots movement, unique in the history of psychiatry due to the important implication of survivors of asylums and psychiatric institutions, typically included fighting for human rights in the mental health system and identifies itself as a social change movement (Oaks, 2006). As discussed by McCulloch et al. (2005), these citizen led perspectives and initiatives continue to affect policies in Quebec, Canada, and internationally. Since the 1970's alternative mental health organizations have contested the pervasive power of the medical model in psychiatry (Corin et al., 1996; Rodriguez, Corin & Poirel, 2001) and pushed the field of mental health towards a paradigm shift that would consider other factors to achieving mental health such as feelings of empowerment, agency, hope, decreased stigmatization, and full participation in society in order to create room for active citizenship. According to Rousseau (1993), "the alternative movement in Quebec rests on two cornerstones: criticism of the health care system and promotion of innovative therapeutic approaches" (p. 538). These innovative approaches include understanding the

social and structural origins of mental health problems[16]. The alternative mental health resource movement has also promoted service user participation – a democratic process that ensures active citizenship through mechanisms that allow for greater political action (Rodriguez et al., 2006) and a questioning of power relationships. This includes questioning the power imbalances that may exist between the service user and the mental health practitioner. In their study on integrating services and practices, Rodriguez, Corin, Poirel & Drolet (2002) also illustrated how service users and practitioners require space, time, and flexibility in their interactions in order to make changes toward well-being and autonomy. The alternative movement has successfully created room for itself as a paradoxical political partner and ideological opponent to the approaches rooted in the biomedical hegemony[17] in the health care system in Quebec. This conflictual collaboration represents a dialogue and tension that is no doubt vital to ensuring a continued evolution, participation, and democratization of the mental health system.

Critiques of the biomedical hegemony have extended from service users to practitioners and researchers. David Cohen (1995) discusses the risks of using a unilateral biological approach to psychic suffering. He posits that several problems arise from the purely biological causation of mental health problems and makes several recommendations to the *Comité sur le bilan d'implantation de la Politique de santé mentale du Québec,* including funding and training for alternatives to medication, the creation of psychosocial crisis centres, and the recognition that mental health service users have the right to be supported in their decision to stop taking medication (p. 6). Some researchers suggest that the main downfall of the biomedical model is that it is not founded on strong scientific results and that many medications are discovered by accident and lack scientific credibility (McCulloch et al., 2005; Oaks, 2006; Rodriguez et al., 2001). Furthermore, some authors such as Jacobson and Curtis (2000), refer to recovery in terms of the survivor's movement as a "manifestation of empowerment" (p. 334).

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[16] Dorvil (2005) also maintains the subjectivity of psychiatric diagnosis from a sociological perspective and states *"sans référant social, la folie n'existerait pas*" (p.219).

[17] This refers to the power of the medical authorities in psychiatry today (McCulloch et al., 2005) due to a purely biological causation of mental illness that was postulated

2.1.2 Empowerment

In the 1990's, whilst the concept of recovery was gaining terrain in the literature, 'empowerment' was being conceptionalised. The term *empowerment* had already become a "popular term in mental health programs" (Chamberlin, 1997, p.43) as evidenced in Quebec's *Plan d'action pour la transformation des services en santé mentale* (1998). In 1998 the MSSS called for a clarification of the concept of empowerment; a committee called *Le comité de pilotage du Guide d'appropriation du pouvoir*, which was made up exclusively of mental health service users was in charge of defining the concept of empowerment (Blais, Bourgeois, Judon, Larose & Lecompte, 2004 as cited in Rodriguez et al., 2006). They worked in collaboration with the *Comité de la santé mentale du Quebec's* service quality working group and together they contributed to the definition of empowerment used by the MSSS in 2004 in the document entitled *Guide pour le developpement des competences en santé mentale.* As cited in Rodriguez et al. (2006, p.114) the guide included the following excerpt:

> *"l'appropriation, par une personne utilisatrice de services en santé mentale, du pouvoir quant à la conduite de sa vie est un processus continu qu'elle-même a décidé d'entreprendre et qu'elle gère en fonction de la connaissance qu'elle a d'elle-même et en fonction de ses expériences, de ses besoins et de son parcours. Ainsi elle peut prendre la parole en toute liberté, exercer ses droits et assumer ses responsabilités librement et de façon éclairée, décider de toutes les facettes de sa vie, tant sur le plan individuel que collectif, et défendre ses droits."*

Manning (1999) discusses empowerment as a model that "reflects the consumer voice" (p.102) and rebalances the distribution of power between the mental health service user and the mental health practitioner. Manning, Zibalese-Crawford and Downey (1994) developed a study (as cited in Manning, 1999) consisting of 11 group interviews with service users and their families as well as 17 individual interviews and participant observation. Their research led to the identification of major themes of empowerment being self-determination, decision-making, information, respect, involvement, contributing to others and 'coming out' (p.106). In an effort to develop a working definition of empowerment,

Judy Chamberlin (1997) directed a research project in which she created an Advisory Board of consumer/survivor self-help practitioners. Together they defined empowerment as having 15 qualities, which echo the findings of Manning et al. (1994). Chamberlin (1997) also briefly discusses the importance of evaluating empowerment outcomes in the context of psychosocial rehabilitation programs that claim to advance elements found in the working definition of empowerment (p.46).

2.1.3 Psychosocial rehabilitation

The *Association québécoise pour la réadaptation psychosociale* (AQRP) was founded in 1990 and it defines psychosocial rehabilitation as follows:

> *"La réadaptation psychosociale intervient dans toutes les dimensions de la personne: biologique, psychologique, sociale et environnementale. Approche globale, elle aide l'individu à rétablir ses capacités physiques, intellectuelles, psychologiques et sociales. Elle lui assure aussi un soutien global et continu selon ses besoins et ses désirs dans les milieux de son choix. Ainsi, elle facilite sa participation et sa contribution à la vie communautaire"*
>
> (AQRP, 2010)

Nonetheless, psychosocial rehabilitation practitioners have been criticised for not understanding the importance of empowerment. Corrigan and McCracken (2005) discuss the importance for psychosocial rehabilitation practitioners to move the focus away from symptom reduction and to place more emphasis on the individual's needs, rather than on the services available. According to Corrigan and McCracken (2005), psychosocial rehabilitation practitioners were trained to ensure that a service user was first deemed 'functional' before returning to work and independent living settings; traditionally, functionality is positively correlated with symptom reduction. This is inherently disempowering as it maintains the practitioners in the position of decision maker and expert. Davidson, Stayner, Nickou, Styron, Rowe and Chinman (2001) caution that people in prevocational training programs are continuously told to fulfill prerequisites of being 'normal' and never enter the job market. Both articles discuss social inclusion as necessary

aspects of rehabilitation and Davidson et al. (2001) cite social inclusion as a "basis for recovery from mental illness" (p.375).

Initially, accounts of recovery were used to build practice models for use in psychosocial rehabilitation services. In 1996, Marianne Farkas began discussing rehabilitation and how it must be adapted to fit into the concepts of empowerment and recovery. Farkas and Vallée (1996) stated that recovery is the goal of rehabilitation (p.1) although they lament the fact that empowerment discourse was not well translated into practice or policy. Farkas (1996) states that although service users go through a process that is recovery, "rehabilitation is that process by which practitioners facilitate recovery…focus[ing] on people regaining valued roles in their communities so that they have success and satisfaction" (p.6). Deegan (1988) also makes a similar distinction between rehabilitation and recovery; she describes the former as the services that are available and the latter as the life experience or process through which the person living with mental health problems is going. More recently, Davidson et al. (2006) have made the distinction between recovery-oriented care and recovery; they describe the former as the role and responsibility of the mental health care provider and the latter as the role and responsibility of the service user.

2.1.4 Longitudinal studies

The recovery orientation also found its roots in longitudinal studies conducted with people with severe and persistent mental health problems. The studies showed that the majority of these people obtained their goals of autonomy and recovery and no longer needed to be 'in the system' (Harding, Brooks, Ashikaga, Strauss and Breier, 1987). The longitudinal studies are typically entrenched in a positivist philosophy and aim to develop evidence-based practices. The meaning of recovery for the purposes of these studies seems to be conceptualised as a cure or the attainment of sufficient functioning to no longer require services, rather than a process, a journey, and/or the fulfillment of a life project. As discussed by Farkas (1996) and Anthony et al. (2003) these longitudinal studies were the empirical basis for this paradigm shift that was particularly influential for policy makers. It

is worthwhile to note that the experiential basis of recovery through the lived experience of mental health service users had already been documented through consumers/survivors/ex-patients narratives and stories

2.2 Negotiating the meaning of recovery – the new paradigm?

Recovery is neither a new concept nor is it a homogenous one. The way that this orientation is interpreted and the meaning prescribed to it depends on the location of the person who is deciphering it. This section will review recovery, both as a journey, a practice orientation, and as a service orientation from the point of view of services users, practitioners, and key decision makers.

2.2.1 Perspectives of service users

As aforementioned, first person accounts of recovery in mental health have been documented for decades and some survivors are well known in the literature for sharing their narratives. These accounts often discuss reconstructing one's identity following the historic and oppressive socialisation of their role as mental patients and the trauma of being labelled as mentally ill (Goffman, 1968). Also, some of these narratives discuss the process of recovery and the various actors (individual, family, system) that can facilitate or hinder that process.

In Québec, Rodriguez et al. (2000) conducted a research project that studied the lived experiences of people who frequent alternative mental health resources. Their objectives included evaluating and questioning practices in those settings from the perspective of the service users. Although the authors did not directly employ the term recovery, this qualitative study evaluated the quality of services and practices in the alternative mental health settings by investigating concepts that are found in the discourse and literature on recovery. These include: hope, life trajectory, subjective experience of suffering and what this means, and service user perspectives. The 60 service user narratives that were analysed in this study reveal deeply personal and unique experiences that do not necessarily fit into the descriptions proposed by psychiatry or traditional mental

health practice models. The narratives revealed four ways in which practice can foster positive change within the service user: 1) by allowing for increased latitude and flexibility in describing an experience of suffering; 2) by giving the service user the appropriate time to work on himself and work through his personal history; 3) by reconfiguring interpersonal relationships; 4) by allowing service users to take their place in both social and cultural spheres – at their own pace and in their own timeframe (p.91-92). This study of service user narratives in settings that provide alternative mental health services and practice reveals the importance of taking the time to simply listen, but more poignantly it reveals the necessity for a larger, less medicalised definition of what constitutes a therapeutic relationship.

The following three studies (Ridgway, 2001; Jacobson & Curtis, 2001; Mead and Copeland, 2000) discuss recovery and the conceptualisation of recovery. The conclusions indicate that a type of therapeutic relationship, new to traditional service delivery settings, but perhaps already in place in alternative mental health settings fosters recovery. This relationship is characterised by mutual support, empowerment, and partnership. Ridgway (2001) set out to determine whether common patterns exist within the lived experience of recovery in individuals (p.336) and contribute to a more complete conceptual understanding of recovery. She examined user testimonials from before the 1990's (Deegan, 1988; Leete, 1989; Lovejoy, 1982; Unzicker, 1989). Using grounded theory to determine the critical concepts found in recovery, the first person narratives were analysed with a constant comparison methodology. The core narrative that was exposed was a shift in the lives of these 4 individuals from feeling trapped in chronic disability and relegated to a stagnant life situation to a much more complex and dynamic life story that was best understood as a unique ongoing journey (p. 337). Common recovery themes included: the reawakening of hope after despair, breaking through denial and achieving understanding and acceptance, moving from withdrawal to engagement and active participation in life, active coping rather than passive adjustment, moving from alienation to a sense of meaning and purpose, a complex non-linear journey that involves support, and partnership. This position of partnership, Ridgway concludes, is an essential location for practitioners in order to facilitate recovery. Another analysis of service user narratives comes from Jacobson and

Greenley (2001) wherein the participants described recovery as a journey. Like Ridgway (2001) the authors were interested in developing a conceptual model of recovery in order to move forward in developing recovery-oriented services in the State of Wisconsin. Their analysis determined internal and external conditions that together contributed to the process of recovery. Internal conditions included hope, healing, empowerment, and connection. External conditions included an implementation of the principles of human rights, a positive culture of healing and recovery-oriented services. Finally, an article by Mead and Copeland (2000), who are self-described as "consumer leaders" (p. 315) and are executive directors of a peer support centre in the United States explain the meaning and significance of recovery from their own experiences. They list the key facets of recovery as hope, individual responsibility for wellness, education, self-advocacy, and peer support. They conclude by citing the need for mutual support in clinical mental health service settings and discuss the importance of choice and self-responsibility with regards to medication.

2.2.2 Perspectives from policy and practice

The previous section focused on service user accounts of what it means to be 'in recovery' as well as practices that can facilitate the recovery journey. The following section will provide a brief overview of services and system transformations that have taken place in the name of facilitating recovery.

With his 1993 article *Recovery from Mental Illness: The guiding vision of the mental health service system in the 1990's*, William Anthony foretold of recovery-oriented systems even in institutional settings. Service user narratives all point to the need for services and practices that will facilitate recovery. There is evidence through organizational shifts that programs are changing in order to accommodate these services and practices, yet the evidence that these recovery-oriented services and practices are actually being dispensed is lacking. It has been noted that concrete, operational changes in the system are needed in order to foster the development of recovery-oriented practices (O'Connell et al., 2005). Anthony (2000, p.161) outlines essential services needed in a recovery-oriented system as being treatment, crisis intervention, case management, rehabilitation, enrichment,

rights protection, basic support, self-help and wellness/prevention. He also examines certain characteristics or "recovery system standard dimensions" (p.163) that can be used to identify a recovery-oriented system[18] and he points out that "a number of systems are declaring the development of a recovery-oriented system to be their intent" (p.159). These systems include Québec and Canada[19]. However, the MHAP leaves substantial room for interpretation of recovery by individual program managers, stating :

> *"Il n'existe pas un modèle unique qui sous tende le rétablissement, mais des attitudes et valeurs qui donnent espoir aux personnes utilisatrices de services et maximisent leur qualité de vie"*
>
> (Government of Québec, 2005a, p.19).

Le Comité de la santé mentale du Québec commissioned a manuscript to investigate the ways in which service quality is evaluated in Québec from the point of view of service users. The results of this investigation resulted in the book entitled *Repenser la Qualité des services en santé mentale dans la communauté: Changer de perspective* in which the authors (Rodriguez et al., 2006) discuss the relevancy of not confusing a transformation of services, as we are witnessing in the years following the MHAP, with transformations in practice. The evaluation of practice quality was determined with respect to the results expected by service users. Three transversal quality indicators are discussed; these indicators cut through any specific practice approach and go beyond a technical application of interventions. The quality indicators include a) the relationship with the practitioner, including attitudes and behaviors of the practitioner; b) the multiplicity of experiences, including having space to describe and name an experience of suffering in various ways depending on the service users' point of view; c) considering the primordial place of the service users' in treatment application, referring to increasing dialogue and exchange of information with regards to different treatments ranging from ECT to therapy.

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[18] These include but are not limited to: a mission statement that describes recovery as the driving vision, seeking service user and family perspectives for evaluations (rather than relying solely on measured outcomes such as statistics since recovery is difficult to objectively measure), and leaders who reinforce recovery.

[19] In Canada, the Kirby Mental Health Commission (2006) stated that "recovery must be placed at the centre of mental health reform" (p.42)

The MHAP's guiding vision includes encouraging the participation of service users, encouraging social integration and recovery, as well as, recognizing the rights of people with mental health problems to make their own decisions (p.3). When discussing recovery, the MHAP states, *"le plan d'action réaffirme la capacité des personnes de prendre le contrôle de leur vie et de participer activement à la vie en société"* (Government of Québec, 2005a, p.12). Moreover, the Mental Health Commission of Canada (2009), which also notes that recovery is not a cure, but a journey, states that

> "a recovery orientation is founded on the principles of hope, empowerment, choice and responsibility….the objective must be to ensure that people living with mental health problems and illnesses are treated with the same dignity and respect as their fellow citizens and have the opportunity to lead full and meaningful lives in the community, free from discrimination" (p. 8).

Chamberlin (1997) posits "nearly every kind of mental health program claims to 'empower' its clients, yet in practice there have been few operational definitions of the term" (p.43) and as discussed by Farkas (1996), meaning has to be given to the *words* surrounding recovery in order to "provid[e] a comprehensive process that allows consumers to hope for a full life in their community, that takes that hope seriously and then figures out what approaches turn those hopes into a reality" (p.7). Jacobson and Curtis (2000) describe the different examples in the United States to move beyond the superficial re-labelling of services as recovery-oriented. They cite these strategies as including:

> "education, consumer and family involvement, support for consumer operated services, emphasis on relapse prevention and management, incorporation of core planning and advance directives, innovations in contracting and financing mechanisms, definition and measurement of outcomes, review and revision of policies and stigma reduction initiatives" (p. 335)

Both policy makers and practitioners have shown an interest in using the concepts found in the recovery concept to formulate models of care and advance system transformations. Often this is coupled with the impetus to create an efficient system that reduces costs as well as the amount of services available. Health policy, including mental health policy, is becoming increasing results-oriented, with the MSSS developing databases

and tools to measure outcomes of clinical practice. Such databases include information on relapse prevention, prevention of hospitalization, length of time hospitalized, and intensity of follow up. Recovery values such as choice, hope and autonomy are difficult to measure in a results-oriented health and social services system. Several authors discuss the recovery approach as being a process-orientation that is humanistic rather than scientific and is rooted in the personal meaning of experience rather than a diagnosis (Corrigan, 2004; Deegan, 1993; Padilla, 2001 as cited in Bonney and Stickley, 2008; Slade, 2009). Psychiatric literature describes recovery in terms of a biomedical approach stating that "complete recovery [is] the loss of psychotic symptoms and return to the pre-illness level of functioning" (Warner, 2010). This 'clinical' definition of recovery that is also espoused by the aforementioned longitudinal studies (Harding et al., 1984) is reliant on outcome studies that often express recovery as being akin to a cure. The importance of symptom reduction is rooted in a biological causation of mental health and many authors and policies (Canadian Mental Health Commission, 2009; Davidson et al., 2001) discuss the irrelevance of symptom reduction in terms of developing active citizenship and well-being.

With the move towards first line mental health care, the central presence of psychiatry is diminished. However, as stated by Bonney and Stickley (2008) "the drive for a measurable and uniform service could compromise the creativity of individual expression for both workers and people with whom they work" (p.150). These authors believe that even if professionals within the system prescribe to recovery-oriented practice, they will struggle to do so. The reality in Québec is that new mental health policy explicitly states the importance of recovery concurrently with the importance of performance outcome measures. The latter is achieved within an orientation of results-based management, which generally requires a scientific or statistical analysis. The personal process of recovery makes outcomes difficult to measure. Nevertheless, there have been attempts to measure recovery; in a health system that is predicated upon the ability to measure outcome, this can be considered vital. Giffort, Schmook, Woody, Vollendoft and Gervain (1995) developed a 41-item scale called the Recovery Assessment Scale (as cited in Corrigan, Salzer, Ralph, Sangster and Keck, 2004). However, I question the relevancy and practicality of measuring

an individual's personal journey. Harding (1994) as cited in Jacobson and Curtis (2001) states that outcome signifies the end of a journey; this is in opposition to the service user narratives that have helped to conceptualize recovery as a never-ending process that ebbs and flows.

2.3 Social work

In a 2004 document entitled *Psychosocial assessment and the social work profession,* the OPTSQ states that the role of social workers is to "promote the social functioning of individuals, families or communities…[in order to] help them meet their basic needs" (p. 1). More recently, in a reference guide published by the OTSTCFQ[20] following Bill 21[21], the evaluation of social functioning is referred to as the distinctive marker of the social work profession. Nevertheless, the evaluation of social functioning contributes to a practice in mental health that might be too easily persuaded by a still dominant medical approach to focus on a person's basic functioning and symptom reduction as sufficient goals for social work interventions. Following Bill 21, the OTSTCFQ discusses social work's role in the mental health field as:

> *"évaluer le fonctionnement social, déterminer un plan d'intervention et en assurer la mise en œuvre ainsi que soutenir et rétablir le fonctionnement social de la personne en réciprocité avec son milieu dans le but de favoriser le développement optimal de l'être humain en interaction avec son environnement"*
>
> (Loi 21, 2009, p.4 as cited in OTSTCFQ, 2011, p.3).

The OTSTCFQ emphasizes the classic person-in-environment approach in order to provide a global approach to the evaluation as well as a continued consideration for social work values such as self-determination, respect, and autonomy.

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[20] In 2009-2010 the OPTSQ changed its name to the *Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiales du Québec*

[21] Bill 21, also known as the Bill modifying professional codes in the field of mental health and human relations, was adopted on June 28, 2009. It resulted in a new definition for practice for most professions in mental health, including social workers.

According to Healy (2005) social workers construct their practice in an active and ongoing manner, often using theories or conceptual frameworks loosely and in relation to their organizational contexts. In her book *Social Work Theories in Context: Creating Frameworks for Practice*, Karen Healy discusses how each practice interaction on the part of a social worker is unique as it includes a negotiation of both purpose and practice with service users, organizations, families and society. Essentially, social work practices as well as service user needs and goals are constructed and contextually specific. Healy's message is simple:

> "by understanding the ideas that underpin our institutional contexts and formal theory base we can critically use them and, where necessary, change them to achieve the values and goals to which we are committed" (2005, xi).

To illustrate this, Healy has created a model illustrating four elements by which social work practice is constructed: institutional context of practice, formal professional base, framework for practice, and practice purpose. The model is meant to be dynamic, with each element influencing and counter influencing the others. The contextual dynamics affecting social work practice have been discussed for the last several decades in both British and Australian literature (Hawkins, Fook & Ryan, 2001; Scott, 1989). Scott (1989) discusses social work practice as a form of meaning construction in which professionals consider the multiple realities of not only the service user, but also themselves and the organizations in which they work. In other words, it is posited that the ability to construct practices by considering the individual experiences of suffering of each individual is a defining characteristic of social work (p. 40). Hawkins et al. (2001), Healy (2005) and Scott (1989) discuss the construction of meaning in practice whilst considering the professionals' understanding of the organizational context of practice. These authors discuss how theory in practice is nuanced by organizational contexts that create situations in which professionals are facilitated or hindered in their ability to practice from their espoused professional base. The discussion of meaning construction and practice construction is relevant to this research project in the following way: the ways in which first line mental

health practitioners discuss being in recovery and recovery-oriented practice will affect how their interventions are constructed.

2.3.1 Mental health social work

There is much room for interpretation as to a professional's role – especially considering the diverse areas of work available to social workers (hospital, community organization, international, private practice, etc…). As such, the literature does show divergent views and opinions on the question of what a mental health social worker's role is and what her priority should be as well as which approach she should use. A dichotomy has existed within the social work profession since its beginnings. The 'founders' of social work – Jane Adams and Mary Richmond - were focused on community/social justice work and clinical/case management work respectively. In 1900, Mary Richmond disputed the idea that social work's major role should be advocacy, stating that individualized client services is the profession's central mandate (Barker, 1995). These differing perspectives of micro versus macro work, clinical versus community, are still valid today and prominent in mental health social work (McLaughlin, 2002; Corrigan & McCracken, 2005). There are several possible factors that affect how social workers practice within a mental health setting. These may include their roles, tasks and other approaches (ex. psychosocial rehabilitation, psychotherapy) to practice other than biomedical or recovery. In the book entitled *Social Work Practice in Mental Health* edited by KJ Bentley (2001), various social work roles and tasks are discussed such as that of crisis counselor, diagnostician, therapist (using varying approaches such as cognitive behavioral, psychoanalytical, psychodynamic, etc…) and case management (embracing models of empowerment and strengths-based approach). Dorfman (1996) also discusses the multiple roles that mental health social workers can assume, stating, "the nature and number of these roles depends on where a clinician practices, the therapeutic goals, and the client population" (p.41).

Bentley (2003), Johnson (2002), and Takahashi and Turnbull (1994), support the notion that social workers should serve as a resource for physicians, discussing the importance for the clinical social worker to better understand medication in order to support

the physician in the administration of the pharmacological treatment (read: ensure compliance of patients); non-pharmacological treatments are down played and not considered central to treatment. Bentley et al. (2005) discuss the results of a survey they conducted concerning social work roles and activities regarding psychiatric medication. They begin with the assumption that in order for a clinical social worker to have more opportunities in the psychiatric setting they must learn to "serve clients more responsively with regard to medication-related issues" (p.296). They later state the desired changes in standard practice as a:

> "more thorough and in-depth education for social workers about psychiatric medication…more extensive interaction with the medical community…better definition of appropriate role of social work regarding psychiatric medication"(p.297-299).

Takahashi and Turnbull (1994) discuss the importance for social workers to understand psychiatric genetics because "the biochemical abnormalities that result from the presence of defective genes form the basis for psychiatric interventions" (p.2). As such, the authors postulate that if social workers understand these biological underpinnings, they can spare their clients non-pharmacological treatments such as psychotherapy that ignore the fundamental 'biochemical abnormalities'. Bentley, Walsh & Farmer (2005) conducted a quantitative study. The survey they designed was completed by 994 social workers concerning social work roles and activities regarding psychiatric medication. This study assumed that mental health social workers want to take on more responsibility within a biomedical framework and the recommendations given were in that perspective. They note that the social workers surveyed consider themselves to be key players in encouraging a client to see a doctor and to consider or take medication. The authors admitted that the 26% response rate to their questionnaire might be because "some social workers still do not see medication as salient to their work" (p.296). This study did not look directly at the role of the organisational structure in shaping the social workers professional perception, nor did it give consideration to the influence and importance of the organization of work that may keep social workers from renewing their practice toward a recovery orientation. O'Connell et al. (2005) also conducted a quantitative study to "assess the degree to which

recovery-oriented practices were perceived to be implemented in mental health and addiction agencies…" (p.379). The questionnaire used was completed by 967 people; a mix of management, professionals, service users and family and friends of service users. Their findings indicate that the principles of recovery have on the most part not been operationalised into practice (p. 382). The study did not focus on social workers exclusively, nor did it focus exclusively on managers. Moreover, this quantitative study did not seek to understand whether respondents were able to establish recovery-oriented practice or what actions were needed in order to do so.

In contrast, McLaughlin (2002) states that clinical social work has been criticized for its overreliance on the medical model. Cohen (1995), Corrigan & McCraken (2005), and Manning (1999) are a few examples of social work professionals and authors who have discussed the importance of putting the person before the illness and promoting recovery, empowerment and wellness as primordial. They support alternative or even complements to medication such as place-train programs (Coriggan & McCraken, 2005) whose goal is self-determination and recovery by "recognizing an individual's desire for independence and providing in vivo assistance" (p.31). Cohen (1995) discusses client-centered interventions placing an emphasis on the psychosocial. Manning (1999) also discusses the importance of developing an environment in which clients have a voice. She states, "the disease model of care, whereby the provider or 'expert' administers to the patient in a passive role, creates a differential distribution of power between care provider and care receiver" (p.103). Therefore a social worker's role would also be to encourage the client to take an active role in the decisions surrounding his treatment and this requires knowledge of both pharmacological and non-pharmacological treatment options in order to provide fair and complete information to the client. For at least twenty-five years, the literature from Québec has expressed concern and interest with social work's role regarding psychiatry and medication. Cohen (1988) discusses the professional roles that social workers might play[22] in studying the prescription of psychotropic medication. Cohen (1988) reviews the

[22] In fact, he states that social work is "one of the major mental health professions" (p.14).

literature concerning social workers' perceptions of their role with psychiatric medication. He cites the many adverse secondary effects of medication as a point of entry in which social workers may be able to contribute to practice knowledge. This practice knowledge, includes assessment including drug and medication history, assessing and monitoring adverse psychological and social effects of the psychotropic medication, involving patients in treatment planning and disclosing information regarding medication (Cohen, 1988, p.18). The crux of his argument however, is that there is a gap in knowledge regarding the impact that social workers can have by informing patients of possible adverse drug reactions. Cohen (1988) argues that social workers are in a position to assess the impact of this on a patient's social functioning in order to understand human behavior not just from a biological perspective, but from a psychological and social perspective as well. More recently, Gérin (2002) conducted a qualitative study with 10 subjects (social workers in alternative and hospital mental health services) to understand their relationship with the biomedical model in their practice. The study aimed to understand a social worker's relationship with psychiatry and medication and how that affected her perceptions of her clients as well as her own professional role. The findings suggest that social workers in both settings were critical of the biomedical model.

Corin, Bibeau, Martin & Laplante (1990) discuss how problems and solutions can be interpreted in different ways depending on your reference point. They discuss a "system of signs, meaning and action in mental health" (p.115) to determine the way that individual perceptions and interpretations differ and create reactions and therefore actions. The influence of managerial style, administrative procedures, and clinical priorities will likely shape the perception and interpretation of recovery. The result is a particular work organization that will affect what type of interventions are nourished and whether or not the paradigm shift that is fundamental in the recovery orientation reaches front line professionals.

CHAPTER 3 – MENTAL HEALTH POLICY IN QUÉBEC

In order to understand and critique the changes outlined in the MHAP and the other changes (or lack there of) imposed by the State that affect the mental health sector a brief historical overview of mental health care in Québec is necessary. The evolution of the mental health service delivery system in Québec will be reviewed beginning with treatment within the asylum model of care in the 19th century and ending with the development of integrated health service networks and the rise of neoliberalism. In Québec, psychiatry and the mental health system were influenced by three major political and social movements, the first being the *Rapport Bedard* in 1962, followed by the *Politique de sante mentale* in 1989, and most recently the *Plan d'action en sante mentale: la force des liens* (MHAP) in 2005.

3.1 Evolution of traditional treatment contexts in psychiatry

The objective of the first section of the chapter is to place the MHAP into context in order to understand how it was built upon previous policies. This is important because mental health care in Québec has been influenced by several societal and political factors. Boudreau (1984) describes psychiatric care in Québec as being the object of political challenges that shaped the way it is organized and managed today:

> *"Ces courants et contre-courants, ces vagues périodiques d'enthousiasme et d'indifférence en ont modelé et remodelé les structures d'organisation et la matrice de gestion"* (Boudreau, 1984, p.14)

As will be evidenced, caring for people with mental health problems in the 19th century involved the creation of asylums in which they were housed. Following societal movements, scientific experiments, and political changes hospitals created space in order to treat mental health patients. Finally, a wave of deinstitutionalization following econcomic, societal, and political pressures returned mental health patients to the 'community'.

3.1.1 Asylum model of care (1839-1962)

In the asylums, treatment was characterized by mostly involuntary long term hospitalization focused on remedying 'moral disorders'[23] (Paradis, 1993 as cited in Fleury & Grenier, 2004); this contributed to the social exclusion and stigmatization of those labeled as 'crazy', an already marginalized group. This discrimination led to the abusive and inhumane treatment methods[24] used in institutions (read: asylums) that were collectively ignored by most members of society. As of 1801, the Québec government was financing the religious institutions that were caring for the people deemed to have 'moral disorders'. The religious orders constituted the professional care within the health and social services domain until the 1960's in Québec.

In 1953, chlorpromazine was introduced for the treatment of psychosis. The face of psychiatry in North America changed with the introduction of chlorpromazine – earlier discharges, reduction in hospital beds, inauguration of an open-door policy, and a reduction in the more primitive treatments aforementioned (Cancro, 2000; Gérin, 2002; Lopez-Munoz, Alamo, Rubeo & Cuenca, 2003). Some argue that the introduction of such neuroleptics revolutionized psychiatry and made it a true medical field[25] (Lopez-Munoz et al., 1998, p.205); others (Cancro, 2000) agree stating "finally we were like other doctors in that we had a treatment that actually worked" (p.334), but are able to see the continued misapplications of the 'neuroleptic era' mainly in the failure to provide adequate psychosocial services. The discovery of neuroleptics as well as the influx of modernist psychiatrists after World War II who were seeking objective, scientific and universal solutions to mental illness positioned mental illness as a curable disease and therefore pertinent for the medical community.

In Québec, the Quiet Revolution in the 1960's was the social movement that resulted in an increase of governance by civil society. It provided the opportunity for

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[23] Fleury & Grenier (2004, p.39) state that according to Pinel, the appropriate treatment was isolation from the environment that led to the bad habits that in turn caused the moral problems.

[24] The beginning of the 20th century was characterized by insulinotherapy, lobotomies and electroconvulsive therapy (Cancro, 2000) in order to control the patient. In this purely asylum model of care, "the use of physical restraints was pervasive….dignity was in short supply" (Cancro, 2000, p.334).

[25] The current hegemony of the biomedical model is rooted in the research that took place.

different groups to have a voice; mental health patients and their supporters denounced the inhumane treatments they were receiving in the asylums and in society in general. As discussed in Chapter 2, people involved with or affected by mental health issues have historically been frontrunners in influencing public policy; in fact, without a strong, politicized alternative mental health resources movement in Quebec, many policy and practice changes would have never been realized. After a new government was elected in 1960 promising to modernize Quebec society, an ex-psychiatric patient Jean-Charles Pagé wrote a book, *Les fous crient au secours* with a post-face by a prominent modernist psychiatrist, describing the living conditions within the asylum (Gérin, 2002; Fleury & Grenier, 2004; Rodriguez et al., 2006; Wallot, 1988). Society responded to with the *Rapport Bedard* in 1962, which promoted a move away from the asylum model of care; every general hospital was to create 200 beds for psychiatry and psychiatric hospitals were created (Fleury & Grenier, 2004).

3.1.2 Transformation of psychiatric services (1962-1987)

Mental illness was no longer seen as a moral problem but as an illness for which a cure may be provided. The *Rapport Bedard*, and the subsequent "adoption of the concept of community psychiatry" (Rousseau, 1993, p.535), is the first tangible example of the innovations and political strength of the mental health movement in Québec. Notwithstanding, the conception of mental illness continued to be entrenched in a perspective of chronicity. In an effort to rebuild and modernize the State following the Quiet Revolution, the government created several organizational entities. A salient point for social workers was the establishment of para-medical services, such as social services, psychology, and occupational therapy, which saw an increase in personnel of 158% (Boudreau, 1984, p.91). This resulted in the professionalisation, and perhaps even institutionalization[26] of social work in mental health services. The *Rapport Bedard* resulted in a massive wave of deinstitutionalization, which Dorvil (2005) describes as the

[26] The 'management' of social problems such as unemployment, abuse and poverty in a hospital or institutional setting continues to be scrutinized

displacement of patients outside of the hospital and into other resources or onto the streets resulting in a rise in homelessness (p.210). In response to this wave of deinstitutionalization, the decades following the *Rapport Bedard* saw the birth of mental health rights organizations, often through the organized movement of psychiatric survivors who denounced the conception of mental illness as a medical problem to be treated like any other illness[27]. However, Jetté (2005) explains that in the first half of the 1970's the government was unable to rid itself of dehumanizing and bureaucratic characteristics and in fact the dynamic and innovative practice of these citizen led groups was swallowed up by the technocracy of the public system.

The 1980's were significant in that a serious economic recession, coupled with a global conservative political climate, led to many cuts in social and health programs. Québec's unions, mobilized citizens, and attachment to the Welfare State buffered it from some of the effects of these changes; moreover, a resurgence of community groups in the early 1980's responded to the needs of citizens in place of the State. Therefore, many of these groups were in a position to not just critique the existing services, but create their own services. The economic recession which forced the State to tighten its purse strings, the lack of services and support that was the result of a poorly planned deinstitutionalization and the strong critique of the omnipresence of psychiatrists led to decisions in the health sector that resulted in the grass roots creation of crisis centres (Fleury & Grenier, 2004). It was in 1982 that the various alternative mental health resources joined forces to create the *Regroupement des resources alternatives en santé mentale du Québec (RRASMQ)* whose manifesto emphasizes a critical position towards psychiatry, promoting interventions that take into account the whole person, empowerment and self-help (RRASMQ, 1999).

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[27] The ex-psychiatric/survivor movement argued that mental health problems are not caused by a brain illness and that a cure is not the paramount objective. This also has political implications : resolving mental health problems is not the sole responsibility or expertise of an all-powerful medical professional. More recently the Kirby Commission (2006) advised that "treating mental illness like physical illness is best understood to mean that both types of illness must be treated with equal seriousness, by providers, by all Canadians — and particularly by governments" (p.41)

3.1.3 Toward a community partnership (1987-2005)

In 1987, the *Rapport Harnois*[28] served as the basis for official government policy on mental health service organization. The *Politique de Santé Mentale* (1989) was born out of several years of deliberation in which the State recognised that the intended evolution of mental health practice had not taken place; the biomedical perspective at the institutional level being too prevalent to allow for adequate development of services in the community and the neoliberal perspective at the government and societal levels did not support financing the necessary services. The overarching directive of the *Politique de Santé Mentale* was that a biopsychosocial approach was to be favoured. The legacy of this policy is that it recognised the central position of the person with mental health problems; thus mental illness began to be reframed as mental health. It is with this policy the hospital began to lose its centrality in caring for people living with mental health problems. Rousseau (1993) contends that the *Politique* positioned the community resources[29] in a complementary and unfavourable position to the psychiatric resources; Rodriguez et al. (1996, p.45) and Dorvil (2005, p.233) elaborate by pointing out the paradox in the *Politique* which highlights the central place of the service user yet places emphasis on needs evaluations and individualised treatment plans that maintain the power of professionals and institutions. Six years after the policy was established, the government announced that it had not been adequately transformed into action. Echoing the shortfalls of deinstitutionalisation, it had failed in establishing a viable partnership with the community. Service users had not become full participants in the decision making process.

The implementation of integrated services in Québec began in the mid-1990's with the goal of providing more efficient service following the failure of past partnership goals (Fleury, 2002). The idea was that service providers within a specific geographic region

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[28] Dr. Harnois and his team submitted a report entitled *Pour un partenariat élargi,* in which they critiqued the way deinstitutionalization was handled. It stipulated the gross under-funding of community resources and the need for a stronger partnership with the community sector in order to alleviate the State of its responsibility to society as well as a more prominent inclusion of users of the system in decision-making (Gérin, 2002).

[29] Rodriguez et al. (2006) discuss essential services in the commnunity as rights and advocacy ; community support regarding basic rights and needs such as clothing, housing, food ; crisis intervention ; community treatment ; mutual aid (p.190)

would be under the same umbrella of coordination and flexible, mobile multidisciplinary teams would be created (Fleury, 2002; Fleury & Grenier, 2004; Perron, 2005). However, Perron (2005) discusses the potential that this organisational model has to undermine the application of empowerment and recovery models in practice by way of its technocratic approach. In the article entitled *Réseaux intégrées de services en santé mentale et enjeux des pratiques*, Perron (2005) posits that the integrated health service networks may be risky in terms of free choice for the service user and autonomy of the community organisations[30], even though these networks' principle claim is to improve 'community care' and therefore full citizenship of users of the system (p.167-169). Perron (2005) remarks that the management model of continuity of care is very technocratic and rigid and does not consider the subjective experiences of users and their personal trajectory with the service providers. The author questions how the position of an organization, ideologically and institutionally, can colour the conception of empowerment. Her findings indicate that the ideological position of organizations needs to be flexible in order to accommodate the realities of the users (p.64). Rodriguez et al. (2002) posit that the most important aspect of integrated service networks is the intended capacity to respond to the needs of service users by remaining flexible in terms of practice approaches in order to focus on the unique objectives and goals of the service user. Several central aspects of the integrated health services orientation are integral to the more recent transformations in mental health policy and service organisation such as hierarchisation of services, services offered by multi (inter) disciplinary partners, evidence based services/interventions, and the beginnings of shared decision-making.

3.2 The Mental Health Action Plan 2005

Despite the changes from an asylum model of care to community oriented care over the last half century, the ubiquitous power of the psychiatric hospital (read: asylum) is

[30] As with Rousseau (1993), Perron (2005) points to the need for community organizations to remain critical of the traditional system and raises concerns that the technocracy of the public institutions will envelope the alternative, critical, and independent voice of these organizations that are at a 'power' disadvantage relative to the State and the public sphere

illustrated by the way that these political changes can have profound societal effects; the pervasiveness of the medical model and stigmatization linked to mental health problems are disturbingly unwavering despite various political modifications. Notwithstanding increased attention and awareness of mental health issues in society, the policies of the Québec government reflect neoliberal orientations. Thus, programs are structured in a way that costs less. The MHAP's goal to reduce care given in specialized and costly services is evidenced in the strengthening of primary care services. In the second part of this chapter we will review the development of the MHAP, it's major orientations, including recovery, and the potential impact on social work practice as well as the paradox between a recovery-oriented system and a results-oriented system.

3.2.1 Bill 25 - reengineering of the State

In December of 2003, following a period in the late 1990's of budgetary constrictions due to an economic crisis, the Québec government began a major reengineering of the health and social services network. This reengineering included a change in governance from regional boards to regional agencies whose mission is to "ensure the governance of the local health and social services networks in order to improve performance as well as contribute to the health and wellbeing of the population" (Government of Québec, 2010). This was done in the context of modernizing the State using a health services integration model (Perron, 2005, p. 162). Following the adoption of Bill 83 in 2004, the MSSS created 95 CSSS, which offer a range of health and social services (Government of Québec, 2005b). The CSSS, also known as local service networks, are the nucleus of the integrated health service networks, whose explicit goal is to better serve the public. CLSCs, community organizations, medical clinics, non-institutional resources, and university hospital centres offering specialized services are included in the CSSS. It is within the CLSC that the first line mental health teams were created. Partnered

with these local service networks to create an integrated network[31] are specialized institutions such as psychiatric institutions and certain hospital centres that have not yet fused with a CSSS. The 2 principles guiding this reform are those of populational responsibility[32] and hierarchy of services[33].

The CSSS are also responsible for clinical and organizational projects that include organizing a network of mental health services in order to link the orientations of the MHAP with the local needs (Dorvil, 2005). The clinical projects are the means by which the different actors in a local service network work together to respond to the needs of specific clientele. Lariviere (2005) discusses his concerns surrounding these clinical projects - concerns that are relevant for social workers. The author asserts that the clinical projects, whether they are in mental health or another sector of the CSSS, are all too often based on a medical hegemony that too easily overlooks the contributions of a more social assessment of populational needs (p.6). With continued biomedical hegemony in mental health, this assertion is particularly relevant to the roles of social workers and other professionals that dispense psychosocial services in the CSSS.

It is through these clinical projects that the CSSS implemented its first line mental health program with 3 objectives – accessibility, continuity of care and service quality (Government of Québec, 2005a)[34]. Using the framework of the clinical projects, the idea was to create integrated service networks to respond to the diverse needs of people and their families living with mental health problems. This relies on interdependence between different service providers within the local service network (CSSS) and external partners

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[31] Specifically to better service clients with complex or chronic problems, integrated service networks offer a continuum of services to a specific client group that includes an elevated level of intensity of follow up for a substantial period of time

[32] This refers to a responsibility to offer services and programs for people who consult at the local service networks (CSSS) as well as for those who do not consult. Dorvil (2005) describes the populational approach as an approach in with the CSSS are "*chargées d'élaborer et de realiser un plan de services pour les populations de leur territoire avec la collaboration de leurs partenaires*" (p.212). Larivière (2005) stipulates that this designates the importance to improve and not just maintain health and well-being of the population (p.6)

[33] This implies an improvement in complementarity and service integration between front line (1st line) services and specialised (second and third line) services as well as between medical and psychosocial services in order to offer the right service, at the right time, to the right person, by the right professional (Dorvil, 2005, p.212)

[34] This echoes elements outlined by Canada's Kirby Mental Health Commission which stated that mental health reform must include access to a wide range of services that are dispensed at the community level and are integrated to foster a continuity of care (Kirby, 2006 in Fleury, 2008)

and an increased responsibility of service providers to ensure a continuity of care so that organizations are no longer working in a silo. Theoretically, when integration occurs at the clinical level various practice approaches and procedures are coordinated in order to ensure continuity of care and services for people living with mental health problems. This might concern integration with regards to individualised intervention plans, liaison, and case management. Integration is also meant to occur at the administrative level; mechanisms related to governance, management of resources, and evaluation of the system are aligned. At the administrative level this might concern integration with regards to coordination and strategic planning. In the past, the asylum was the sole gateway to services (Fleury and Ouadahi, 2002); with the MHAP, the goal is to create a gateway (*guichet d'acces)* [35] to a plethora of services in order to meet a person's needs. Emphasis is placed on a 'single point of entry' to request services, thereby eliminating duplication of services and ensuring continuity of care (Government of Québec, 2005a, p.37). However, simply ensuring clinical and administrative integration from the position of a manager or administrator does not consider the service users' personal integration of services. Rodriguez et al. (2002) explored how integration of services is achieved in different mental health contexts. Analysis of the discourses of services users and practitioners indicated that contexts in which the service user is given the space to construct and integrate the services that are pertinent him places that person in a central and active role.

3.2.2 The MHAP: the strength of partnerships?

The major impact of the MHAP on the psychiatric hospital is that it will no longer remain the central establishment in the Québec mental health system**.** This shift from second to first line is in part due to historical and cultural elements in which there is no longer a need to be seen by a specialist (psychiatry) as a first course of action. Specifically,

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[35] The *guichet d'acces*, has been described as the core of the 1st line mental health teams. It is the first place where a person who is seeking services will be evaluated by the 1st line mental health team in order to determine whether or not the service offer can respond to that individual's needs and which level of service the person requires - community organization, 1st line mental health team, 2nd line specialized mental health services (Government of Québec, 2008).

> *"le plan d'action détermine quelles sont les niveaux de services qui requièrent des améliorations sur le plan national, afin d'assurer l'accessibilité, la continuité et la qualité des services offerts….Il établit en conséquence des priorités d'action à l'intérieur du continuum de services qui devrait être mise en place"* (Government of Québec, 2005a, p.65)

Dorvil (2005) describes the MHAP as recognition of the capacity of service users to make choices and be active participants in decision making (p.211; Government of Québec, 2005a, p.3) at all levels of mental health care service provision. The goals of the MHAP are to offer the required mental health services in the service user's community and to adopt a model of shared care based on partnership, liaison, and the hierarchisation of services. As with past policies, the MHAP emphasizes the centrality of the person with mental health problems and focuses on 5 directives: recovery; accessibility to local services; continuity of care; partnership between the institutions and community organizations; and efficiency (Dorvil, 2005; Government of Québec, 2005, p.12). In this way, the MHAP echoes the *Rapport Bedard's* attempts to decrease stigmatization by moving care away from the institutions and towards the community. With the new MHAP, the State and the institutions are officially recognizing the concept of recovery[36] following thirty years of criticism from the community sector.

The MHAP's explicit desire for a harmonious partnership with service users, professionals, the medical community, and community resources is supposed to eradicate a fragmented mental health system. This is in line with Anthony's (2000) assertion that fragmented systems that do not help users connect with community resources cannot promote recovery. However, Dorvil (2005) cautions that the "…*pouvoir hospitalier tente et réussit à transférer la discipline asilaire au sein de la société civile dans le contexte désinstitutionnel."* (p. 227) and points to continued hospital (read: biomedical) control over mental health services even in the community.

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[36] "*La priorité qu'il faut accorder au rétablissement de la personne dans sa globalité et au développement de moyens qui lui donneront espoir et faciliteront sa participation active à la vie en société"* (Government of Québec, 2005a, p.11)

3.3 Tensions following the Mental Health Action Plan

The tensions arising from the MHAP are not related exclusively to the MHAP itself, but also to a larger ideology entrenched in economic factors. This results-oriented strategy, focused on performance outcome measures, is ironically the overarching ideology in which the philosophy of recovery, focused on a process, has been articulated.

The rise of these two seemingly opposing orientations can be better understood by examining the emergence of neoliberalism and the links to evidence-based practice. Neoliberalism is the term used to denote the dominant political-economic discourse that has characterized many western governments since the 1980's. It is often typified by its determination to implement certain economic policies, namely, fiscal discipline, public expenditure priorities, tax reform, financial liberalization, appropriate exchange rates, trade liberalization, structural adjustment, privatization, and deregulation. Neoliberalism has been called:

> "the defining political economic paradigm of our lives; it refers to the policies and processes by which a relative handful of private interest is permitted to control as much as possible of social life." (McChesney, 1998, p.7, in the introduction to Noam Chomsky's *Profit over People*).

The current Liberal government formalized a public-private partnership and has passed bills that place a strong emphasis on individuals and community organizations to guarantee social and economic development. The MHAP seems to be in communion with the State's goals of decreased social regulation, responsibilisation, increased efficiency, and a belief in the capability of the private sector.

Furthermore, evidence-based practice approaches came into prominence in the late 1990's at the same time as the aforementioned budget crisis. Simply stated, evidence-based practice refers to interventions that have had proven effects on desired outcome based on empirical research (Gray and MacDonald, 2006). Although there is a need in our public health system to offer a certain standard of care that has been proven to be efficacious, evidence-based practices entrenched in a neoliberal welfare State only consider positivist, objective, and modernist knowledge to be scientific. The prominence of evidence-based

practice is partly due to the neoliberal goals of obtaining cost efficiencies and creating policies and practices that are driven by systematically collected proof (Niessen, Grijseels & Rutten, 2000, p.859).

3.3.1 Financing the transformed mental health system and practice implications

According to the MHAP, funding for health and social services changed in 2003 from a budget per organization that led to several inequalities between the urban and rural centres to a budget per regional centre (*Agence*). The *Agence* receives a budget from the MSSS and is responsible for distributing it to the different organisations in its region. The organisations are therefore accountable to the *Agence*. In addition, the MHAP specifically states that the mental health sector is following the leadership of the MSSS in adopting a results-oriented management model (Government of Québec, 2005a, p.48). The MHAP goes even further stating :

> "*L'atteinte des cibles sera possible dans la mesure ou les différents partenaires et, au premier chef, les professionnels de la santé accepteront de modifier leurs pratiques pour instaurer une véritable culture de travail en réseau axé sur l'atteinte des résultats"* (p.50)

Social work mental health practitioners are encouraged by the strategic entities to renew their practice toward a recovery orientation whilst changing their practice in order to respond to performance outcome measures. The paradox lies in the fact that mental health social workers practice in an era in which two seemingly opposing orientations are being operationalized: objective scientific evidence belies interventions, yet supporting recovery, an unique journey that "relies on first hand experiences as [being] an equally valid source of information" (Davison et al., 2009, p.323) is a major directive in care delivery. As such, the social work mental health professional and her manager must work in a context that requires them to achieve certain statistical results and report them to the system. The way in which these system requirements are interpreted and imposed on the practitioners in first

line mental health teams will influence the role of the practitioner as a facilitator of recovery or as a technocratic agent of control.

The parallel prominence of evidence-based practice at both the strategic and operational levels is influential on social work mental health practice. Trainings that are offered by the CSSS, external supervisors that are hired, and the development of services and practices are executed within an evidence-based framework. Some argue that this reductionist approach is simply inappropriate for social workers because it "represent[s] an unwelcome privileging of apolitical positivism" (Goldstein, 1992 as cited in Gray & MacDonald, 2006, p. 8). People living with mental health problems are faced with a variety of complex issues such as health, poverty, employment, education and stigma. Many evidence-based mental health practices have been critiqued for being simplistic, individualizing, for sustaining power imbalances, and for failing to draw connections between mental health problems and structural inequities (Gray and MacDonald, 2006; Teghtsoonian, 2009). This practice approach coupled with a results orientation requires social work professionals to be accountable and prove to the *Agence* who holds the budgetary envelope that they are indeed being efficient and efficacious.

As illustrated above, the MHAP is not the first political attempt at instituting community or primary care mental health services. Perhaps past failures can be attributed to the lack of funding and resources given to the community sector. Fleury and Grenier (2004) reviewed the literature and highlighted certain contextual conditions necessary to successfully apply reforms, including recognition of the expertise of partners, and interest to collaborate, adequate distribution of power, and common ideologies (p. 50). The fundamental challenge that has been articulated by alternative resources and more recently by researchers in the field is a renewal of practice at the institutional level. The RRASMQ has stated that it is not enough to call for a change in the location of interventions (ie. into the community) but that the essence of mental health practice must be questioned (RRASMQ, 1987 as cited in Rodriguez et al., 2006, p.87). Essentially, a renewal of practice cannot happen just because practitioners are working in a different location.

Changes in practitioner attitudes, perceptions, beliefs and prejudices will be at the heart of a true renewal of practice towards the principles espoused by the recovery model. The MHAP is the policy in Québec that hopes to achieve this renewal. As cited in Fleury & Grenier (2004, p.50), Shortell et al. (1993) note that most of the reforms in our health system do not meet their intended goals because of a lack of clear implementation strategies. Many authors with differing conceptions of recovery agree that it is a concept or process in which a person with mental health problems can recover without professional intervention (Anthony, 2000; Davidson, 2009; O'Connell et al., 2005; Harding et al., 1987) and places importance on the individual's responsibility for his or her recovery journey. Paradoxically, this might be intertwined with results-based management models so that the operationalization of a recovery-oriented service is one that emphasizes short term follow ups, refusing treatment to people who do not show up to appointments (individual responsibility), and approaching each service user in a homogenous way.

CHAPTER 4 – METHODOLOGICAL CONSIDERATIONS

This chapter presents the various dimensions related to methodological considerations. It begins by situating the project and the researcher followed by a presentation of the theoretical aspects related to the research design itself. I will describe the methods used to collect data and also discuss the factors that influenced the process by which results were obtained. This chapter is primordial to the understanding of the different steps taken in this project. I will begin with a discussion on the notion of reflexivity and how it is relevant to the research process. This chapter continues with a detailed presentation and discussion of the research objectives and questions, building on and refining the objectives and quesrions mentioned in Chapter 1 and integrating these with the theoretical and conceptual perspectives reviewed in Chapters 2 and 3. I will continue by presenting the research strategy and design. The chapter concludes with a look at the limits of this project and ethical considerations.

4.1 Reflexivity

When discussing reflexivity, I am referring to an awareness of my relationship with the research study and the influence my experiences and beliefs have had on the research. Moreover, the nonlinear research process itself has shaped the object of inquiry and the subsequent reflections. In both quantitative and qualitative social research studies, data is collected and analyzed in a systematic and rigourous manner (Neuman, 2003). However, the interpretive nature of qualitative research positions the researcher close to the research setting (Brodsky, 2009; Neuman, 2003). Some scholars (Dowling, 2008) discuss the importance of making reflexivity explicit to reveal how it relates to methodological considerations.

My disciplinary background in mental health social work has influenced the design of this study. For several years I practiced social work in a psychiatric hospital, first as an intern and then as a professional. During this time I practiced as a caseworker, liaison agent, and more recently a brief period as a clinical-administrative manager. As a social worker in a psychiatric institution I was perplexed by the ways in which I could fulfill my

profession's social justice mission[37] whilst working in a technocratic and medicalised work environment. My practice was initially informed by anti-oppression social work theory and practice (Dominelli, 2001), which has been described as 'modern critical social work' (Healy, 2005); early on in my career, a colleague introduced me to the concept of recovery. I was increasingly aware of how institutional contexts could facilitate or hinder social work and recovery-oriented practice. It is thus that links began to form between work organization and social worker practice and the influence of our overarching government policies; I was personally challenged by the operationalization of recovery practice and what it meant to my colleagues and myself.

Although I had the capacity to be critical with regards to the structural factors affecting service users as well as my institutional context and my practice perspective, I needed further training in order to bring these analyses together and be a more effective practitioner. Moreover, the attitudes of some colleagues and of the organization was still hostile to the concept of recovery and the fundamental practice changes that were required, even though I sincerely thought that a recovery orientation was an ideal that could be fluidly entrenched in both our practice as well as institutional contexts. Thus, questions surrounding intervention practice in clinical mental health settings led me back to university and toward academia. I re-entered the university milieu as a master's student and had the opportunity to work as a research assistant. These experiences expanded my understanding of social, political, personal, and economic conditions and contexts that influence mental health policy and practice. After years of reflection on what aspect of recovery interested me the most, I realised that my immediate concerns regard the micro-processes of the operationalization of recovery practice. This is no doubt influenced by my academic background in management and a brief professional experience as a middle manager in a psychiatric institution.

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[37] The first purpose and objective of social work according to the CASW as listed on its website is to advance social justice and it lists its first strategic direction as the pursuit of social justice. The Internation Federation of Social Workers (IFSW) also lists human rights and social justice as "fundamental to social work" (2000, para.1)

4.2 Objectives and questions

The main aim of this research project is to explore the development of recovery-oriented practices in first line mental health teams in Québec. As stated in the introduction, the shift to a recovery orientation in policy is done concurrently with an impetus to manage the health care system from a results-oriented perspective. In the context of the mental health reforms outlined in Chapter 3, and of the recent philosophical transformations regarding recovery presented in Chapter 2, there seems to be a de-emphasis on the traditional medical model of care. In addition, there is a formalization of tools, procedures, and a changing work organization that are supposed to be recovery-oriented, thus resulting in a renewal of practice. This study seeks to better identify what and where barriers to an effective paradigm shift lie; that is, whether the MHAP and recovery literature is understood and available, its interpretation, and more provocatively the willingness of managers and social work professionals to develop concrete mechanisms so work organisation[38] fosters recovery-oriented practice. The objectives, and subsequent creation of the interview guide, have evolved over the course of this research project[39]. In a non-linear fashion, and with an on going analytical process, the objectives have been refined in accordance with the emergence of themes, categories and priorities in the interviews. Considering this, the general research objectives are:

1) To develop a better understanding of how a renewal of practice toward recovery can be achieved

2) To determine the impact, if any, that the MHAP and transformation of service delivery has had on social work practice

[38] Work organisation refers to the operationalisation of the directives set out in the MHAP

[39] Initial objectives included : 1) determine whether variations exist in the level of appropriation of new recovery based interventions between social workers and managers in the first line mental health teams; 2) Determine the weight of the organizational framework and its influence on practice; 3) Describe and explain the professional and organisational relationship betweem managers and social workers; 4) Describe how managers and social workers in first line mental health teams are experiencing mental health reforms; 5) Identify management models integrating clinical practice.

3) To investigate the microprocesses of implementing recovery-oriented practice in first line mental health teams, including the roles of both social workers and their managers

4) To explore the coherence between the social work professional value base and the recovery orientation's value base

In order to reach these objectives, managers and social workers from two CSSS were interviewed. Given the emergent nature of this qualitative study, the research questions also evolved and changed during the study. In order to discuss in detail the empirical objectives of this study, I will present the research questions as they relate to four major themes found in the literature review – recovery, mental health policy, work organisation, and social work practice.

4.2.1 The concept of recovery

Although recovery has been conceptualised by many authors, as aforementioned, I am interested in determining how social workers and managers in first line mental health teams perceive and understand the term. I would like to understand how they conceive of recovery – their attitudes and beliefs about services users being in recovery. This is crucial in order to be able to address the first objective of understanding how to renew practice toward a recovery orientation as well as the fourth objective of determining the coherence, or saliency, of recovery for social workers. Hereafter, the term 'participants' will refer to both social workers and managers.

- How do the participants define mental health problems?
- Do the participants believe that service users can recover? How do they define being in recovery?
- Is their recovery discourse compatible with the recovery discourse in the literature?
- How do they apply recovery concepts to their interventions and planning? What are the factors that constrain or facilitate the application of recovery, as they perceive it?
- How are service user needs, satisfaction, and goals assimilated into practice? Do these include working with the community in which users live and assisting them with goals beyond symptom management? What is a 'life project' and how is it determined?
- How are stigma and discrimination reduction a part of practice?

4.2.2 Mental health policy

Recovery is a value-laden orientation; choice, hope and autonomy are difficult to measure in a results-oriented system. Health policies are increasingly results-oriented and the State has developed tools to measure outcomes of clinical practice. I would like to know if the MHAP has had an impact on social work practice in the first line teams; in other words, has the transformation of service delivery resulted in a change in the interventions dispensed. This is important to know because only a renewal of practice will facilitate the recovery journey of a service user, thus actualising the directive of the MHAP to develop a recovery-oriented system.

- What management practices or approaches are favoured in the transformed mental health system?
- What are the performance objectives assigned to managers? What are the challenges of working in a results-based managerial environment?
- How have the overall health reforms influenced or changed social work practice?
- Are interventions in the first line teams different than those in the specialised teams or community organisations?
- Has the MHAP influenced the development of services?
- What is the role of the first line mental health teams with regards to facilitating recovery?

4.2.3 Work organisation

By determining how managers operationalize and develop their teams, I developed a better understanding of team structure, work organisation, and organisational priorities. This will help identify factors related the objective of determining the microprocesses of implementing a recovery orientation in both services and practices as well as determining the role of the manager in facilitating this.

- What are the current tools, or procedures, available to front line social workers and their managers to foster recovery-oriented practice and service delivery?
- What factors, both organisational and professional, facilitate or hinder the operationalization of recovery-oriented practice?
- How do organisations, and particularly direct managers, facilitate social workers in practicing with a recovery orientation? How does work organisation affect social work practice?

- How do participants elaborate their team's mission and service-orientation?
- How is a connection between recovery vision and practice articulated? How do leaders and managers reinforce recovery?
- How are CSSS empowering staff to implement recovery-oriented practice? What tools are they given?
- Is there a hiring process that favours staff with recovery competencies?
- How are non-traditional ideas, activities, and interventions are encouraged?
- What is included in the employee orientation? Is culturally competent training and education offered?
- Describe team structures in terms of size, interdisciplinarity, formal rules and informal rules?

4.2.4 Role of social workers in the change

The fundamental challenge following the dissemination of the Plan has been a renewal of practice at the State institutional level that fosters recovery. The social worker's role and perspective is central to this study. Given that social workers and other front line workers implement policies after they have trickled down various managerial levels, it is often they, along with users, who stumble upon problems with action. Organisational change literature suggests that this change, particularly for staff, requires the organisation to create system changes and empower staff to act on the new vision (Senge, 1990; Kotter, 1995). As discussed by Dupuis (1989) as cited in Corin et al. (1990) organisations are not operating in isolation and therefore not all the power is in managerial hands. Professionals are at the centre of the organisations and will have as much influence in the outcomes of this reorganisation. Thus, clarifying how recovery-oriented language imposed by the MHAP is being operationalised at the front line is important; understanding the role of the organisational context in shaping the social workers' professional perception and the influence and importance of the organization of work is crucial to addressing all five of the aforementioned objectives.

- What are the approaches/orientations used by the first line mental health social workers? What influenced the appropriation of this approach?
- How do the social workers describe their role on their teams? Who assigned the role/tasks to her? How do they describe the role of others on the team, including their managers?
- What is their role as professionals in determining if a service user is 'in recovery'?

- How long has the social worker been practicing? What is her professional experience?
- How do social workers in first line mental health teams construct their practice? How do social workers articulate their purpose (promotion of social functioning or of social cohesion or other?)?
- What are the guiding values for a social worker? Is it compatible with the related recovery discourse?
- Are first line mental health social workers experiencing a renewal of practice rooted in a recovery orientation?

4.3 Research Strategy

Little is known about the factors that promote recovery-oriented practice in Québec first line mental health teams and there are few published examples of how social workers can achieve this renewal. The purpose of this exploratory study is to generate new ideas in order to refine the topic and inform future research design. There is limited information in the literature that investigates how the organisation of work for first line mental health workers affects recovery-oriented practice. A qualitative methodology is valued given that it allows for an intimacy with human experience and "privileges the point of view of social actors in apprehending social realities" (Mayer, Ouellet, St-Jacque, Turcotte et coll., 2000, p.159-160). Given the limited understanding of this phenomenon, exploratory research is most appropriate (Neuman, 2006). The inductive approach of qualitative research will allow the researcher to piece together which variables influence the construction of practice in the first line mental health teams. The interpretive approach of qualitative research will allow the researcher to use an analytical process that will interpret the meanings, values, experience, opinions, and behaviours of the participants. Informal analysis begins with data collection and guided subsequent data collection (Mayer et coll., 2000; Moustakas, 1994); thus the research strategy, as well as the analysis, is not linear. The researcher seeks to observe and interpret meanings in context; it was neither possible nor appropriate to finalize research strategies before data collection had begun (Patton, 1990). This technique allowed me to meet the goal of making explicit the implicit facts, values and beliefs in the institutional documentation and compare and contrast it to what is found in the literature and, most importantly, to the implicit beliefs held by the respondents. I did not consider a

positivist approach and a quantitative methodology because I am not interested in obtaining statistical or standardized information that would provide an overview of a situation. The study is looking at a phenomenon that is in constant movement - the subject of inquiry is not simply the establishment of a recovery orientation but the process by which a recovery orientation is established. In addition I hold the position, unlike positive inquirers, that the information obtained from participants is not external and absolute. Thus it is not discoverable through objective study only. I am seeking an in-depth understanding of the participant's experience in order to be able to question whether mental health reform has achieved a renewal of mental health practice; this understanding and questioning can only be obtained through qualitative methods. This study uses both interpretive and critical perspectives. My initial theoretical professional base of anti-oppressive theory permeates throughout my work as both a social worker and a researcher. I am interested in determining what processes may be keeping participants in reinforcing the status quo, in this case the hegemony of the biomedical model. As discussed by Nurom (2008) a critical orientation questions political, historical, economic and societal structures in order to prompt transformations.

4.3.1 Content analysis

I initially considered using the techniques found in grounded theory to allow me to pinpoint common themes and concepts in the interviews and to examine trends and patterns in the documents. Harvey (2010, p. 44) discusses Creswell's (2007) writings on grounded theory stating that it "enables the researcher to move beyond description and generate theory which can help to explain a social process". Much as Harvey was interested in understanding the process of achieving health and well-being, I am interested in understanding the process of achieving a renewal of social work practice. Moreover, I felt that the process-oriented perspective of recovery merits a process-oriented approach to researching its application. I was particularly interested by Harvey's (2010) deepened understanding of the social justice perspective and her push to find an approach to grounded theory that is sensitive to context and social change. It is in this way that I was

introduced to the methodological approach of constructivist grounded theory based on the writings of Charmaz (2006). Moreover, Harvey states "a constructivist grounded theory methodology is ideally suited to social work, health promotion and interdisciplinary research with a social justice agenda" (p. 47).

Although I originally considered a constructivist grounded theory approach as outlined by Charmaz (2006), after the initial open coding phase I changed the analytical method to a content analysis in order to answer the 'why' questions and identify existing conditions in the process of establishing a recovery orientation from the point of view of participants. Since I am not looking to create a new theory, grounded theory was not pertinent.

4.4 Research Design

The recruitment, data collection, and data analysis steps took place over the course of seven months. The data collection phase took place over the course of four months. The eleven semi-structured interviews lasted between one and two hours, depending on the participant. The recorded interviews (recorded with the informed and free consent of participants as discussed in the following section on ethical considerations) were transcribed verbatim and were made anonymous. Throughout the entire process, memos and journal notes were kept in order to facilitate the analysis and reflect on theories, data, methodological considerations, and content.

4.4.1 Data Collection

- Document analysis to understand the organisational frameworks and the orientations officially held by CSSS, Professional Order of Social Workers, and Quebec Ministry of Health and Social Services. How are each of these instances attempting to integrate recovery?
- Semi-structured interviews using an interview guide based on the research questions and analytical objectives. We have chosen to conduct interviews that will allow us to have an in-depth understanding of the meaning that the respondents give to their

practice and their social realities (Mayer et coll., 2000; Quivy & Van Campenhoudt, 1995). Such semi-structured interview guides were also used by Gérin (2002) to assess social workers perception and approach in psychiatric hospital and alternative settings. Data will be recorded using a recorder, which was described by Patton (1990) as "indispensable" (p. 348). Moreover, it will make it easier for us to focus on the interviews

4.4.2 Sampling

Given the qualitative methodology, the sampling method was non-probabilistic, that is, the sample was not chosen at random (Mayer et coll., 2000). I have chosen snowball sampling; although this method is typically used with populations that are very specific or not well known (Grinnell, 1997 as cited in in Mayer et coll., 2000), I feel it is pertinent for this study because the mental health reforms are recent and because the concept of recovery may not be known or used by respondents. In this way I had access to participants through two entry gates, first through those social workers and managers who are already discussing recovery and trying to bring the concept to the forefront of practice, and secondly through the front line social workers and managers who may be further from the 'rhetoric' of recovery. I understand that the referral process may introduce a strong bias, but I believe it is preferable to intentional sampling, where researcher bias and preconceptions (possibly inaccurate preconceptions) are strong. I also prefer it to accidental sampling for this study, since that technique is favoured in populations that are known to be homogenous and the participants can be accessed easily and conveniently (Statistics Canada, 2006, para. 6-20). In one of the research sites, one manager, with an expressed interest in developing recovery-oriented systems and practices was the key respondent and provided the names of all of the social workers in her team. I interviewed all of the social workers with whom I was able to make contact, as well as, another manager. In the second research site, I contacted the manager through one of the community organisers at that CSSS. At first that manager only felt it was pertinent to provide the names of social workers with experience working with clientele described as having severe and persistent mental health problems.

However, she later provided a few additional names. I interviewed all of the social workers with whom I was able to make contact. It is important to note that in this CSSS I was not provided with the names or the access to all of the social workers in the mental health team.

According to Patton (1990) as cited in Mayer et coll. (2000) there do not exist specific rules or criteria when it comes to the sample size in qualitative research (p.87). Although it is suggested to use the technique of saturation[40], I interviewed eleven participants, as many as I could recruit at the two research sites. This method relied on two or three key informants to refer other potential participants who meet the inclusion criteria; thus it is possible that I did not reach saturation. In line with this technique, I also diversified the sample as much as possible by interviewing both social workers and managers from mental health teams in two CSSS.

4.4.3 Participants

Participants included social workers and managers practicing in first line mental health teams. I targeted the first line mental health teams of two CSSS on the island of Montreal due to their heterogeneity regarding population and proximity to psychiatric specialised services[41]. The first CSSS shares its territory with a psychiatric institute and the second CSSS shares its territory with a general hospital that has a psychiatric unit. Neither the psychiatric institute nor the general hospital is part of the CSSS.

Initially, I required that the participants have at least five years of mental health experience. The Government of Québec released the MHAP in 2005. It would be pertinent to interview participants that have straddled the duration of the implantation of this reform and are able to provide a perspective that is rich and contextualised. However, the reality is that both CSSS had a large number of newer, less experienced staff. Notwithstanding, although some participants only had one to two years of experience in mental health, they all had at least five years experience in the public health and social services system. The

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[40] That is to say the sample size was large enough when we stop obtaining or learning new information from the participants

[41] A study by Rodriguez et al. (2002) showed that organisations with closer ties to psychiatric institutions experienced greater fragmentation

social workers that I interviewed are front line practitioners working with individuals requesting services from the recently formed first line mental health teams. The managers that I interviewed are directly involved in the organisation of work for the practitioners or the implementation of strategies that are a direct result of the requirements found in the MHAP. In addition, one clinical coordinator[42], who is a psychologist by profession, was also interviewed.

4.4.4 Interview Guide

The interview guide was conceived with the objective of being flexible enough for participants to express their viewpoints surrounding five themes related to the research objectives. In order not to lead the participants in their answers, concepts surrounding recovery, mental health policy, and social work practice were discussed without necessarily employing the term recovery. Each of these themes will be discussed in detail thus making links between the literature and theories and the empirical objectives of this project. The questions outlined in section 4.2 were the springboard for the interview guide. These questions were inspired by the literature review and my professional experience and constructed based on the research objectives and questions. This guide was validated and modified following a pre-test interview with a manager/social worker who works in the rehabilitation unit of a psychiatric hospital. Moreover, during the actual data collection, certain questions were excluded due to lack of relevance and others added due to continual analysis and literature reviewing; the process was organic. The interview questions were generally open-ended, allowing the participants to express and elaborate their responses as they saw fit. The final interview guide can be seen in Annex 1.

[42] Although the clinical coordinator does not have an administrative role, this person provides clinical support to the members of the first line mental health team. The clinical coordinator's influence on the clinical direction of the team is important, as this person will support, advise, organise trainings and supervise the practitioners.

4.5 Analysis of Results

Following the interview process and the transcription of all eleven interviews, the analysis of the data began. Mayer et coll. (2000) discuss the data analysis as the researcher's attempt to uncover relationships in the content of the data; in this case, the participant discourses. The data collection and analysis phase were carried out before a formal theoretical framework was defined. As such, although there were some concepts loosely defined for the purposes of the interview guide, I initially read through the data in its entirety in order to allow for the emergence of themes. While reading through I asked critical questions of the data related to recovery and social work practice.

Mayer et coll. (2000) and Neuman (2003) discuss the different steps in coding qualitative data. Before beginning the coding phase of data analysis, I read through all of the transcripts in order to become entrenched in the material and try to understand the responses and how they relate to each other. I took many notes during this phase concerning the many aspects of the participant discourses that were salient to me. Following this phase I began the exhaustive and systematic open coding phase (Peretz, 1998 as cited in Mayer et coll., 2000). Another aspect of this process, as discussed by Mayer et coll. (2000), is placing the concepts, words, and phenomena that emerge from the content into meaningful and critical categories in an attempt to make connections between the categories. I was then able to ask questions about the main problematic and redefine the research questions. The initial open coding phase was inspired by a constructivist grounded coding strategy as detailed by Charmaz (2006). As such, I read through the transcripts without apriori categories or a fixed conceptual framework and allowed for the emergence of themes. This initial coding was tight, line by line coding that I inserted into a margin to the left of the transcripts. I wrote 1-5 word sentences, often word-for-word (Charmaz, 2006; Julien, 2008), as I searched for critical terms, events or themes. Throughout this process I assumed a reflexive stance and was keenly aware of how the analytical process may be affected by my experiences. I realized that my knowledge and particular research areas such as recovery influenced me. Moreover, I was concerned with

the fact that the participant discourses were context dependent. As such, I kept memos that I filed under personal, analytical, or methodological in order to increase awareness of my position and remain alert to other concepts or themes. During the course of the open coding phase I reassessed by research objectives and realized that the most appropriate approach would be content analysis. This approach was also helpful in analyzing the documents that were provided by the two research sites in order to "identify the stated priorities of the organization as well as reveal implicit political perspectives (Julien, 2008, p. 120). Following the open coding phase, a preliminary coding framework was made with notes on possible emergent themes. This was refined and altered after discussions with my research supervisor; an overall structure for the codes was determined. The second step of the coding process was axial coding in which code labels were assigned for themes without a limit as to how many. Some initial code labels included team structure, performance outcome measures, recovery, and professionals. The third phase is called selective coding which "involves scanning data and previous codes" (Neuman, 2003, p. 444). I found that the axial and selective coding phases were dynamic and even while I was writing the results chapters I was continuously making connections between themes and data, adding themes and dropping others, and reorganizing my analysis around core ideas.

During the analysis of the emergent themes, I went back to my interview grill to see which themes and pertinent discourses related to the analytical objectives I had originally outlined. The initial analysis resulted in a description of the two research sites; in other words, the first step was to develop a portrait of each CSSS. However, the objective of this study is not to present a description of each CSSS. What followed was a deeper analysis that allowed for an examination of the role that context plays in the conception of recovery. What will be presented in the following two chapters illustrates how the different conceptions of recovery are influenced by organizational conditions. Within those contexts social workers claim their position as mental health professionals in particular ways. Of course, neither research site typifies in an absolute way a particular context; however, there are clear indications of specific conditions that influence the conceptualization of recovery in first line mental health teams. While writing the results chapter, I included the emergent

themes and also stipulated when they were matching with initial concepts; this allowed for an evaluation of the how my initial research questions and problem statement corresponded with the emerging data. Discussions will include making links between the CSSSs' current work organisation and recovery-oriented practice and will consider which of the current structures and procedures are facilitating, constraining or neither in terms of renewing practice toward a recovery orientation. The goal is not to place one CSSS in stark contrast to one another; the scope of this research cannot be generalized to all mental health teams in Québec.

4.6 Limits

- Through the use of key informants a total of eleven social workers or managers responded to my request for an interview. A more substantial sample may help with generalizing the findings. However, given that the research sites are general, first line mental health teams the transferability of findings to a similar milieu is feasible. Moreover, the varied experience of the 11 participants in the two different research sites allowed for a more in-depth comprehension of the problematic.
- The recovery model in the literature itself calls for a service user perspective at the centre of the value-base. However, I maintain the importance of obtaining a professional perspective since the operationalisaton of recovery requires a congruent meaning base from both the professional and the service user. The service user's voice is beyond the scope of this study, although the I believe it to be the next step in order to determine if and how social work interventions have changed following the strategic and philosophic transformations in the Québec mental health care system.
- The interviews, data collection, coding, and analysis were all conducted by one person, increasing the risk of bias. Mayer et coll. (2000) discuss the importance for a researcher to be vigilant with regards to possible bias that might be introduced in the data collection process (p.62). As aforementioned in section 4.1 on reflexivity, my professional experience as a mental health social worker and manager positions

me as a member of the 'in-group' with respect to the participants in this project. On the one hand, this ensured that the terms and language used during the interviews was not offensive and that it was easily understood. However, data collection and analysis can be influenced by subjective factors. It is important to note that objectivity and neutrality are not associated with qualitative research; thus, researcher subjectivity and influence is a limit of all qualitative research. In order to maintain rigour and validity, I used personal memos that served as a journal of sorts. This allowed me to remain reflexive and limit any potential bias.

4.7 Ethical Considerations

The confidentiality of the participants was maintained. The transcripts were made anonymous and both the written transcript and the recorded verbatim are stored in a secure location for seven years after which they will be destroyed. In order to preserve confidentiality all identifying markers of the participants have been deleted from the verbatim. Furthermore, the female gender is used for all participants to preserve confidentiality. In one research site, two managers and four social workers participated and in the other research site, one manager, one clinical coordinator and 3 social workers participated.

All of the participants signed consent forms (see Annex 2) and they kept a copy of the signed agreement. Thus, the informed and free consent of the social workers and managers that participated in the research project was assured. The goals and context of the study, the reasons why I was asking for first line mental health social workers and managers to participate, the research process as well as the expected completion date of the research project was explained to them. They were also informed that they could end participation in the project at any time. There were no risks to the participants for taking part in the project. The inconvenience lay mostly in the time accorded during their regular work hours to meet with me.

The project was granted an ethics certificate from the University of Montreal as well as the Research Ethics Board at one of the CSSS (Annex 3 and 4). The other CSSS did not require a separate ethics certificate.

CHAPTER 5 – RECOVERY AND THE ORGANISATION OF SERVICES

An analysis of the two research sites indicates a significant complexity and leeway in the operationalization of the MHAP and the way it is interpreted. This analysis has allowed for certain organizational and strategic factors to emerge that influence both social work practice and the understanding of recovery. The analysis of the interviews allowed for the following dimensions to emerge: mechanisms put in place by the MHAP including the contextual aspects related to the development of the first line mental health teams; and the mechanisms in place related to work organization that support recovery oriented practice.

5.1 Mechanisms in place following the MHAP

The 95 CSSS and their respective first line mental health teams in Québec are developing under particular historical and contextual situations. The development of the first line mental health teams in the CSSSs differed according to several factors, such as the existence of a mental health team prior to the MHAP, geographic location, transfers from the second line, and the professional experience of professionals and managers. The CSSS were faced with the task of operationalizing it under conditions specific to their territory, therefore reactions to the MHAP were not homogenous. In order to ascertain how participants are experiencing mental health reform, they responded to questions related to mental health policy and work organisation[43] including: What is your perception of the transformations in mental health policy in Québec? What have been the positive aspects of the reform? What have been the negative aspects? The impression participants have of the MHAP varies depending on their past relationship with specialized mental health (read: psychiatric) services. The following analysis will elaborate on how both managers and social workers located at a CSSS that shares its territory with a psychiatric institute question the way in which the different aspects of the MHAP can come together to optimize its operationalization. Conversley, results indicate that participants in a territory

[43] Work organization refers to the operationalization of the directives set out in the MHAP.

that is partnered with the second line team at a local general hospital seem to be place more emphasis on a positive reorganization of services and further collaboration with partners.

5.1.1 CSSS and psychiatry – the meeting of two cultures

The analysis revealed shared concerns between the two research sites regarding the perceived support from the second line as well as the influence of the second line particularly in relation to the medicalization of mental health care and the loss of a community orientation.

We see that when a CSSS shares a territory with a psychiatric institute, the role of medical staff, and the availability of respondant psychiatrists,[44] is considered pivotal. In this context, close ties with the psychiatric institute influence the need for adequate psychiatric staff and medical support. Parallel to this is the difficulty to integrate and retain psychiatric and front line medical staff:

> *"Je pense que les gestionnaires ont voulu recruter un médecin généraliste et n'ont pas pu. Les psychiatres sont arrivés. Il y en a une qui est arrivée qui, au départ, c'était très intéressant son rôle, parce qu'elle venait aux rencontres d'équipe et pouvait faire des discussions de cas avec nous. Petit à petit, ça s'est un peu amoindri et là elle fait une demi-journée par semaine et elle ne vient plus du tout aux rencontres d'équipe." (SW3)*

Furthermore, an analysis of the interviews reveals that access to mental health care even at the community or first line level can be difficult due to two conditions. The first seems to be a universal requirement elaborated in the MHAP - a client must have a medical referral in order to receive a psychiatric consultation. Given this first constant condition, access to care varies according to the availaibility of medical or psychiatric staff. Thus, professionals working in a CSSS that does not have stable psychiatric availability interpret the MHAP as a badly organized policy:

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[44] In the summary of the MHAP (Government of Québec, 2006, para. 9) the respondant psychiatrist is defined as "*Le psychiatre répondant d'un territoire local est le principal interlocuteur des intervenants de première ligne qui ont besoin de l'avis d'un spécialiste. Le psychiatre répondant devient le mandataire de la 'responsabilité populationnelle' et, à ce titre, il doit établir et maintenir des liens avec les fournisseurs de services de 1religne de son territoire. Selon les situations, il peut aussi offrir des traitement"*

> *"... J'ai une vision très critique sur un aspect de cette réforme. Une des assises premières de la réforme, c'est les médecins de famille. Or, c'est le chaînon manquant de cette affaire. Il y en n'a pas des médecins de famille et je n'ai pas l'impression qu'il y en a de plus en plus. Je ne sais pas si je me trompe, mais j'ai presque l'impression qu'il y en a au contraire de moins en moins. La réforme repose sur la prise en charge des médecins de famille en première ligne des cas de santé mentale. Mais ça n' existe pas cette affaire. […]Même s'il y en avait, on passe à un deuxième palier de problème, des médecins généralistes qui sont confortables avec la santé mentale, qui sont aptes, disponibles, volontaires, motivés pour travailler avec ce type de problématique, je regrette, mais c'est loin d'être la majorité. C'est une minorité, dans ma perception, de médecins de famille qui sont positionnés de cette façon par rapport à la santé mentale. Disons que ça complique un peu les prises en charge et un suivi adéquat, de qualité." (SW1)*

> *"il y a peut-être des conditions que le Ministère avait promis et qui n'étaient pas là et qui des fois, nous font faire de la face si veux. Par exemple, le psychiatre répondant, ça fait à peu près un an et demi que ça doit être au rendez-vous et ça n'y est pas."(M2)*

We see that the uneven distribution of resources leads to an interpretation of the MHAP as a policy that is lacking a solid foundation, as medical referrals are required to access a psychiatric consultation; the wait for a psychiatric consultation in the first line can be long. Thus, the availability of not only responding psychiatrists but of family doctors is essential. Nevertheless, we see that a lack of fluidity in the relationship with the psychiatric team results in frustration and delays in access to services, especially for CSSSs that do not yet have a stable schedule with respondant psychiatrists. The presence of doctors on the team seems to be a source of assistance to the professionals. In fact, one respondant (SW3) discussed the lack of a family doctor on the team and the waining availability of a psychiatrist as reducing the team's ability to respond to the requests from referring doctors and the clients.

> *"GPs are asking for psychiatric consults and we want them to first try themselves because what is happening is that, since the [second line] is not taking any clients at all, the first line is getting engorged, there are a lot of waiting list, especially for psychiatric evaluations, about 6 months" (SW2)*

Paradoxically, we see that social workers in a first line mental health team that shares a territory with a psychiatric institute feel that their work is more medicalised despite the lack of medical staff[45]:

> *"Je trouve que c'est certainement pas moins médicalisé. Des fois, j'ai l'impression que ça l'est plus que jamais"(SW1)*

> *"Je pense que c'est vraiment le modèle médical qui prime." (SW3)*

In contrast, we see that when a CSSS has a strong and equal partnership with the second line and the availability of responding psychiatrists, the question of supporting the staff with regards to medication or psychiatric consultation becomes moot. In this context, participants did not discuss contraints to practice as relating to medical staff. In fact, the participants rarely initiated the discussions surrounding medical personnel:

> *"La personne arrive au guichet. Elle n'a pas de médecin traitant mettons. Parce que c'est sûr que pour l'accès en psychiatrie, ça prend toujours une référence médicale. On ne se sauve pas de ça. Mais dans notre guichet, on a aussi un psychiatre qui vient deux demi-journées par semaine et aussi, on a un médecin généraliste qui vient deux demi-journées par semaine, donc il peut nous dépanner quand on n'a pas de médecin." (M3)*

> *"Dans le plan d'action, ils parlent d'instaurer des psychiatres répondants dans les équipes. Ici, on en a un. On a un psychiatre répondant qui est super fin et qu'on peut consulter régulièrement dans des cas pour dénouer des impasses. Il peut même faire l'intervention avec nous pour dénouer des impasses" (SW6)*

In order to respond to client needs, one social worker (SW6) described an example in which she consults the responding psychiatrist, who is from the second line, in order to bypass a psychiatric evaluation with the client and save time. Thus, the social worker is assisted in her practice and is able to meet the administrative constraints related to time and accessibility. However, this mode of functioning may maintain the perception of clinet problems and subsequent interventions within the limits of diagnostic labelling:

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[45] This point is elaborated in Chapter 6 – Recovery and social work practice

"Je l'ai consulté récemment pour une dame que je suivais pour une dépression et qui avait un médecin aussi au CLSC. À un moment donné, il y a une petite rechute à la dépression, c'est l'hiver, il ne fait pas beau. Le médecin a fait une référence pour une consultation psychiatrique, parce qu'il se disait, est-ce qu'il y a un trouble bipolaire pour qu'il y ait des sauts d'humeur. La référence psychiatrique s'est retrouvée ici, alors on m'a dit que plutôt que de faire voir la madame par le psychiatre, ce qui va être long, parles-en au psychiatre de ce cas-là et voit un peu s'il juge pertinent de la rencontrer ou non. J'ai parlé de la cliente au psychiatre pour voir s'il pensait qu'elle avait un trouble bipolaire, de personnalité. Ça m'a beaucoup aidée de pouvoir lui parler. Il a dit, ben non, il n'y a pas de trouble bipolaire. On ne devient pas bipolaire à 55 ans. Avec une intervention, ça devrait l'aider. Il a appelé le médecin pour dire qu'il lui avait parlé et que, dans quelques mois, si ça n'allait pas mieux, il la rencontrerait. Ça a permis à tout le monde d'économiser du temps. J'ai vu la madame à matin, je lui ai dit ça et elle était toute contente".

The interviews suggest that the first line mental health teams remain a medicalised and quasi-institutional environment; several social workers at both sites expressed concern that the team was losing its community focus following the re-engineering of the health and social services system. Both managers (M2) and social workers (SW1, SW4, SW6, SW7), discussed the loss of humanity due to the large size of the CSSS and the subsequent tight performance controls needed to manage such a large organization. The sentiment that the CSSS has lost the proximity with the community and the feeling of working in a large technocratic machine was pervasive in the interviews:

"[…] Avant, c'était des centres locaux de services communautaires et là […] c'est des grosses machines. Ça fait hiérarchique. Les intervenants, on trouve ça [bien] dur d'avoir perdu la proximité" (SW6)

"C'est pas des besoins locaux. C'est des besoins qui sont définis par le Ministère. Est-ce qu'on va faire par exemple une recherche, un TS va arriver en réunion, j'ai l'impression qu'on a tel type de problématique ici à Lachine, on va faire une petite recherche s'il a vraiment un besoin à ce niveau-là, on va mettre quelque chose sur pied. Autrefois, il y avait beaucoup cette approche-là dans les CLSC et dans les quartiers, mais aujourd'hui, si la problématique que tu identifies rentre pas dans le temps du Ministère, oublie-ça, tu seras pas encouragé à aller plus loin et à mettre sur pied quelque chose là-dessus. Et tu auras pas de budget" (SW1)

> *"Reste qu'on est quand même une institution assez grosse. On a l'impression que, des fois, le communautaire est loin et j'imagine que le communautaire, c'est la même chose. Ils trouvent qu'on est loin." (SW5)*

We also note that a distancing from the CLSC community based model can be intertwined with an increased sentiment of medicalization, and even psychiatrization, of mental health problems. The relevance of this for social work practice will be discussed in the following chapter.

> *"Il y a eu quand même quelque chose d'important, c'est qu'avant ça, on était dans le CLSC, juste la bâtisse adjacente ici. On était au premier étage du côté des services courants médicaux. […] On avait l'impression de faire partie du CLSC à ce moment-là, parce que c'était la même salle d'attente que services courants ou services jeunesse. C'était quand même un contexte différent. Tandis que là, les choses qu'on trouve quand même significative, c'est qu'on a pris les locaux de l'ex clinique externe [du l'institut psychiatrique]. On trouve qu'au plan symbolique, ça a quand même une signification parce qu'on a souvent l'impression qu'on est devenus l'externe du [l'institut psychaitrique] mais première ligne." (SW3)*

The two social workers (SW3, SW4) that previously worked in a CLSC setting feel that the first line mental health team is medicalised and an extension of the psychiatric team. However, the two social workers (SW1, SW2) that were transferred from the psychiatric team have different concerns. They both feel that more support is needed from the second line. We see that previous experience in psychiatry leads to a conception of mental health care that is solidly anchored in professional and medical intervention, contrary to the recovery paradigms that have been reviewed in the literature:

> ***"****they are transferring to the first line and it is getting overloaded and we are not getting any support from the [second line]. I'll say it. "(SW2)*

> *"[…] C'est comme si on voulait mettre la psychiatrie de côté. On ne peut pas travailler en santé mentale sans avoir un apport psychiatrique" (SW1)*

It is evident from the analysis of the interviews that the professional location of the social worker or manager, that is to say, their previous experience, approach and training, affects their conception of first line care, mental health, and recovery-oriented practice.

The following section will discuss the influence that transfers and hiring of personnel can have on the first line mental health team and social work practice.

5.1.2 Transfer of professionals and of money

The transfer of resources from the specialized mental health teams to the CSSS in order to create the first line mental health teams differed according to territory. Some CSSS received transfers of personnel and patients, whilst others received transfers of funds as positions were closed in the specialized teams. It is important to note that at the time of the interviews between November 2010 and January 2011 neither CSSS had yet attained their maximum level of development.

In accordance with the MSSS's documentation concerning the orientations to be taken when organizing care and services in the first line mental health team (Government of Québec, 2011) the CSSS count social workers as a large part of their first line mental health team:

> *" On a dans l'équipe des travailleurs sociaux. La plus grande masse, c'est des travailleurs sociaux et psychologues" (M1)*

> *"On est de toute façon dans l'équipe ici, en nombre, je dirais qu'on est quand même plusieurs travailleuses sociales." (SW3)*

We find that when CSSS received transfers of money rather than receiving transfers of personnel, they were also able to then hire new practitioners, often made up of professionals with previous CLSC (read: community) experience.

> *"Il y a eu le transfert d'argent. Une enveloppe plus que des personnes. Mais ça voulait dire quand même des coupures de postes et de lits. Des postes non-remplacés, dans le sens que la personne part à la retraite ou quitte, on ne remplace pas le poste. On a fermé des lits. C'est comme ça que ça a été des transferts d'argent plutôt que de personnes." (M3)*

Conversley, we find that when CSSS received transfers of personnel and patients following the reform, the management of the two different work cultures becomes primordial for the manager, perhaps even trumping the imperative to develop recovery-oriented services and practices:

> *"il y a toujours le reflexe professionnel de tous les professionnels [de la psychiatrie] ou d'ailleurs, des gens qui était ici avant son rôle d'expert par rapport à décider pour tout le monde tout le temps. Il y a une culture là-dessus ça c'est clair, la culture n'est pas disparu. Mais je pense que autant [de la psychiatrie] comme les autres personnes, parce qu'il y avait aussi une culture de CLSC qui était plus ouverte sur la communauté. […] il y a quand même une mélange des différents choses par rapport à tous les intervenants, […] des fois une faiblesse est compensé par….des fois tu voit la force de tel culture par rapport à l'autre » (M1)*

In both CSSS the managers expressed the need to hire more professionals to complete their teams. We also note that the CSSS that already had a functional mental health team prior to the reforms are currently more mature in terms of development, training, and size. This is important since the ability to develop recovery-oriented services and hire staff that is open to renewing practice toward a recovery orientation rests on the foundation of having a complete team; in other words, having a complete team makes it easier to organize services. The reasons cited for this were both political and financial:

> *"…j'ai de la misère à faire mon recrutement. […] On est allés voir à [CSSS x] et [CSSS y]. On se questionne [sur nos services]. Quand tu as ta grosse équipe, c'est plus facile de [developper des services], mais quand tu as des bouts d'équipe[…]On peut toujours faire des pressions, mais si [l'Agence] ne me les donnent pas [l'argent pour] mes 6.3 postes, parce que quelqu'un [doit] payer [pour les postes] si on paie nos psychiatres répondants." (M2)*

The managers interviewed discussed privileging individuals with a recovery orientation when hiring. In order to evaluate candidates for selection, the managers described looking for passion and knowledge of the mental health field. It seems that passion and values that include hope and empowerment be considered alongside scientific knowledge (such as DSM or evidence-based interventions) or professional experience when selecting a candidate:

> *"[…] j'ai un bon exemple d'un travailleur social que j'ai embauché récemment, qui n'a pas beaucoup d'expérience, qui a travaillé dans des organismes communautaires, mais un beau jeune, passionné par ce qu'il fait. J'étais impressionnée parce qu'aux questions d'entrevues, il a vraiment intégré le rétablissement. J'ai dit c'est merveilleux que vous croyiez dans le pouvoir du client comme ça" (M2)*

> *"[…] quand j'embauche un jeune professionnel, je veux quand même qu'il ait des connaissances de base minimales en santé mentale. Je veux quand même aussi qu'il ait une ouverture d'esprit, la croyance aussi dans la capacité du client de se rétablir, qu'il soit capable de travailler en équipe. Idéalement, j'aime mieux s'il a fait au moins un stage en santé mentale, en tout cas quelque chose de base." (M3)*

Although union constraints with regards to hiring professionals is not necessarily present, a written test to ensure hiring based on competency within a unionized system is sometimes used:

> *"…ils sont engagés au CSSS. Ils peuvent être engagés au service à domicile. Ils font partie du CSSS, ils ont le droit d'appliquer en santé mentale. Il n'y a plus d'entrevues à cette étape-là, mais ils ont un test spécifique à la santé mentale. Il faut quand même qu'ils soient capables d'écrire sur des vignettes, répondre à des questions de psychopathologie […] Le test, il faut quand même le traverser." (CC1)*

This test, along with other hiring tools such as an interview guide, are regulated by the managers in charge of hiring. One component that is essential in order for the team to be composed of professionals that share a recovery orientation is the conception of recovery held by the managers. An interview guide or written test that focuses on psychopathology, medication, and the DSM and ignores competencies that are more value-based such as a focus on the person, empowerment, strengths, and on understanding the personal meaning that clients have of distressing situations[46] will result in hiring staff with diagnostical abilities that remain entrenched in the hegemony of psychopathology and the related hegemony of scientific (read: evidence-based) practice and knowledge.

5.1.3 Service offer

There are some pivotal differences in the organization of the guichet in the two CSSSs. The interview questions with regards to service organisation included: How were services organized prior to the reform and how are they organized now? Were services

[46] adapted from Slade, M. (2009)

accessible prior to the reforms and are they accessible now? Describe the typical pathway a service user will take to access services. The objective was to identify the accessibility of services, the roles of different partners, and identify how and if directives of the MHAP such as accessibility, hierarchy of services, and populational approach were understood and implemented. The responses indicate divergent perceptions and levels of satisfaction with the service offers based on how the guichet was developed and is maintained.

The maturity of the two CSSSs has resulted in different service offers (at the time of the interviews). Along with managers and a professional team composed of social workers, psychologists, nurses as well as occupational therapists and nutritionists, the first line mental health teams include a clinical coordinator who has a pivotal role regarding the clinical management of the team. Both CSSS that participated in this project have as a clinical coordinator a psychologist with work experience at a psychiatric institute. This person is usually responsible for developing the service offer. The clinical coordinator supports the clinicians, manages the waiting list, and ensures that requests are properly oriented and distributed. The clinical coordinator has two major roles according to the participants interviewed. The first is evaluation and orientation of new requests and the second is support for clinicians. The first role is discussed mostly with respect to reducing waiting lists, a quantitative measure:

> *"Les changements qu'on a commencé à faire, on a fait une liste d'attente…De plus en plus, l'évaluation du guichet d'accès et l'implication accrue de la coordonnatrice professionnelle à cette tâche-là…" (M1)*

> *"And how it worked here before the coordinator was hired was with a cartable. People on the waiting list were put in the cartable and whenever an intervenant felt like it would go and take one. Some people were doing triaging trying to take cases that were less work. But now with the coordinator she cleaned all that. Every 2 weeks she assigns cases...she is a psychologist here" (SW2)*

The clinical coordinator that participated in this project also describes the role in terms of ensuring smooth functioning of the *guichet d'accès*[47]:

> *"Je reçois, je lis toutes les demandes qui arrivent à l'équipe santé mentale, au guichet d'accès, pour m'assurer que c'est recevable. Après, c'est les intervenants du guichet d'accès qui le traite et qui, dépendamment de l'orientation qu'ils décident, orientent dans les équipes de soin dans l'équipe santé mentale. Et là, je relis les demandes que le guichet m'envoie, pour voir dans quelle sous-équipe je l'envoie. J'attribue à tel ou tel intervenant les cas." (CC1)*

At the time of the interviews, the two participating CSSS had a very different organisational structure. The differences in the organizational structures and organigrams that are currently in place in the two CSSS that participated in this study are striking and can be viewed in Annex 5 and 6. One way that a CSSS can organise its services is to create speciality sub-teams or continuums each with a particular service offer. Access to the continuum is based on the problematic faced by the client. These continuums are meant to be flexible and interrelated :

> *"on a trois continuums qu'on a appelés les troubles affectifs, les troubles relationnels et les troubles sévères. Les professionnels donc sont divisés en sous-équipes, mais n'ont pas nécessairement dans leur case load simplement une clientèle… Quelqu'un qui a une majeure en troubles affectifs n'a pas nécessairement juste des personnes déprimées ou anxieuses ou quelqu'un qui est aux troubles relationnels n'a pas juste des personnes qui ont des troubles relationnels. Les cases load peuvent un peu varier, mais ils ont une majeure dans ce continuum-là." (M3)*

We can see that teams that are not divided by a continuum currently have a more rigid service offer, although practitioners are able to claim a certain room to manouver within the structure :

> *"Un moment donné, il faut penser qu'une intervention est terminée…donc pour les clients avec des troubles transitoires ont va penser à les offrir des services avec une durée limitée, 12-15 rencontres. Après ça, on a quand même un volume qui va probablement augmenter des personnes avec des*

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[47] The '*guichet*' is the place where requests are received, evaluated and oriented. It will be further discussed later in this Chapter

> *troubles psychotiques à qui on offre un suivi à intensité variable. Et aussi on a une masse au niveau des troubles de la personnalité. Ils ont fait des changements au niveau [de la deuxième ligne] ou éventuellement les services pour les troubles de personnalité vont changer donc éventuellement nous allons offrir plus pour ça, mais on ne va pas s'attarder là-dessus pour cette année. Donc ces les trois segments principaux" (M1)*

> *"…je pense que malgré certaines directives qu'on a avec le nouveau plan d'action, on peut s'arranger aussi, pas nécessairement faire tout au pied de la lettre. Je pense qu'on peut répondre à des gens qui ont peut-être besoin sur une longue période, mais selon différentes intensités, et c'est un peu ça qui se dessine présentement." (SW4)*

Some social workers claimed to feel increased professional confidence and competency when part of a speciality team:

> *"Il y a certains endroits où, en santé mentale, ça continue d'être un niveau très généraliste, d'être des bons cliniciens, des bons évaluateurs, des bons thérapeutes, peu importe les cas. Nous ici, on l'a vraiment spécialisé un peu plus. On n'a pas les moyens de la deuxième ligne, et on n'est pas des cliniciens chercheurs dans tous ces domaines-là, mais on a une longueur d'avance pratique, à force de côtoyer les mêmes patients, sans faire des longues recherches ou des stages, ils arrivent à se spécialiser cliniquement, de façon pragmatique, alors que le rôle de la deuxième ligne, c'est de spécialiser de façon scientifique…" (CC1)*

Nevertheless, a team divided into continuums, regardless of the claimed flexibility, risks labeling both clients and professionals. The focus on training clinical specialists in the first line may be an indication of the pervasiveness of diagnostic criteria in order to provide treatment. Thus, the development of professional 'experts' or specialists may risk a continued marginalization of people living with mental health problems who are "experts by experience" (Slade, 2009). This sentiment was echoed by one social worker:

> *"Est-ce que les [clients] ont tant besoin de spécialistes que ça? On se fait souvent dire, 'vous êtes des spécialistes en santé mentale'. Ça me chicote un peu, parce qu'on n'a pas tant besoin de spécialistes, je crois. On a besoin de généralistes. Je ne suis pas parfaite, je ne peux pas tout faire, mais je me vois comme généraliste et fière de l'être." (SW6)*

The clinical specialisation of the first line as well as the continued 'scientification'[48] of specialised services may well be paradoxical movements in a would-be recovery-oriented system that is service user led and considers the user or professional narrative as evidence of good practice.

The division of the team by continuums resulted in the implementation of a variable intensity follow up[49] in its severe and persistent continuum, which is described as follows:

> *"On […] voit [les clients] d'une fois par semaine ou deux et ça peut aller jusqu'à une fois aux trois semaines ou au mois…En théorie, c'est ça. Le suivi d'intensité variable c'est à domicile essentiellement. Nous, dans les faits, ce n'est pas tout à fait ça. Dans les faits, on a cette clientèle-là, mais on en a d'autres. On va à domicile, mais on fait aussi beaucoup de rencontres au CLSC parce que les gens sont souvent capables de venir. C'est aussi thérapeutique pour eux de se mobiliser à venir. C'est ce qui est différent. On fait quand même beaucoup d'intervention au CLSC." (SW6)*

Although seeing clients in their milieu de vie is encouraged in the severe and persistent continuum, it must be justified in the other continuums as stated by a social worker in the relational continuum:

> *"Je pense que ça serait vraiment questionné, à savoir effectivement le fondement clinique pour offrir ce service-là, mais oui, je pense que ça pourrait être fait" (SW5)*

One of the managers explains a potential reason as to why flexibility has seemingly been stifled since the reforms:

> *"les déplacements mettons plus dans le milieu de vie, il n'y en a pas énormément…ceux qui étaient du CLSC avant travaillent beaucoup de cette façon-là...Mais c'est une réalité avec laquelle il faut vivre et qui est un manque du système, parce que dans notre système de statistiques, c'est sur que les déplacements ne sont pas tenus en compte et tout ça" (M1)*

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[48] I am referring to the focus on objective, positivist, evidence-based practice and research

[49] According to the *Agence de la santé et des services sociaux de Montréal*, the variable intensity follow up in the community is a service dispensed by the CSSS in which interventions take place outside of the institutional setting (at home, school, work, park, etc..). The *Agence* states that 2-7 interventions per month are the benchmark for this kind of follow up. The number of interventions depends on the client's needs and level of autonomy (Government of Québec, 2009, p. 6)

The interviews demonstrate that in the current political context in which the reforms have taken place, a results-oriented management style is influencing work organisation and subsequent practice.

5.1.4 Performance outcome measures and management agreements

The imperative to gather statistical measures and meet the demands of the management agreements set forth by the *Agence* was omnipresent in the interviews at both sites. There are certain quantitative outcome measures that cannot be circumvented by the first line mental health teams. Managers must ensure that their professionals see at least 4 clients a day and open and close 60 new files a year in order to meet the requirements to receive budget renewal.

Analysis of the interviews with managers reveals a preoccupation with the performance outcome measures that they need to provide.

> *«…moi la façon dont je le vois, c'est un rendement de l'équipe, tu comprends? Alors, c'est le rendement de l'équipe par rapport aux indicateurs ... Ça se peut que dans un mois, un intervenant qui a une charge de cas plus lourde au niveau de l'investissement en temps, c'est correct. L'autre, elle en a moins, et la moyenne des deux va donner un rendement." (M1)*

> *"…de 2005 à 2010, il y a une pression qu'on avait peut-être moins avant, mais que je respecte et que je trouve tout à fait correcte, au niveau des agences. On est imputable. On reçoit des ressources et on a un certain nombre d'usagers à voir et un nombre d'interventions à avoir en fonction des heures travaillées. C'est une […] réalité que moi-même… J'y crois, mais là où la marche est haute, c'est que ce discours-là n'est pas intégré chez les intervenants. On a des listes d'attente." (M2)*

In addition, when the purpose and role of the performance outcome measures are not properly moderated a disconnect can occur between management and professionals:

> *"Il y a une espèce de révolte où les gens vont te dire, nous on touche à la douleur, on ne peut pas donner des chiffres comme ça…" (M2)*

All managers agreed that client needs are more important that statistical requirements, although this might only be translated into practice when the manager acts as

a protection or buffer between the professionals and the statistical requirements of the *Agence* and MSSS :

> *"[…]Si les besoins continuent et qu'ils sont là, on va jamais arrêter nécessairement de donner des services à quelqu'un. Ou la personne peut revenir même si le dossier est fermé." (M1)*

> *"Par exemple, on ne va pas dire qu'après 10 entrevues, tu dois fermer ton dossier. On ne parle pas de même." (M3)*

When the managers do not take on the role of 'buffer', professionals seem to be more stressed and preoccupied with statistics. An analysis of the interviews with the social workers in this situation indicates that they are answering to the needs of the *Agence* above the needs of their clients:

> *"[C'est] une approche qui est gestionnaire. La réingénierie de l'État, on la voit maintenant. […] Je ne sens pas la préoccupation humaine, sans un soucis de gestion point à la ligne. Et l'humanisme, on le voit pas là-dedans" (SW1)*

> *"[…] aider des gens, je comprends qu'il y a un certain minimum de performance à donner, c'est tout à fait normal. Mais de là à focuser que sur ça, j'en peux plus. C'est pas pour ça que je suis allée en travail social. Aider les gens, ce n'est pas une question de performance." (SW4)*

The following interview extract from a social worker describes a form (Annex 7) that is called the Client Committment Form, again implicating the management agreements and illustrating the heavy hand of the administrative body, the *Agence* :

> ***"****C'est un formulaire d'engagement avec le client, parce que ce qu'ils ont commencé à relever, c'est le nombre de rendez-vous manqués. C'est très dérangeant pour nous. […] c'est un style de gestion axé sur les résultats et les données probantes. Il faut voir que c'est ça. Il vient de l'Agence. Ça a diminué un peu, mais à un moment donné, c'était constant. Les pressions […] de l'agence, on n'était pas performant, etc. Ça les inquiète. Ce formulaire-là est arrivé un peu… On a commencé à [comptabiliser] les rendez-vous manqués, les rendez-vous annulés. C'est cadré, oui et non…il y a ça, l'engagement du client, qui parle un peu du cadre et qu'il faut qu'il se responsabilise et se mobilise"(SW3)*

Both managers and social workers described feeling at odds with the CSSS's position toward the *Agence* and feeling that the results-oriented system is not adapted to what is supposed to be a new practice reality:

> *"Ici, je sens qu'on est plus au service de l'agence que l'inverse. Je considère que l'agence, je suis son client, alors qu'ici, quand on a une commande de l'agence, c'est comme en politique…pour chaque poste qui m'est accordé, chaque personne doit voir au moins 60 clients par année. 60 nouveaux clients. Ça, c'était durant la période de transition. C'est vraiment un calcul mathématique qui est dur pour les gens de comprendre. Au niveau du CSSS, des heures travaillées, ils calculent le nombre d'heures travaillées en fonction du nombre d'interventions qu'il y a eu. On cible une statistique. […] Aussi, le système n'est peut-être pas adapté pour répondre aux nouvelles réalités, alors des fois, c'est frustrant. Comme quand tu fais des activités hors site dans les cabinets de médecins, tu ne peux pas nécessairement les [comptabiliser]." (M2)*

> *"On sent une grande pression. Je prends conscience beaucoup de ça cette année. Avant, j'étais dans le plan d'action, dans la réforme santé mentale. Je n'ai pas vu venir du tout l'aspect réingénierie de l'État. Ça, je ne l'avais pas vu. Et là, je le vois. On sent la pression, on nous en parle. La pression de l'agence ou ministérielle sur la gestion des services, sur le mode de gestion des services. On sent que c'est très très clair maintenant que les directives viennent d'en haut. Elles ne sont pas discutables, elles ne sont pas discutées non plus. On nous informe et il faut que ça passe par là. C'est sur toutes les modalités statistiques, les cibles statistiques, toutes ces choses-là. Ça couvre à un peu près tous les aspects du travail sont rejoints par ça d'une manière ou d'une autre tôt ou tard." (SW1)*

However, when the CSSS seemed to be more in control of the negotiations with the *Agence* it was due to the way the results orientation and the management agreements were understood and interpreted to the professionals by the managers. Although most social workers acknowledged the problems with imposing administrative analyses on psychosocial interventions, an analysis of the interviews indicates priorities that do not exclude quality from quantity. Both managers and social workers seem to be satisfied by this balance. Statistics are discussed in a manner that indicates the team's suppleness in this regard.

> *"des fois, les gens vont dire, j'ai peur que la boss vienne me voir pour me dire que mes statistiques ne sont pas assez élevées. Mais dans les faits, ça n'arrive pas vraiment, en tout cas, j'en ai pas entendu parler. Mais c'est quand même une préoccupation des intervenants…. Mais dans les faits, je pense qu'on est capable de faire fi de ça et faire notre job avec notre identité professionnelle. Dans mon travail, ça ne m'affecte pas, mais quand j'ai des discussions comme en ce moment plus philosophique, je trouve ça un peu fâchant […]Des fois, on a des procédures à suivre qu'on trouve un peu infantilisantes. J'avais un exemple en tête… Les statistiques c'est un bon exemple. Parce que même si tu n'as pas quatre statistiques, des fois, on fait des appels, des démarches, qui ne comptent pas comme quatre statistiques" (SW6)*

> *"Les intervenants le savent que les statistiques... C'est à partir de ça qu'on est financé. On reçoit notre argent à partir de ça. Des fois, je dis que les statistiques sont à l'État ce que les profits sont à l'entreprise privée. Ça ne veut pas dire que parce qu'on a des statistiques, on n'offre pas des services de qualité." (M3)*

One of the strengths of the social work field is that it is largely experience based. As social workers meet with clients, service users, families, community organisations and other professionals their 'toolbox' is filled and practice evolves. Although the professional experience of social work practice is personal, it does not happen in a vaccuum. Mental health social workers have to ensure that their practice evolves, whilst negotioating with organisational pressures to perform. Healy (2005) posits that many social workers in varying practice contexts are alienated by the way in which social work theories, and perhaps even values, are set in opposition to institutional contexts; conflict occurs when practice framework and organizational context are not in line. Thus, the social workers and managers who experience consistency between their practice framework and organization context express a more positive work climate. In a results-oriented era, entrenched in a weakened yet pervasive biomedical model, will the struggle to achieve a positive work climate lead to compromises in social work values in the mental health field? It is perhaps for this reason that teaching and training are necessary to highlight recovery as a process and to reinforce the notion of participation in which social work interventions are user-led rather than service-driven. Many participants in this project were mindful of the existing

medical approaches based on diagnostic criteria[50] as well as the results-oriented approaches that emphasize quantity of interventions. However, there are other negotiations that are taking place during social worker and client interactions, which will be discussed in the following section.

5.1.5 Establishing links with partners

In the analysis, several aspects regarding work organization were brought up that directly affect the way in which social workers practice. These include the *guichet d'accès* and accessibility to services that continue to be reliant to some degree on diagnosis. The centrality of the *guichet d'accès* to the mental health teams is evidenced in the discourse of the managers that participated.

> *"le guichet d'accès, ça c'est installé ici. C'est la pierre angulaire [...] du Plan d'action" (M1).*

> *« On a mis le guichet d'accès au cœur de toute l'offre de services, pour l'accessibilité aux services et autour du guichet" (M3)*

Moreover, it is also described as the unique gateway to all mental health services in the territory:

> *"tout passe par le guichet. Quelqu'un qui se présente au CLSC, c'est l'accueil psycho-social. L'accueil envoie la demande au guichet. Après ça, tu as toute la communauté, les médecins, la deuxième ligne. » (M1)*

> *« Le guichet d'accès évalue et fait une évaluation dans le but d'orienter vers les bons services. Donc ça ne veut pas dire qu'on absorbe tout, parce que le guichet est la porte d'entrée des services en santé mentale pour tout notre territoire." (CC1)*

It is important to note that the centrality of the *guichet d'accès* and its use as a truly unique gateway in order to avoid multiple evaluations of clientele is promoted when positive partnerships are developed. The implication of service users and community

[50] It is useful to remember that their are different ways to conceptualise suffering that are not necessarily encompassed by diagnostic labels. In fact, reductionist labelling may mask the different ways that suffering is articulated.

partners to determine the organization of services is impactful for several reasons. Firstly, service users have historically not had a voice with respect to the services and practices that affect them directly; secondly, reorganizing the relationship with services users and community partners allows for a renegotiation of power; thirdly, if all actors are sitting at the same table, then a common language and knowledge can be created; finally, it is a first step toward establishing a sense of working together toward the same goal and with the same philosophy – a recovery orientation:

> *"[…] on s'est assis avec nos partenaires, communautaires, institutionnels, les utilisateurs de services, pour travailler le projet clinique en santé mentale. C'est là qu'on a pris ensemble connaissance du plan d'action en santé mentale." (M3)*

The analysis of the interviews shows that satisfaction with the functioning of the *guichet d'access* can be attributed to a participative process in its development. In fact the impact of the partnership committees that include stakeholders from institutions, communities, and citizens is important to underscore:

> *"On a continué à avoir des comités de travail en partenariat, partenaires communautaires, institutionnels, utilisateurs de services. Entre autres, le guichet d'accès a été un grand travail qu'on a fait ensemble pour définir notre cadre de référence du guichet...on a réussi, je pense, quelque chose de pas mal extraordinaire. On a fait [le guichet] en première ligne, comme c'est prévu dans le plan, mais on l'a fait conjoint, dans le sens où il est conjoint CHUM-CSSS. Il est géré par moi au CSSS, mais j'ai des membres du personnel du CHUM dans mon guichet…" (M3)*

It is important to underscore that this development of services with the partners is not a standardized procedure or occurance. Not all CSSS negotiated recovery-oriented services and practices with several partners, including service users. In fact, we see that the CSSS that developed strong links with partners and service users not only elaborated the service offer but the notion of recovery as well. The result is a continual reflection and development of practice:

> *" On a beaucoup requestionné nos pratiques et on y travaille encore, c'est du continu. […] Aussi, on a beaucoup travaillé la notion du rétablissement, mais pas juste nous, on a fait des rendez-vous Jeanne-Mance et, entre autres, on a*

eu 2-3 dont le thème principal était le rétablissement.[…] Avec les utilisateurs de services, les partenaires, tous ensemble. On a eu des présentations sur c'est quoi le rétablissement, qu'est-ce que ça veut dire quand on parle de rétablissement. Se questionner là-dessus, réfléchir ensemble. Ensuite, on en a eu un autre [rencontre] où on s'est posé la question si nos services sont orientés rétablissement ou non. Comment on peut répondre à ça? Beaucoup de réflexion autour de ça pour arriver tranquillement aussi à se questionner par rapport à nos pratiques. Aussi, le fait que les utilisateurs de services sont là, ça change tout. Quand on écoute ce qu'ils ont à nous dire, on ne peut plus réfléchir, travailler de la même façon. Ça change tout, parce qu'on ne peut pas ignorer ce qu'ils nous disent, ils sont là, autour de la table." (M3)

Currently, some participants express trepidation with their geographic proximity to a psychiatric institution as well as that institution's influence in both the development and current organization of services. When asked if the institutional partners respect the evaluation and orientation decided upon at the *guichet d'accès* the responses were quite different. In a CSSS that is still struggling to develop a fluid and equal partnership with the psychiatric institution that offers specialised mental health services in its territory, we see that successive evaluations without any interventions are the result. A social worker that was transferred from the psychiatric institution and now works at the *guichet d'accès* describes her practice reality:

"There is a patient that is being followed for schizophrenia for 10 years in Laval. She moves, and she had 3 incidents in the past year. She is not stable. She has been stable for one month. So the psychiatrist says absolutely second line. I called the psychiatrist and explained how the plan d'action works that usually it is the [family doctor] that prescribes and when there is a problem they refer to the CLSC. [The family doctor responds:] 'No no this client has to be seen 2-3 times a year by the psychiatrist'. So I say okay, send me a report and I'll present it to the guichet d'access…[for access to the 2nd line]. It was refused. There is such […] rigidity. Part of the mental health plan was that first line will make the decision if the client has to be referred to second line but now what happens is that when we decide it is turned down every time. So then what happens is that we have to go back to the psychiatrist and say 'Your consult is not enough'. […] Many times what the [psychiatric institute] wants is when the psychiatrist refer with an evaluation they want the psychiatrist…to re-evaluate. What's that message that you are sending? It does not make sense. It is like saying a social worker evaluates her client and

> *they say no, lets have another social worker to re evaluate , to confirm or unconfirm..it does not make sense[….]That's how it is at the [second line]. No support, this is how it works. We get so many consults for emergency, for follow up with psychiatrists. You cannot do that at the CLSC, that is not our mandate […] When it comes to the second line services we have no say, no control. It is not participative. They decide." (SW2)*

> *"there are 2 psychiatrists that come here. One comes once a week and the other once a month...a person cannot have an evaluation with the psychiatrist without a consult. So there is waiting time that comes with that. The patient can wait 4 - 5 months to get the first set of evaluations, go back to the GP, the GP continues to prescribe, after 2-3 months it is not working the GP send another consult the patient has to wait another 4-5 months. So you know, on that note that is a big problem…" (SW2)*

In contrast to this, when strong relationships are developed with the second line partners (albeit these partners are located at the local general hospital) the relationship is more fluid resulting in greater accessibility to care for the client:

> *"À l'hôpital, il n'y en a plus de [Module d'Évaluation-Liaison]…quand on évalue au guichet que c'est une situation qu'on envoie à l'hôpital en deuxième ligne, il n'est pas réévalué pour voir s'il est admissible à l'hôpital. Il est admis…on ne réévalue pas s'il va être admis dans les services. À partir du moment où dans l'évaluation guichet…on dit cette personne-là s'en va dans l'équipe de première ligne, on ne questionne pas ça. On l'envoie là, c'est tout. On le prend…. (M3)*

This is partly due to the functioning of the guichet d'access as a truly unique gateway to all mental health and psychiatric services in the territory. They emphasized collaboration and fluidity in the relationship. One full time professional and employee from the second line team is a fully integrated member of the CSSS first line mental health team:

> *"c'est une guichet commun psychaitrie et CSSS. Donc il n'y a qu'une porte d'entrée et c'est ici." (CC1)*

However, the partnerships that the MHAP requires are not only with the local second and third line institutions. The partnerships must also be established with the community partners. One of the CSSS succeeding in having a community partner as a member of the

guichet d'accès in order to establish a unique gateway to all mental health services both institutaionl and community. Eventually, the community partner felt that its presence on the *guichet d'accès* was irrelevant. All participants felt that the community offered valuable services despite the current disconnect with these partners. Social workers discussed their practice as being intrinsically connected with the community:

> *"Je pense que notre profession a toujours été, on était comme le bras extérieur des établissements" (SW7)*

Rodriguez et al. (2002) explored how an organizational model can affect the interventions that are offered to service users. They studied the gaps between the discourses and actions of community workers and service users in community organizations in order to explore how service integration is operationalized in specific contexts. Their conclusions included a striking similarity between the concerns of community workers and of the service users. They also indicated a need for practice models that allow for both service users and community workers to consider their own subjectivity and enrich practice through experience, dialogue, and negotiation. The report spoke critically of the institutionalization of community organizations and the difficulties breaking away from psychiatric models of care.

In order for practice to be renewed toward a recovery orientation, a continual dialogue with partners, especially service users is necessary. The implication of partners and service users cannot stop once the service offer has been developed. All three of the managers and the clinical coordinator stated that a renewal of practice had taken place mostly due to changes in policies, tools, and procedures. Most social workers felt that although their practice philosophy or values has not changed[51] new tools and procedures have changed the organization of their work and the way they intervene with clients. One tool that is central to practice in public mental health settings, although its content differs with each team, is the Personalised Intervention Plan, or PII (*Plan d'Intervention Individualisé*).

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[51] This will be elaborated in the Chapter 6 – Recovery and social work practice

5.2 The mechanisms that support recovery-oriented practice

Determining the team structure and resulting work climate was considered imperative in order to understand the conditions under which social workers and their managers perceive their roles and the recovery orientation. The analysis was based on responses to questions relating to roles and responsibilities, tools and procedures, user participation, team meetings, and staff training. Social workers who were consistently dissatisfied with their service offer discussed the lack of flexibility to respond to specific client needs, resulting in them feeling powerless to help their clients. Participants discussed practices that were flexible, client centred, and reflexive largely due to a work organisation that includes group case management, time to plan interventions with clients, and time to reflect on practice. Interview questions regarding professional roles resulted in discussions surrounding practice modality and the professional autonomy and work climate that the different modalities create. The topic of interdisciplinarity was a common sub theme when discussing professional roles. The enrichment of interdisciplinarity, and the way in which professional roles are integrated and differentiated, is discussed with respect to practice modes. In the next chapter we will analyse results concerning practice approaches. However, with respect to team structure, I was surprised that participants discussed practice modalities in response to questions surrounding the integration and differentiation of professional roles and work climate. The two major modalities continue to be individual case management and group work; there are variations in the ways in which individual follow-ups are organised. We see from the analysis that team structure can lead to a high level of individual autonomy and currently places less emphasis on teamwork or in a practice modality that could be described as group case work[52] rather than individual casework. The social workers expressed high levels of satisfaction with the group casework modality and attribute it to stronger interdisciplinarity, reflexivity, support, and autonomy.

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[52] This approach ensures that professionals have a 'social' support in that they always have a colleague as a back up. Moreover, clients can benefit by having access and ebing exposed to a variety of professionals. This approach can foster practice flexibility and stimulate creativity (Lavoie-Tremblay, M., Bonin, J-P et al., 2010)

5.2.1 PII (Plan d'Intervention Individualisé[53])

The major tool that has been introduced into mental health practice is the PII. One objective of the PII is to ensure service-user led mental health practice; thus the centrality of this tool in the MHAP to shift the position of the client from a passive player to an active participant. The development, conception, and implementation of interventions based on a PII is supposed to be co-constructed with the client. In addition, other procedures, such as a four session co-evaluation of a new client aims to asses the relevance of client needs with the service offer and has as an objective the elaboration of the PII.

The PII was formalised in recent years and one participant (SW4) discussed how it has helped her to structure her practice so that the client is more implicated. Nevertheless, the analysis of the interviews underscores the fact that the PII is simply a tool and the way in which it is used impacts its effectiveness. Annex 8 and 9 are examples of the formalised PII for each CSSS that participated in this project. As we can see, one model of PII is simply a one-page form that includes sections on description of needs, objectives, interventions, and duration of service. This model however will likely change soon in order to promote a recovery-orientation:

> *"au niveau de promouvoir les anciens pratiques versus [les nouvelles], c'est que…on ne le ferai pas cette année on avait pensée mais là finalement ça va etre pour la prochaine année, changer le plan d'intervention. Et puis d'avoir un plan d'intervention axée sur le rétablissement soit par le* strength model *(Charles Rapp), ou l'équipe du CSSS […] qui a quelque chose intéressant là-dessus. Alors ça va ammener aussi des changements." (M1)*

Again, the administrative pressures to focus on specific aspects of service development and budget controls are held responsible for the delays related to improving the PII :

> *"…On avait mis l'argent de coté, mais il faut le mettre plus vers la prevention de suicide pour la grille. Mais, peut être ça va être encore mieux l'année prochaine notre équipe va être complète. » (M1)*

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[53] Although the English term is Personalised Intervention Plans, the acronym PII is used by both English and French speakers. Thus for this report, the term PII is retained.

Another PII model is a four-page form including a user guide with a definition of terms that creates a common language between service users and practitioners as well as significant room to describe the aims of the PII for the service user. Moreover, the PII includes space for an evaluation of the interventions. However, when a formalised evaluation period in which to elaborate the PII is not in place, some social workers feel under pressure to intervene and end treatment due to statistical requirements:

> *"…Il n'est pas dit qu'on ne peut pas passer une rencontre à regarder l'objectif et arriver à quelque chose d'au moins plus concret et circonscrit, qui pourra m'enligner et me permettre d'évaluer un peu mieux. Je trouve ça important de toujours le faire avec le client. Souvent, ça va être après deux ou trois rencontres d'évaluation. Je veux prendre le temps, mais ça passe vite, quand on fait trois rencontres d'évaluation, des fois quatre, et on sent que le client a encore beaucoup de choses à dire et il faut qu'il ventile" (SW3)*

The development of the PII has been fundamental in the progress of the first line mental health teams. Initial evaluations, interventions, and discharge or end of treatment planning for all professionals are anchored in the PII. The centrality of a PII focused on specific objectives may be a cautionary tale however; by focusing on specific objectives, or as discussed by one participant (SW6) by developing a service delivery system that only allows professionals to offer services when a client has objectives in mind, the recovery orientation may lose its value-laden, normative position.

Although several social workers expressed a satisfaction with the way new tools such as the PII and new procedures such as limiting the length of follow up for certain clients has helped them to structure their interventions, this modus operandi may be an obstacle to developing recovery-oriented practice if closer attention is not given to what it means to offer a good quality of practice:

> *"Je pense qu'un des aspects positifs….je vais parler pour moi, mais ça me structure un peu plus, donc ça me permet de vois plus de gens par année de desservir plus de personnes" (SW4)*

In fact, one participant (SW6) did mention that the service offer only allows professionals to offer services when a client has objectives in mind that are attainable via

the practice modes already in place. As discussed by Rodriguez et al. (2006) it is imperative to allow for different ways to express oneself, to describe mental health problems, and to articulate one's valued form of life if we are to assure practice that is at a high level of quality. In an era of recovery in which client participation has become formalised and institutionalised, this perceived negotiation on the part of social workers might be seen in a different way by their clients. As discussed by Williams (2002), if practitioners acknowledge the many points of suffering a person may experience then it is easier to find a place to collaborate. This author continues by discussing the importance of cultural and ethnic subjectivity, which are often ignored in mental health services and states that "mental health services need to address a wide range of perspectives that people can bring to the experience of illness, treatment and healing" (para. 4). In addition, Corin and Harnois (1991) as cited in Rodriguez et al. (2002) discuss the importance for practitioners to begin with the needs of the client whilst planning interventions that take into consideration their attitudes, values, and the meaning they attribute to their experience.

5.2.2 Training and continuing education

We see that when the training process is embedded in the team structure, a social support is created amongst the professionals and a sense of team cohesion. This is relevant to practice renewal in this period of transformations; change can be difficult to manage and support and training can alleviate some of the stress related to change for the professionals:

> *"Maintenant, l'équipe est plus importante et on est capable de former et de soutenir, parce qu'ils travaillent beaucoup en équipe. Les gens ne sont pas laissés seuls. Il y a vraiment beaucoup d'entraide et c'est drôle parce que j'ai des nouvelles personnes qui sont venues du CHUM et ce qui les a frappées c'est l'entraide. Il n'y a personne qui se sent supérieur. On peut demander n'importe quand de l'aide à n'importe qui dans l'équipe."(M3)*

When there is a strong preoccupation with training, it leads to a training process that is formalised and structured and resembles an initiation phase.

> *"tous nos professionnels qui intègrent l'équipe de santé mentale commencent toujours au guichet. On commence la formation dans le guichet…Dans le guichet, on voit tout." (M3)*

Two of the social workers (SW5, SW6) described recovery trainings that took place before they arrived on the team. There is a strong relationship between the development of mutual support amongst professionals and continual discussion and reflection on recovery-oriented practice and services, which occur in team meetings and with colleagues.

In contrast, we see that when recovery specific trainings are not offered and when a structured 'initiation' phase is not in place, mutual support amongst professionals and continued recovery oriented discussions are absent. There is a strong concern with this that is mitigated by a perceived control from the *Agence*. Two of the social workers (SW1, SW3) discuss trainings related to evidence-based practices such as cognitive behavioural approaches in the absence of training and information related to other types of interventions and approaches:

> *"C'est sûr qu'on sent aussi qu'il y a des formations qui nous sont… mais qui sont dirigées par en haut. Il y a une formation entre autres dans laquelle j'étais inscrit mais j'ai pas pu participer sur la toxicomanie, les dépendances. Les collègues me disaient qu'en cours de formation, ils ont fini par comprendre que la formation était donnée mais dans l'intention de… Ce qu'on faisait c'était de leur fournir de l'information parce qu'il y a une cohorte que c'est prévu que les problèmes de toxico, ça va être traité en première ligne aussi éventuellement. On a des exemples comme ça que les formations sont dirigées, sont prévues d'en haut[…] sur le rétablissement comme tel, non." (SW1)*

The other two social workers expressed a lack of recovery trainings and discourse due to a pressure to provide statistics and prepare for the accreditation process by Accreditation Canada:

> *"Pas tant que ça. Peut-être plus dans les années précédentes, il y a un an ou deux. Mais maintenant, c'est beaucoup l'agrément qui s'en vient, des choses comme ça. Les statistiques qu'il faut produire, les listes d'attente qu'il faut réduire" (SW4)*

> *"Nobody talks about the recovery model here" (SW2)*

In contrast to the affirmations of the social workers, one manager explained that there is an attempt to imbue recovery values in all of the trainings :

> *"Je dirais que c'est plus actuellement imbriqué à travers d'autres formations. Je pense que de plus en plus, quand il y a des formations pointues en santé mentale, le concept de rétablissement est sous-jacent, […]. Je pense que c'est une valeur qui doit être toujours comme en dessous. Mais je pense qu'on a du travail à faire là-dessus." (M2)*

Finally, another perspective on training was offered by the participant who had the most experience as a social worker with 24 years in the public health system including 15 years working in the CLSC with a homeless population. Rather she describes her professional trajectory as the best school:

> *"Je pense qu'avec toute mon expérience, je pense qu'une des plus belles écoles que j'ai eues, c'est les premières années dans l'itinérance." (SW7)*

Perhaps one of the reasons social workers talk about learning on the job or social work as an experience based profession is because institutional context is so dissociated from professional context in school that a new negotiation of what practice looks like is done when on the job. On a daily basis, it is the social workers and other professionals in the first line mental health teams that give means to the concept of recovery from a practice standpoint. As such, at the micro level, social workers play a large part in their daily interactions with their clients in supporting the development of recovery-oriented practice. As discussed by Healy (2005), theories, including recovery, will provide a "thread rather than an entire context for practice" (p.xiii).

5.2.3 Flexibility

We see from the interviews that certain tools, such as the PII moderates the amount of flexibility a professional can have when planning interventions with the clients. We see that when CSSS organize the work of their professionals to allow time and space for evaluations and intervention planning, the team members express a higher level of flexibility in terms of follow up length and duration.

In theory, the procedure of having four co-evaluation sessions with a client creates room for flexibility in follow up:

> *"Est-ce que ça va être un suivi individuel, de groupe. Est-ce qu'on peut penser à offrir plus l'un dans un premier temps et dans un deuxième temps, offrir l'autre. Des fois, ça nous permet de voir un peu à qui on a à faire. Ça nous permet de situer aussi est-ce qu'à cette personne-là, on va offrir plus 10 rencontres d'abord, pour voir un peu comment la personne fonctionne et après on prolonge pour un autre bloc de 10 rencontres. On peut renouveler." (SW5)*

> *"…si la personne va bien, on a atteint nos objectifs et on n'a plus de raison de se rencontrer et, que d'un commun accord, on décide de ne plus se rencontrer, on va quand même dire aux gens, rappelez-moi si ça ne va pas. On a cette flexibilité de ne pas fermer les dossiers. On peut les rouvrir facilement, ce qui rassure beaucoup les gens[…]dans l'autre continuum c'était aussi flexible" (SW6)*

Although the participants express the centrality of the client in the planning and intervention process, their statements reveal a certain rigidity in the service offer. One social worker discussed the need to claim a certain amount of room to manoeuvre, implying that the flexibility was not inherent in the work organisation.

> *"[…Il ne faut pas penser que le PII est une fin en soit] Si ça ouvre sur autre chose à un moment donné ou il arrive d'autres évènements, on s'enligne sur les besoins du moment… Je me garde cette latitude […]. Je ne sais pas jusqu'où ou pendant combien de temps encore je pourrai le faire, mais... Je réclame une latitude à ce niveau-là. Ça prend de la liberté. Il y a des choses que je ne suis pas mandaté officiellement pour le faire, mais il y a des choses que je fais… Il y a des situations des fois où les clients sont mal pris, il faut agir, il faut que ça bouge. J'accompagne des clients par exemple dans certaines situations, mettons viens t'en, on part, on y va. Embarque dans mon auto. Alors qu'on sait qu'on est pas couvert par les assurances pour faire ce type de chose. C'est des choses que j'ai adressé déjà, mais je n'ai jamais eu de réponse là-dessus. Je prends la latitude de le faire. Je ne le fais pas souvent. Mais je le fais quand je sens qu'il faut que je le fasse." (SW1)*

The analysis revealed uneasiness with certain tools such as the PII in that such a tool can actually introduce a certain rigidity that does not allow for a flexible follow up:

> *"... il y a vraiment plus, dans l'organisation des services, un plan d'intervention avec un nombre de rencontres. C'est sûr qu'il y a une souplesse, mais quand on fait une révision de case load avec la coordonnatrice clinique et le chef de programme, ce qu'on nous dit, c'est qu'il faut fermer les dossiers. Les gens peuvent bien sûr revenir en repassant par l'accueil, le guichet d'accès [...] Par la liste d'attente, bien sûr." (SW3)*

Managers state that flexibility and creativity are integral. Flexibility refers to the capacity for social workers to be creative and impliment practice approaches that are 'outside of the box' :

> *"Si justement il a une bonne idée qui peut être profitable à l'équipe, on va dire oui, ça serait le fun que tu présentes ça à l'équipe. Si quelqu'un a une idée qui peut faire du chemin, absolument." (M2)*

However, the concern and cynicism with respect to the Agence and management directives is pervasive in the discourse and in the discourses of other participants working in a first line team that is not yet fully developed. There is a strong preoccupation that the flexibility and creativity with which they may be imbuded is mitigated by administrative rather than clinical pressures :

> *"J'ai une collègue ici qui a fait 15 ans de yoga et on s'est dit, pourquoi on essaierait pas... Parce qu'il y a eu à un moment donné un peu de pression, mais pas pression, mais on nous a suggéré, il faudrait faire des groupes. On avait l'impression que ça venait de l'agence et c'était un peu parachuté. On s'est dit, pourquoi on essaierait pas de faire un groupe avec une approche plus axée sur le psychocorporel. On a commencé l'année passée, on a fait un groupe ouvert...vraiment une partie yoga, une partie relaxation, une partie discussion. Vraiment pas axé sur le verbal, plus sur quand je vis des choses dans le corps, est-ce que ça peut être relié à une émotion. Quelque chose de plus global" (SW3)*

5.2.4 Reflexivity

We see from the interviews that having time to reflect on practice is fundamental for the professionals who currently enjoy a work organization that allows for reflexivity:

> *"On a des endroits, des lieux pour discuter de nos impasses "(SW5)*

> *"“On est en évaluation continue de nos services pour que la personne, ce que moi je suis en train de faire, on s'entend pour travailler ensemble sur tel objectif. C'est important. Quand la personne vient nous consulter et on s'entend sur un objectif, la personne s'attend à ce que ça aille mieux, que ça va l'aider. Moi, comme professionnelle, je m'attends aussi que la personne que j'aide, ça l'aide. Si ça ne va pas mieux, c'est important qu'on se questionne ensemble." (M3)*

> *"…C'est de prendre du temps, de dire dans quoi je suis. Est-ce que j'ai la collaboration, qu'est-ce que je vais lui offrir, du groupe, de l'individuel, court terme, moyen terme. Dans cet accueil de quatre rencontres, c'est un peu un moment transitoire pour dire, vous êtes à la bonne place, tout ça, mais on n'est pas mariés ensemble. On va voir ce qui est possible de faire. Je trouve que c'est nouveau pour eux d'avoir cet espace-là pour prendre le temps de voir si j'ai un patient collaborant, prêt à travailler, ou si c'est pas mûr du tout." (CC1)*

One social worker explained that even though the time taken to reflect is not part of the statistics, it is still encouraged:

> *"…Réfléchir à faire cheminer le client. Il faut avoir du temps pour ça. Il faut se nourrir aussi. Avec des lectures, discuter avec des collègues. Tout ça, ce n'est pas comptabilisé, mais ça prend du temps et c'est utile de le faire aussi."(SW5)*

Reflexivity is also dependent on the team support structure that is in place. As aforementioned, when formalized trainings that foster a sense of social support among professionals and a work organisation that allows for reflexivity are in place, professionals will have networks within which to reflect on, and perhaps, renew practice.

Despite a lack of formalised trainings and development of team cohesion, informal support networks can be developed. The interviews reveal that these informal support networks and practice discussions are viewed in a postive light by social workers with professional experience in the CLSC network and in a negative manner by social workers with experience in an institutional psychaitric setting :

> *"Autant [l'équipe qui vennait de la psychaitrie] vont venir nous voir pour nous demander des choses par rapport au fonctionnement CLSC auquel ils*

sont moins habitués, autant nous on va se servir de leur expertise pour avoir des liens [avec la 2ieme ligne] ou des choses comme ça. On a une belle équipe" (SW4)

"Je me dis que si quelqu'un arrive malgré exemple une schizophrénie, j'ai une dame en tête, c'est pour ça que je vous en parle. Elle va quand même tellement bien cette dame-là. Elle prend sa médication de façon régulière. C'est sûr qu'elle garde des voix qu'elle entend des fois, mais on a regardé ensemble différents trucs qu'elle pourrait… On a fait l'essai de différents trucs pour l'aider à composer avec ces voix au quotidien et faire en sorte qu'elle fonctionne quand même bien. Elle y est arrivée et je trouve ça génial de la voir aller… Sauf que cette dame demeurait quand même inconfortable, dans le sens où elle continuait d'entendre ces voix parfois plus fortes, d'autres fois moins. On s'est vraiment concentrées, elle et moi, et sur qu'est-ce qui la dérangeait dans son fonctionnement quotidien et c'était ça. Je lui ai proposé différentes choses et ce qu'elle a trouvé comme truc entre autres c'était de se mettre un mp3 dans les oreilles quand les voix sont trop fortes et d'écouter de la musique…. Elle s'occupe beaucoup de sa petite-fille, elle l'élève pratiquement. Je pense qu'un de ses buts c'était d'être capable de continuer à le faire, parce que sa propre fille est bipolaire et elle est plus moins stabilisée. C'est beaucoup ma cliente qui s'en occupe. Un de ses buts c'était de pouvoir continuer. C'est une belle réussite, je suis bien contente. À l'heure actuelle, où on en est avec cette dame-là, c'est qu'on n'a plus de rendez-vous régulier. C'est un dossier que je laisse ouvert et au besoin, elle va m'appeler… En fait, ce dossier-là, je suis venue pour le fermer cette année je pense. J'en parlais avec l'équipe du 2ieme ligne qui a été transférée ici et c'est eux qui me disaient bien non, ne ferme pas ce dossier-là. Tant mieux si elle va bien, mais tu le laisses ouvert et au besoin, elle va venir te revoir. C'est même pas mes supérieurs, c'est mes collègues." (SW4)

"There is no team structured support. So here it's mostly everybody does their own thing" (SW2)

Participants (M1, CC1, SW5, SW6, SW7) that expressed the feeling of being in a solid team unanimously described their work environment as stimulating and enriching.

"… c'est le fun de se retrouver avec une équipe qu'on a, à peu près la majorité, le même sens, on comprend bien la mission, on est bien dans cette mission. On est différents d'une personne à l'autre, on a nos propres couleurs, mais c'est le fun de voir qu'on est pas tout seul." (SW7)

"On se consulte beaucoup sur les cas, quand on vit quelque chose de difficile ou on est bloqué. C'est vraiment intéressant pour ça" (SW6)

"Je trouve que c'est un bon climat. Les gens sont contents d'être ensemble. Il y a une bonne atmosphère d'équipe. Les gens travaillent fort, on est assis chacun à notre bureau, mais on se parle. Il y a une bonne collaboration. On sent qu'on peut s'entraider, se parler. Les gens sont intéressés par le travail. On a des diners, juste pour vous dire, deux diners cliniques par semaine, où on se fait des diners comme dans la télésérie In Treatment. On écoute ça comme outil pédagogique et on discute après de c'est quoi nos perceptions, et du client et du thérapeute. Chaque entrevue dure 20 minutes et à chaque mercredi, on discute d'une capsule et on en discute ensemble. Le jeudi, on se fait des diners cliniques aussi, si les gens veulent parler d'un sujet, d'un client, on en discute. Même sur l'heure du diner, on travaille." (SW5)

5.2.5 Professional autonomy

The importance of autonomy for the professionals who participated in this project was undeniable. They expressed a satisfaction related to being able to make intervention decisions and interact with clients according to their training and experience. Autonomy regarding interventions is negotiated with institutions, with clients and with professional base. Thus although participants agreed that professionals have autonomy to practice in whichever way they see fit, pressures do exist to use specific approaches. These pressures or influences seem to be directly related to the proximity with a psychiatric institution, the composition of the team (professionals transfered from the second or third line) and the expectations and options availbale to the clients. That is to say that not only did participants express the fact that the CSSS requires them to use certain approaches such as the cognitive beahvioural approach, but clients request to be treated with that approach as well. The lack of treatment options or approaches is a concern not just to social workers and to the potentail for a renewal of practice toward recovery. The lack of options is a major concern for clients and for the establishment of recovery-oriented services to support a client in his or her recovery journey.

"C'est sûr que le [la thérapie cognitive-comportementale] est très fort en ce moment depuis quelques temps. Les psychologues sont formés comme ça beaucoup. Je n'ai pas senti de… Je pense que c'est plus les clients qui ressentent des pressions, indirectement, sans s'en rendre compte, parce que

les services offerts sont beaucoup axés sur le cognitivo. Il n'y a pas beaucoup d'autres alternatives." (SW3)

Overall, the social workers discussed professional autonomy in terms of having the space and freedom to intervene with their clients as they judge appropriate. Intrusion into their daily interventions or clinical management of their caseload is perceived as inappropriate.

"J'avais été rencontrée en février et [ma superieure] me demandait de presenter trois dossiers […] pour voir un […] peu comment je fonctionne…C'est plus notre role à nous en tant que professionnels autonomes à s'assurer que tout ça est correct. Personnellement, je pense plutôt que notre gestionnaire decrait verifier nos charges de cas, la ourdeur. Mais regarder dans les dossiers, il me semble que c'est basic" (SW4)

"Je ne sens pas d'intrusion ou de jugement. Je pense qu'on fait confiance à notre jugement professionnel et on fait confiance aussi au fait que si on ne sait pas ou on a des questionnements, on peut l'apporter en équipe" (SW5)

"[…] Chaque professionnel est autonome et se surveille lui-même" (SW6)

The importance of professional autonomy lies in the room to maneuver that it gives to the professionals. However, the crucial question is not simply the fact that organizations are allowing for this professional freedom, but what social workers are focusing on with this increased autonomy. Does this space give them room to focus on social functioning or on social inclusion and social cohesion?

5.2.6 Interdisciplinarity

The integration and differentiation that the social workers perceived with their colleagues was discussed. Although the term interdisciplinarity might be considered a buzzword, it is relevant in a union dominated public health setting where different professionals have historically worked in silos. Moreover, a balance between integration with other professionals (leading to enrichment of practice and perspectives), yet

differentiation as to a social worker's specific role(s) seems to be valuable for the participants. Interdisciplinarity is being developed and questioned:

> *"[Ce sont] des équipes multidisciplinaires, il y a plusieurs professions. Par contre, on travaille à ammener l'approche interdisciplinaire par rapport à tout ça. On a fait des avances là-dessus. Je pense que l'approche interdisciplinaire, c'est quand même considéré comme une bonne pratique à intégrer, ce qui fait en sorte que quand tu mets les intervenants ensemble avec le client, je pense que tu es plus ammener justement de développer un modèle qui va soutenir le rétablissement chez la personne, en s'assurant toujours que la personne est au centre et que c'est pas les personnes qui décident, mais en tout cas, tu établis une collaboration". (M1)*

Some social workers remain skeptical about the balance between differentiation and integration and are concerned primarly by a potential loss of their role as social worker. With the predominance of evidence-based approaches that are often focused on symptom reduction there is a difficulty in finding language that is common to social work :

> *"Je trouve que ce qui est dommage, c'est que les psychologues ou les psychiatres, qui amènent plus leur langage de diagnostic, DSM-IV, et les clients sont vus plus à partir de diagnostic…je me dis que mes clients ne sont pas que des diagnostics. C'est difficile pour nous TS d'amener ça et nommer ça, sans imposer, mais de faire une balance un peu dans les discussions, ce qui peut être ce que je m'appelle médical ou psychologique ou peu importe." (SW3)*

However, we see that the structure of group casework and a formalized training process has positive effects on interdisciplinarity. When the service offer is predicated on the assumption that a client is accepting services from a team and not from one individual the results are a focus on teamwork. The differentiation and integration of professionals was also discussed. The responses indicate an importance placed on finding common ground amongst the different professionals, which has led to low differentiation and a subsequent high integration of professional roles:

> *"[…] au début […] les gens, c'était une guerre d'approche. Les gens se présentaient presque en disant leur nom et leur approche. Comment on a travaillé fort sur plus, outre les approches, les facteurs d'efficacité en psychothérapie. C'est là qu'on a réussi à rallier pour avoir un langage plus commun. Qu'est-ce qui fait qu'on est efficace. Outre nos cadres*

thérapeutiques, nos approches, c'est quoi les facteurs les plus importants d'efficacité. C'est sûr que là, on est dans la relation, dans d'autres choses. C'est ça qui a permis que finalement, le discours entre les différentes professions s'est rallié autour de ça. On a été moins pris dans des discours de professions ou d'approches. On est sorti de ça."(M1)

"Actuellement, dans la façon dont on fonctionne, et moi ça me plaît, je ne sais pas si ça va rester comme ça, mais ça me plaît bien, il n'y a pas de distinction au niveau du travail dans ce qu'on fait, qu'on soit psychologue ou travailleur social, l'approche ou la formation, il n'y a pas de différenciation qui est faite, dans le sens où tout le monde fait de la relation d'aide, offre de la psychothérapie. Il n'y a pas de distinction entre professionnels. Il n'y a pas une tâche qui est attribuée aux travailleurs sociaux et une aux psychologies" (SW5)

The development of interdisciplinarity rests on the assertion that professionals working in a public care setting are never working alone, as one would in private practice, but in a team. This has important practice implication in terms of the different approaches and professionals that are presented to the client as possible sources of support in his or her recovery journey.

"On travaille beaucoup en équipe. On s'est questionné beaucoup quand on a revu notre offre de services sur c'est quoi la distinction entre être un professionnel en pratique privée et être un professionnel dans une équipe dans un établissement. C'est important de se poser cette question-là. C'est sûr que si moi je suis un professionnel dans un bureau privé, je fais mon affaire toute seule, mais quand je suis en établissement, ça ne porte plus juste sur moi, comme professionnelle, ce que j'offre. Ça porte sur l'établissement, l'offre de services de l'établissement. Oui, j'ai une autonomie comme professionnelle, mais en même temps, je ne décide pas de tout toute seule. L'offre de services est soutenue par un établissement et une équipe. On travaille donc beaucoup plus en équipe...(CC1)

Social workers agreed that their work organization, work climate, and relationship with their managers and coordinator fostered a level of work satisfaction that allowed for better practice. The organization of work and the resulting work climate are nuanced by the CSSS history, team composition, budget and rapport with its partners. Social work

practice, although considered unchanged by the social workers, was perhaps also nuanced by the tools and team structure put into place following the action plan. We see from the interviews that when a team has reached a certain level of maturity, team members have the time to focus on maintaining an appropriate service offer and developing recovery oriented practices rather than focusing on the development of the service offers. Moreover, aspects of their team structure and practice modality, including work climate, flexibility, reflexivity and professional autonomy contribute to increased space to reflect, dialogue and negotiate which in turn creates the potentional to practice from a recovery orientation.

CHAPTER 6 - RECOVERY AND SOCIAL WORK PRACTICE

This chapter is an analysis of the participant discourses related to recovery, recovery-oriented interventions, and current social work practices. As seen in the previous chapter, several procedures, tools, and services have been established following the reorganization of services; the MHAP calls for a renewal of practice toward a recovery orientation, whilst transforming services with a results-oriented agenda. The results reveal a common acceptance of the idea of recovery with variations in the specific interventions that are considered to be recovery-oriented and in the professional evaluation of someone who is 'in recovery'. In other words, the results illustrate the complexity of recovery-oriented practice in our transformed service delivery system. Several common discourses emerged that can be grouped into five prinicipal categories. These include: The definition and explanation given to the problematics experienced by service users; Social work values and practice approaches; Beliefs and attitudes regarding recovery and recovery oriented practice; Participant attitudes and actions with regards to changes in practice.

6.1 The conception of mental health problems

Three questions in the interviews touched specifically on participants' perceptions of the problems faced by their clients. The questions were as follows: What are the principal problems that clients face? What do you think are the principal causes of these problems? Do you believe that your clients can eventually thrive and survive without psychiatric/mental health intervention? We see from the responses that the description of the problems faced by service users, or clients, and the perceived chronicity of these problems varies. The responses indicate that the problems clients face are both a life sentence and a subjective experience of suffering; thus indicating that although a subjective journey through mental health problems is recognized, the journey will always require institutional mental health services. Regardless of which problems the participants identified as predominant, they all described a variety of causes of these problems and invariably included both biological and societal factors.

6.1.1 The problems faced by clients

Responses with regards to the 'problems faced by clients', varied significantly depending on the participants major concerns at the time of the interviews. For example, some participants described the problems based on diagnostic labeling, some described them as more psychosocial in nature and others described the major problems faced by clients as a lack of adequate services to meet their needs.

Seven participants including two managers (M1, M2, SW1, SW2, SW4, SW5, SW6) responded to the question of the principal problems faced by their clients by evoking labels based on the DSM. Three participants, all of whom previously worked in psychiatric settings, stated that the lack of existing services or the need to develop a better continuity of care is the central problem faced by clients.

> *"On est moins dans une demande d'aide que dans une demande de services. Ils ont des problèmes de loyer, dettes, […]. Des problèmes de consommation, mais on tombe aussi dans la demande de services…" (SW1)*

> *"Il y a vraiment beaucoup de diversité [dans les problématiques vécu par notre clientèle]. Ce qui rentre au guichet est très variable, il y a de tout. Il faut s'équiper pour répondre à tout. Ça ne veut pas dire qu'on va offrir des services pour tout ça parce que c'est très spécialisé dans certains cas, mais l'équipe santé mentale doit se relier à des partenaires qui s'occupent de ces clientèles-là..." (CC1)*

> *"the problem is getting psychiatric evaluation. Some of them work, and some doctors refuse to give medication…"(SW2)*

Three participants all of whom have long standing experience at the CSLC level and consist of two social workers and a manager who is a social worker by training (M3, SW3, SW7) evoked life situations or experiences as well as structural issues as the major problems faced by clients. Their conception of the client's suffering is much larger.

> *"On a beaucoup de gens en situation de pauvreté, marginalité, isolement. Beaucoup de personnes en rupture avec leur réseau social qui se retrouvent en centre-ville." (M3)*

The conceptualisation of the causes of the problems as perceived by the participants is multi-factorial, regardless of the conceptualisation of the problem itself. Structural and social (poverty, education, family, loss) reasons and the personal history of the client are discussed (M2 and SW5). The biological causation of the problematics is still pervasive in most discourses, although it is never cited as the sole basis for the problems:

> *"Les causes principales dans l'axe I[54] c'est la maladie, souvent dont les causes sont inconnues. C'est biochimique […]. Et d'autre part, quand on est vraiment dans le social, les causes principales que je voie des fois c'est une faible scolarité. C'est souvent des gens qui sont issus d'un milieu pauvre, sous-scolarisés, où il y a eu beaucoup d'abus sous toutes sortes de forme. On ne parle pas juste d'abus sexuel. Ça, il y en a beaucoup. Du monde […], qui se retrouvent dans les services pour plusieurs raisons, mais vraiment à caractère psychosocial." (SW1)*

> *"C'est assez difficile de répondre à ça dans le sens que ce sont toutes des problématiques différentes. Ce que je peux répondre, c'est qu'il y en a que [la cause des problèmes] est situationnel…Il y en a d'autres qu'on voit que c'est des facteurs héréditaires aussi. Il y en a d'autres, souvent ce qu'on voit chez des gens qui ont des troubles de personnalité, régulièrement dans leur histoire de vie précoce, ils ont souvent eu des difficultés, une enfance difficile, des rejets, des choses comme ça. Ça revient souvent. C'est assez difficile de dire les causes de plusieurs problèmes. Il y en a que ça peut être parfois la suite de pertes dans leur vie, pertes successives, donc perte d'emploi, divorce, perte de contact avec leurs enfants. Ils vont faire une grosse dépression à ce moment et tomber parfois très bas. Ça peut être des causes d'ordre plus psychosocial comme on dit." (SW4)*

> *"C'est biopsychosocial. Au niveau bio, c'est beaucoup les symptômes, si on peut appeler ça du côté maladie. Au niveau d'avoir des saines habitudes de vie. Des fois, les gens dorment tout croche ou mangent pas bien ou ne font pas d'exercice, ça va être de coacher par rapport aux habitudes de vie. Des problèmes de consommation. Au niveau relationnel, des problèmes avec la famille, des amis. Des fois, ça va être des gens qui ont un peu perdu leur réseau, ont peut-être épuisé leur réseau. Au niveau de l'emploi aussi, des gens qui ont de la difficulté à se maintenir en emploi, qui ont perdu des emplois, ont de la difficulté à s'en trouver un, pour toutes sortes de raisons.*

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[54] *Axe I* or Axis I in English refers to the first of five axes in the DSM used to describe and label mental health problems. Axis I refers to clinical disorders and learning disorders. Axis II refers to personality disorders.

Même chose pour les études, les gens qui ont décroché et qui veulent se réinsérer" (SW6)

"Je trouve qu'il y a la santé mentale et la maladie mentale. Une fois que la maladie mentale est stable, je travaille beaucoup avec leur santé mentale […] Souvent, ça peut être en rapport avec les symptômes positifs que leur maladie. Le côté marginalisé aussi. Les difficultés au niveau relationnel et social. Il ne manque pas grand-chose. C'est pour ça que je trouve ça 'le fun' quand on peut les amener à une petite activité. Comme mon client que j'ai accompagné. On est allé visiter le centre. Il faut juste ce petit pas-là. Quand il m'a dit ce matin, j'ai fait 20 minutes. Il est tout fier. Il est avec d'autre monde. C'est très important. […] c'est beaucoup la solitude." (SW7)

6.1.2 The chronicity of mental health problems

When discussing the chronicity of mental health problems participants differentiated between surviving and thriving and discussed quality of life in absolute terms. They questioned the quality of life with which a person living with mental health problems could 'survive' and felt that certain people could not thrive or have an adequate quality of life without mental health interventions or medication. Many participants (M1, SW3, SW4, M3, CC1) discussed the importance of having appropriate services in the community in order for people with mental health problems to transition away from institutional mental health services. However, they focused on the need for family doctors, which are undoubtedly important, without mentioning community resources or alternative mental health resources as possible cornerstones in a client's path to recovery. This may be because fundamentally a biological causation, and therefore solution, is still prevalent in discourse, practice, and service offer:

"Survivre oui. Mais je veux dire, non […] La réponse à ta question qui était est-ce qu'ils peuvent continuer à vivre et survivre, je sais pas. Mais avec quelle qualité de vie. Je pense que dans la plupart des cas, si on n'intervient pas, la qualité de vie va continuer à se dégrader. Où ça se retrouverait, je sais pas" (SW1)

"… when there is no support they break down. And then they are left by themselves and then they are referred here and you tell this client well you will have to wait 4 to 5 months and it is a long time. They stop taking their medication and that is the medication aspect" (SW2)

> *"Il y en a que oui. Sûrement, il y en a qui vont pouvoir. Ils vivaient avant qu'on arrive. Mais il y en a d'autres qu'il va toujours y avoir un besoin quelque part. Parce que ça fait partie de notre travail, aider les personnes à accepter, c'est un gros mot, mais à s'adapter à leur condition, donc apprendre à mieux gérer les voix, être capable de voir les symptômes venir [...] S'ils ont des symptômes positifs, ils entendent beaucoup de voix. La plupart du temps, ils peuvent vivre avec. Ils ont pu se familiariser, ils sont à l'aise. C'est au moment que ça commence à être plus envahissant, ça commence à paralyser, à être une obsession qui devient de plus en plus présente. Être capable d'en parler. On travaille ça." (SW7)*

Several participants framed their responses by citing the need for more or longer services:

> ***"****Comme travailleuse sociale, on sent qu'on est un peu seule aussi à porter ces problématiques-là… Des fois aussi, c'est la complexité et le côté chronique. On a un nombre de rencontres limite. On ne peut pas suivre les gens pendant un an ou deux ans" (SW3)*

One social worker considered the possibility that some clients can have flexibility with regards to the services that they desire:

> *"Ça depend […] de leur niveau de mentalisation un peu, les processus qu'ils ont faits à travers toutes leurs expériences de suivi et comment ils ont réussi à se faire une vie intéressante aussi pour eux. Je pense que oui. Il y a des gens qui n'ont pas besoin à vie d'un suivi ou qui peuvent avoir besoin à l'occasion de reconsulter par exemple, ça oui." (SW5)*

Finally, one of the managers that was interviewed responded to the question in terms of her view of recovery:

> *"Oui, moi je crois au potentiel de rétablissement des gens. C'est sûr qu'on va les amener au maximum qu'ils peuvent être, mais c'est ça le principe du rétablissement. Des fois, y a des gens qui pensent qu'en santé mentale, l'ancienne croyance c'est que ça doit jamais s'arrêter. Mais pour moi, à partir du moment où la personne comprend ce qui lui arrive. […] elle veut faire des changements. Alors au moins, on a un levier. De s'assurer qu'on va l'accompagner et la supporter. Et qu'il y ait une continuité. Parce que quand tu es dans cet état-là, tu ne sors pas de chez-vous depuis déjà très longtemps, on peut penser que si quelqu'un ne t'accompagne pas avec la meilleure volonté du monde… Je pense qu'avec cette volonté, cette croyance que l'on a, oui, je crois fermement que oui." (M2)*

All of the responses rested on the assumption that mental health or medical services are required until psychosocial functioning is restored. Thus, despite naming recovery as a favoured orientation or naming structural or social issues as determinants of mental well-being, a certain chronicity in terms of mental health problems and trajectory in mental health services is evidenced.

6.2 Recovery – a road that social workers have already walked down?

In response to the questions 'What values are at the base of recovery?' and 'Do you think that the social work field has been influential in the evolution and reform of mental health service organization and practice? In what way?', managers and practitioners identified several recovery values; all of the social workers stated that these values were in line with the inherent values of their profession. One social worker articulated it in this way:

> *"On parle de rétablissement et y a rien qui me vient de spécifique. J'ai l'impression qu'on a toujours travaillée en vue du rétablissement. C'est grossier comme définition, mais c'est ça. Ce qu'on vie, c'est le rétablissement de la personne." (SW1)*

It is important to note that the reflections on recovery that follow are based not only on the responses to the above questions, but also on the entire content of the interview which was analysed with particular attention given to the descriptions social workers gave of their practice orientation. I will begin with a consideration of social work values; an analysis of the interviews allowed for a revision of the values or principles that participants consider to be relevant and salient to their practice. These include self-determination, working with the whole person, and empowerment. The second section will presents the results of an analysis of participant responses with regards to social work practice approaches.

6.2.1 Social work values and principles

Client collaboration and self-determination

According to CASW (2005) social workers "uphold each person's right to self-determination" (p.4) as part of the social work value that CASW articulates as 'respect of the inherent dignity and worth of every person'. The Code of Ethics (CASW, 2005) also discuss the social work profession maintaining the client's right to choose, based on informed consent. This principle is not particular to social work. It is at the heart of the MHAP. As such, social workers are supported in upholding this value, not only by their professional value base, but supposedly also by tools such as the PII. When discussing the recent formalization of the PII, the interview questions aimed to explore if reforms have led to changes in the status of service users from passive patients to active citizens. Only one social worker explicitly discussed how the centrality of the user in intervention planning has always been a part of her practice:

> *"Mais j'ai toujours pensé que les clients étaient quand même toujours, en tout cas, ça a toujours été important pour moi que les gens soient partie prenante de ce dans quoi ils étaient en terme de traitement[….] C'est le message que j'envoyais toujours au client, que c'est un travail d'équipe, c'est-à-dire dans lequel ils étaient inclus… L'idée que le client a une place dans tout ce système." (SW1)*

Another social worker described the importance of the lived experience of clients in their journey. She indicates the importance of social relationships and the importance of allowing for an individual to discover his or her path.

> *"À un moment donné aussi, l'estime de soi, tranquillement, s'améliore, que ce soit par des contacts sociaux ou des professionnels. C'est comme un peu graduel, en vivant leur expérience, graduellement, l'estime de soi remonte. […] Il faut laisser les gens tester eux-mêmes, apprendre à découvrir par eux-mêmes" (SW6)*

Others discussed using tools such as the PII in a way that maintains the professional as expert or focuses on objectives related to symptom reduction and basic functioning:

> *"We do the PII with the client. Obviously with some clients is more difficult to do it. But they are always aware of what you are working on, symptoms, medication, budgeting. What we try to do is get them to sign the PII" (SW2)*

> *"Je le fais toujours avec le client, après je rédige ça et le montre au client. C'est à ce moment que je vais lui demander sa signature, s'il est d'accord, s'il y a quelque chose à changer. Dans un premier temps, je fais mon évaluation professionnelle et c'est suite à ça que l'on priorise les difficultés qu'ils veulent travailler." (SW4)*

Prior to its existence some social workers describe elaborating an intervention plan in an informal way, underscoring the way in which this value can permeate through practice despite formalised procedures :

> *"Je vous dirais que c'était peut-être moins formel, dans le sens où c'était souvent un plan d'intervention par exemple qui était écrit dans les notes évolutives. Peut-être souligné."(SW4)*

Social workers discussed respect as a central value in their professional base. In order for clients to move into a position where they make their own choices and decisions in terms of the services and interventions that they receive, then social workers must respect their right to self-determination:

> *"Mais moi, c'est essayer de travailler dans le respect de la personne…C'est sans juger. Je pense que c'est la chose la plus importante. Il y a toujours des enjeux de confiance au début de notre prise en charge. On n'y parvient pas toujours. Il y a des gens [avec lesquels c'est difficles de créer des liens thérapeutiques]. Mais ces enjeux-là sont toujours un peu là, sur la confiance. La confiance s'installe beaucoup à partir du moment où les gens comprennent qu'on ne les juge pas. Ça ne nous empêche pas d'avoir des opinions. Il y a des cas qui sont difficiles des fois. Des gens disons-le parfois exécrables. Mais, sans jugement" (SW1)*

> *"[..] Les valeurs, c'est le respect. Permettre à chacun et chacune une place. Pour moi, c'est des droits fondamentaux. C'est ça que ça veut dire, respecter les droits fondamentaux de chacun. C'est avoir confiance aussi en la personne et en la communauté. C'est vraiment le respect." (SW6)*

Much to my surprise, the social work value of self-determination was not impregnated in the participant responses other than when discussing the PII tool. This may be due to

several factors, such as organizational constraints, lack of appropriate services to respond flexibly to clients needs or desires, and a lack of continued training that is value-laden.

Working with the whole person

According to the IFSW (2004) statement of social work ethics, social workers should be "concerned with the whole person, within the family, community, societal and natural environments, and should seek to recognise all aspects of a person's life" (para. 9). As aforementioned, in a primary care setting, clients consult the mental health team for a variety or reasons and with a full spectrum of problematics. In order to effectively and respectfully address all of the client's concerns, one of the social workers direcly discussed her practice as working with more than just medicalised indicators such as symptom reduction. She goes on to explain that social workers work with the whole person:

> *"[…]Nous, comme TS, on ne travaille pas nécessairement avec les symptômes. Avec l'histoire, les relations interpersonnelles, l'environnement, les habiletés sociales, l'empowerment, les forces" (SW3)*

Another social worker articulated her focus on the client as a whole person, and not as an illness or as a label, in the following way:

> *"Moi, cette histoire de vocabulaire… Pendant deux ans, c'est des clients, pendant deux ans, c'est des patients et après c'est des usagers. On s'en fout. Qu'est-ce que ça change pour moi dans la réalité? Ça change rien. Ça change rien à ma perception non plus. On travaille avec des personnes"(SW1)*

In working with a client from a recovery orientation, and from a social work perspective that is founded on the principle of respect for every indvidual's inherent worth and dignity, professional interventions that treat each person as a whole will support client's participation and more likely focus on identifying and developing strengths rather than illness. This is part of practice that empowers clients in making decisions that affect their lives.

Empowerment

Empowerment is a concept that pre-dated the recovery orientation in public policy and remains a strong approach in social work that focuses on the strengths of the individual and giving people a voice. Social workers described empowerment practice as part of social work values and recovery values, although there are different ways to understand it. Some social workers discuss autonomy as the end result of empowerment, that is to say the autonomy or self-determination to make decisions and choices that affect one's life.

> **"***Empowerment, bien sûr, toujours. De faire en sorte que les clients soient autonomes en bout de ligne, donc prendre leur propre décision, trouver des manières pour les appliquer, avoir un peu plus de contrôle sur leur vie. C'est sûr" (SW1)*

Others discuss finding and developing client strengths as the way to fuel the empowerment process:

> **"***En même temps, j'entendais ça et à la fin de la rencontre, je lui reflétais, mais c'est quand même une force en héritage. Elle me parle de ses grand-mères, qui, contrairement à sa mère, étaient des femmes d'action, des femmes très fortes. Je pense qu'il faut aller chercher ça chez les clients, des choses qu'ils ne voient pas mais qu'ils sont en eux. Elle, c'est son héritage. La façon dont elle me parlait de ses grand-mères, je me disais, il y a quelque chose dont elle peut se nourrir pour passer à travers ça. Moi c'est un peu ça l'empowerment." (SW3)*

> **"***Les valeurs liées au rétablissement, se centrer sur les forces de la personne, l'empowerment, moi il me semblait que ça avait toujours fait partie de ma pratique. C'est vrai que ça fait partie, je pense, des valeurs du travail social" (M3)*

As discussed in Chapter 2, the recovery model moves beyond the empowerment or strengths-based paradigms. However, it shares with them a focus on active participation, control over one's life, the freedom to make choice, and a move away from a deficit-based paradigm of client problematics.

6.2.2 Social work practice approaches

Although the overarching approach that was identified by every participant is the systems approach, the definition of this approach and the reason why it was favoured was rarely demonstrated. It seems that social work and systems approach[55] are used interchangeably.

> *"Les approches utilisés par les travailleurs sociaux? C'est sûr que c'est beaucoup systémique" (M1)*

> *"L'approche n'est pas unique et systématique, mais les gens sont formés d'abord et avant tout là-dedans je trouve …" (SW1)*

> *"Je vous dirais que la plupart des TS utilisent [une approche systèmique]. D'ailleurs, c'est parce que nos superviseurs de groupe et individuel sont en systémique. Il y a beaucoup de gens qui l'utilisent" (SW4)*

> *"Ils sont engagés comme TS en santé mentale, donc on s'attend à ce qu'ils soient pas mal connaissants de l'approche systémique" (CC1)*

The systems approach is also described as a community-oriented approach that some participants feel is social work's contribution to the mental health field. This is important because it illustrates the way in which social work practitioners value the multiple non-institutional resources and pathways that a person might want to take on his or her recovery journey:

> *"Au niveau travail social, on a beaucoup une couleur communautaire. Dans notre façon d'intervenir, on va être beaucoup porté à pas juste se centrer nécessairement sur la personne, mais d'aller voir dans son environnement, dans ses liens, les gens qui l'entourent, la famille, le travail, l'école et tout ça. Je pense que c'est peut-être la couleur que le travail social apporte dans cet aspect-là, de regarder un petit peu les liens que les gens ont avec leur entourage, essayer d'aller travailler ça. Mobiliser des gens dans le milieu, que ce soit des ressources ou des gens autour de la personne. Je pense que c'est la couleur que le travail social apporte plus au niveau du travail en santé mentale." (SW5)*

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[55] a systems approach, or systems theory, typically refers to an overarching social work theory that professionals intervene with clients at the point where they interact in multiple and complex ways with their personal, interpersonal, political, and organisational environments.

Nevertheless, other specific practice approaches were also identified by some of the respondents. These include combining a systems approach with other approaches such as strengths based approach.

> ***"****C'est de voir qu'est-ce qui est là, qui est embryonnaire, qui est un peu le noyau sein qui peut faire en sorte que ça soit une assise pour aller chercher de la force. Je fais un peu l'effet miroir" (SW3)*

The humanist approach was mentioned as the favoured approach by two social workers (SW1, SW5) although it was not defined during the interview.

A solutions focused approach was discussed by a social worker who works in the severe and persistent continuum of her CSSS.

> ***"****Ici, quand on se fait embaucher, notre approche comme travailleurs sociaux doit être une approche systémique. Je suis d'approche systémique, mais par moi-même, j'ai lu sur l'approche centrée sur les solutions et c'est une approche, surtout dans sévère et persistant, qui je trouve marche bien. Aussi, un peu de concepts cognitivo-comportemental. C'est pas mal ces trois-là en majeure partie…C'est une approche qui est très validante, valorisante, centrée sur le positif. Souvent, sur notre continuum, les gens ont une faible estime d'eux-mêmes. Je trouve intéressant dans cette approche, la façon dont je pose mes questions, c'est très validant et je ne suis pas du tout en position de supériorité. Je félicite les gens. La façon de poser les questions fait en sorte que les gens se sentent respectés, valorisés et ça peut débloquer des choses je trouve. Plutôt que de se centrer sur le négatif, on se centre plus sur le positif et après, c'est plus facile de construire autour de ça. Exemple, c'est pas facile ce que vous vivez. Comment vous avez fait pour surmonter ça? Qu'est-ce que vous avez fait dans le passé qui a pu vous aider? Où vous avez appris ces belles valeurs-là? Les gens sourient en répondant. Je trouve ça le fun" (SW6)*

One social worker that previously worked with the CLSC mental health team describes how she uses both a systems approach and a short-term planned approach.

> *"j'utilise l'approche systémique et certains éléments de l'approche court terme planifiée. Justement entre autres pour m'aider à faire des PII, je trouve que c'est une approche intéressante…Au niveau de l'approche systémique, ce que j'utilise beaucoup principalement dans mes suivis, c'est que je vais*

essayer de toujours aller travailler avec les gens de la famille, l'entourage, aller chercher des choses positives ou des outils" (SW4)

"L'approche planifiée court terme systémique comme je vous dis, c'est principalement pour m'aider à établir le PII. On va cibler une difficulté qui est le plus dérangeant pour la personne au moment où il nous consulte. Cette approche-là, la façon dont elle est élaborée, ils ont pour principe que si on s'attaque à améliorer ou régler une difficulté qui est plus dérangeante pour la personne, ça risque d'avoir un impact positif sur les autres difficultés. Les techniques qu'ils utilisent pour aller chercher ces informations sont très aidantes pour moi, pour établir le plan d'intervention" (SW4)

Several social workers discussed using a 'toolbox' of diverse approaches based on the objectives and needs of the client. This perspective indicates suppleness in the practice of social work:

"*Je trouve que c'est toujours une erreur de penser qu'on va passer tout le monde dans le même moule. Tout le monde n'a pas les mêmes besoins. On ne peut pas tout traiter par une seule approche." (SW1)*

"J'ai plusieurs approches. Quand j'étais à l'Université McGill, notre approche c'était l'approche systémique… Je pense que c'est encore la grosse mode. C'est aussi l'approche de réduction des méfaits. C'est aussi l'approche cognitive comportementale. J'ai aussi l'approche réaliste. […] J'ai pas vraiment une approche que je peux dire que je vais observer à 100%. Même avec une personne, je vais observer différentes approches. Mon objectif est de permettre à la personne d'être capable de reprendre la responsabilité de sa vie et de pouvoir être autonome, fonctionner dans la communauté, avoir sa place. C'est ça mon mandat primaire. Je vais tricoter plein d'affaires avec le client pour être capable de faire ça" (SW7)

As previously discussed, flexibility in work organization is important for professionals. In addition, flexibility in terms of service offers and practice approaches is important when establishing a recovery orientation. We see from the analysis that the

social work profession's inherent flexibility[56] may be an important factor in the professional's alignment with a practice modality that is recovery-oriented.

6.2.3 Institutional practice approaches

Many social workers that participated in this project explained a push by their organisations toward approaches that were not necessarily part of their social work training. We see that the current impetus to develop and integrate evidence based practices and the continued conceptionalisation of mental health problems as purely medical makes it difficult for some social workers to valorize certain values and approaches, such as a humanistic approach. This in turn could undermine the capacity of professionals to also articulate the relevance of recovery-oriented approaches that are consistent with recovery-oriented interventions.

> *"[…] Souvent, comme travailleuse sociale, et je m'inclus là-dedans, j'ai une boîte à outils et j'utilise mes outils intuitivement avec les clients qui sont là. C'est sûr qu'il y a une approche systémique qui prime peut-être plus ou humaniste, mais...je dirais que les psychologues ont plus le langage pour amener leur grille, ils ont pu analyser les problématiques des clients. Je pense qu'on a aussi notre bout de chemin à faire en amenant un peu plus notre vision.[…]Dans le savoir-être, j'ai l'impression que c'est une activité qu'on a, mais dans le savoir, et surtout dans la façon de nommer le savoir, j'ai l'impression que là, des fois, on passe à côté. " (SW3)*

Others also described a focus on the medicalised approach since the reforms. Some social workers felt an invasion of the medical model and a threat to the community model of the primary care mandate.

> *"Même en première ligne, c'est difficile de faire de l'intervention en santé mentale parce que tout est filtré par le guichet et n'a accès au guichet que ce qui vient du médical et de l'accueil psycho-social. Dès qu'il y a un besoin de médicament ou d'évaluation en psychiatrie, c'est médicalisé […]" (SW1)*

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[56] "Social work utilises a variety of skills, techniques, and activities consistent with its holistic focus on persons and their environments" (International Federation of Social Workers, 2000, para. 5)

> *"C'est beaucoup la médication par rapport à tous les troubles. C'est correct, tout passe par le médecin souvent. Comme nous, on s'est arrangé très régulièrement sans psychiatre auparavant. On n'avait pas accès comme ça à de la consultation comme on a maintenant. Tout passe beaucoup par les diagnostics." (SW4)*

> *"[…] On parlait tantôt de différences entre avant le plan d'action et après. Ce que je trouve qu'il y a eu beaucoup avec l'arrivée des nouvelles équipes et le plan d'action, c'est que je trouvais que c'était beaucoup l'approche médicale. Très médicaliser la santé mentale" (SW3)*

Although one social worker claims to be unfamiliar with the medical model she describes a change in her evaluations following the reform to include an increased familiarity with diagnosis and medical history:

> *"Ça a pris plus d'importance d'aller chercher l'information liée aux antécédents médicaux, à l'histoire psychiatrique, à m'intéresser à savoir qui est ce client-là, savoir si je suis plus en santé mentale ou pas. D'avoir le vocabulaire aussi. Être plus familière avec des diagnostics." (SW5)*

Another social worker (SW 6) discussed the irrealistic expectations of family doctors that refer patients with the objective to 'cure' them.

From the above excerpts we see that regardless of work organization, level of development and previous professional experience, social workers are faced with the predominance of the biomedical model in mental health. This is important to discover because it overturns the assumption that simply shifting the location of mental health services to the community, local level would necessarily make practice less medicalised; the assumption that recovery being named in policy necessarily challenges the biomedical model and the chronicity of mental health problems is inaccurate. Thus, even at the primary care level, the conception of mental health remains anchored in a psychiatric and medical model. The predominance and influence of a medicalised mental health care setting will undoubtedly affect the way recovery is conceptualized, as will be discussed in the following section.

6.3 Recovery and recovery-oriented practice: definitions, attitudes, and beliefs

The conceptualisation of recovery and the way our mental health system and practice can espouse this orientation is not homogenous. Three dimensions emerged in response to the following open-ended question 'What does the term recovery mean to you?' and following an analysis of discussions concerning recovery. These include: the way practitioners define a client who is in recovery; recovery-oriented systems; recovery-oriented practice. Social workers also questioned the way recent reforms have been translated into practice. The focus on outcome may indicate that the service delivery system is supporting a meaning of recovery that is focused on a service user being 'recovered' rather than being in recovery:

> *"Si t'es capable de fermer rapidement, c'est parce que tu est efficace. Tu est un bon intervenant et capable de guérir vite. De « rétablir »." (SW1)*

> *"C'est un peu abstrait je trouve comme notion. On a un gestionnaire [pour qui] le rétablissement passe par des activités concrètes, la menuiserie, des choses à l'extérieur. Mais nous ici, comme je disais, l'intervention en individuelle seule avec mon client dans mon bureau, pour moi [le rétablissement] c'est très abstrait. Qu'est-ce que ça peut bien vouloir dire, j'aimerais bien le savoir[…] comment arrimer ça à la pratique. Comment lui donner forme. C'est un beau concept, mais c'est ça que je disais. Dans notre pratique, notre intervention, c'est quoi moyens qu'on a." (SW3)*

6.3.1 Being in recovery

The concept of being in recovery was divergent not just between the two research sites but also amongst the participants. Some social workers stated that it is difficult to know when someone is in recovery. Their discourse indicates that the evaluation of recovery should be done by the professional and not by the individual experiencing mental health problems. We see that previous experience in psychiatry leads to a conception of recovery that is bureaucratic. The role of the professional, rather than the individual experiencing recovery, is cited as important in determining when someone is recovered.

This vision of recovery does not consider the process of recovery and interprets the ebb and flow of the recovery process as a sign of chronicity:

> *"Mais où est la limite et où ça commence à être suffisamment satisfaisant pour dire, cette personne est rétablie, même si on sait que personne ne l'est jamais tout à fait […] il y a une chronicité dans certaines choses. Il y a une cyclicité […] Il y a des choses qui vont revenir pendant quelques mois, quelques années." (SW1)*

One manager, who is a social worker by training, spoke about her perspective of recovery. We see that the influence of social work value base results in a conceptualization of recovery that places importance on being person-centred and creating room for people to have hope and dreams.

> *"C'est la croyance dans la possibilité de la personne de se rétablir, dans ses forces. Aussi, que la personne n'est pas juste une maladie, elle est une personne. Que malgré la maladie, parce qu'il y a des maladies qui sont là comme le diabète et tout ça qui sont là, mais malgré la maladie, tu peux faire des choses. Tu peux réaliser, avoir des rêves, susciter l'espoir. La participation aussi de la personne à son plan de soin. S'entendre ensemble sur qu'est-ce qu'on va travailler. C'est quoi les objectifs, le bout de chemin qu'on va faire ensemble." (M3)*

We see that when a manager's conceptualization of recovery goes beyond restoring basic functioning, then that conceptualization is imbued in the discourses of her team:

> *"C'est quand la personne retrouve son potentiel. C'est au-delà du fonctionnement. Elle se permet de pouvoir… C'est pas la croissance personnelle, mais à quelque part, c'est un peu ça aussi. Quand la personne retrouve son équilibre psychologique, social. C'est au-delà d'avoir une reprise de fonctionnement et diminuer les symptômes. Elle est rendue à un processus autre." (SW5)*

> *"Ça peut vouloir dire plusieurs choses. La première partie de ma réponse serait que pour moi, le rétablissement, c'est que les gens qui ont des problèmes de santé mentale sévères et persistants, c'est intervenir avec ces gens-là avec l'idée que les gens ne sont pas la maladie. Les gens sont des personnes qui peuvent très bien faire une vie sans avoir cette étiquette-là. Les gens peuvent faire une vie satisfaisante, sans toujours se rappeler, je suis malade. Par exemple, j'ai des personnes qui m'ont dit, à partir du moment où*

j'ai arrêté de me percevoir comme une personne malade, j'ai commencé à mieux aller" (SW6)

Notwithstanding, participants from both CSSS discussed recovery in terms of functioning and rehabilitation. They mention the importance of restoring functioning in terms of work and housing when discussing a person that is in recovery.

"Recovery approach. Obviously there is that approach, getting the person back on his feet, giving him the tools […]" (SW2)

"Rétablissement, ce que ça veut dire pour moi… C'est sûr que dans le cas d'une schizophrénie, on sait bien que ça ne sera jamais possible de se rétablir de ça, mais ce que moi j'entends par rétablissement, c'est plus rétablissement de la personne dans son fonctionnement de vie quotidien….C'est sûr que quelqu'un peut se rétablir complètement d'une dépression, mais c'est plus comme ça que je le comprends et c'est plus dans ce sens-là en général que je vais travailler avec les gens. Je ne travaillerai pas nécessairement à faire en sorte qu'ils soient rétablis complètement, dans le sens premier du terme, mais je vais plutôt tenter de travailler à ce qu'ils se rétablissent d'une façon à ce qu'ils deviennent fonctionnels à nouveau dans leur vie, quand c'est possible en tout cas […]" (SW4)

"Le rétablissement, ça va être de faire des ajustements, qu'est-ce qui est dans mon style de vie, qu'est-ce qui m'a amené à craquer et là, faire sur le long terme des changements, au niveau du travail, réorientation, fréquenter les gens, insérer des modes de vie ou des loisirs qui sont naturellement antidépresseurs. C'est d'améliorer le style de vie pour éviter d'être malade." (CC1)

"À l'époque, c'était de la réadaptation. C'était comme un cycle, ça faisait partie du traitement. Alors que pour moi, maintenant, rétablissement c'est vraiment intégré. C'est comme une fin en soit. Pour moi, c'est vraiment quelque chose de te donner tous les outils pour que tu sois au meilleur de ta condition. La problématique que tu as va toujours être là." (M2)

One of the CSSS uses a specific schema (see Annex 10) that is described by the clinical coordinator as follows:

"[…] Je ne sais pas si vous avez vu le graphique comme un psychiatre nous l'a conceptualisé. Je trouve que ça aide à préciser les niveaux de soins, mais pour un thérapeute aussi à savoir où il se trouve dans son processus avec le patient. Dans la phase de crise, c'est sûr que le gros de la relation

> *thérapeutique ou des services vise le traitement, la compensation des symptômes. En même temps, il ne faut pas oublier tout le côté réadaptatif, où il va rester en sortant de l'hôpital, et aussi ce qu'il veut faire dans la vie, donc le rétablissement." (CC1)*

As we can see the conception of recovery that is developed is determined in part by the organizational tools and trainings, such as this schema. Two of the social workers working with this schema (SW5, SW6) referred to it when discussing recovery. The third social worker (SW7), who has more experience in the CLSC network and in mental health, did not make reference to the schema.

The schema and the clinical coordinator's position with regards to rehabilitation and recovery influence the service offer and the interventions of the social workers. The clinical coordinator discusses how recovery is an objective that is present during the treatment and rehabilitation phases, but that it becomes omnipresent only after functioning is restored. The interventions in the recovery phase that aim to help a client develop a life project are judged to be most pertinent in an alternative community setting rather than an institutional CSSS setting:

> *"[…] C'est sûr que quand la phase de crise passe, on est dans la phase de stabilisation et qu'on pourrait dire que c'est de la première ligne, le gros de nos énergies, ça va être de travailler à la réadaptation des différentes proportions, dépendant de si on est au début ou six mois ou un an plus tard. C'est sûr que ce qu'on vise, c'est que le traitement soit de plus en plus installé. Peut-être que finalement, il reste juste une rencontre médicale deux fois par année et des médicaments. Comment je dois m'équiper pour redevenir fonctionnel au maximum, fonctionner avec mon logement, me nourrir, travailler, me divertir. L'espace de réadaptation, c'est beaucoup le travail sur des troubles sévères qui se situe beaucoup là, dans un but de rétablissement. Quand on est rendu dans la phase à long terme de se développer une vie, pour nous, on a des partenaires dans le suivi communautaire. On essaie de les transférer pour que cette phase-là soit à long terme dans le suivi alternatif, communautaire, dans la communauté, au niveau de soins plus légers, mais le plus normalisant aussi. Ils ont besoin de soutien encore, mais pas dans des buts de traitement ou de réadaptation pour traiter des problèmes, mais pour se developer" (CC1)*

Thus, we see that the current context of large institutions such as the CSSS replacing the more community oriented, smaller CLSC leads to a conception of recovery entrenched in an institutional mandate; recovery is a process to be focused on by community organizations once the first line mental health team has intervened to ensure psychosocial rehabilitation. The clinical coordinator alluded to the notion that by using the schema the first line mental health team focuses on restoring functioning, whilst the community organisations focus on 'maintaining' recovery. Not surprisingly then, most participant responses in this project liken recovery-oriented practice to reestablishing functioning. This is also in line with the OTSTCFQ description of the role of a social worker. Is it possible that such a reductionist perspective of recovery (symptom reduction and increased social functioning) actually masks other larger societal uses that are linked to mental health and well-being? Concerns related to poverty, access to education, arts, culture, music, literacy, community engagement, capacity building, family, and friends are perhaps dampened by a recovery-orientation that is equated to functioning. If a professional in an institutional or community setting is to assist a person living with or having lived with mental health problems 'recover', then interventions, statistics, management approaches, and work organization must reflect and value the time needed to converse with a client. Thornton and Lucas (2010) suggest that a purely descriptive conceptualization of recovery that considers recovery to be a return to normality will block this orientation from being a model that can truly oppose and overturn the purely biomedical model of mental health[57].

6.3.2 Recovery-oriented service delivery

The two CSSS involved in this project are at different stages of development and have a different service offer. This in turn leads to a different positioning with regards to recovery oriented service delivery. The previous chapter looked at the current service offers and work organization in the two sites. This section will analyse participant

[57] Phelan, J.C. (2005) discusses how the recent imperative toward emphasizing the genetic and biological causes of mental illness actually increases stigmatisation in terms of desired social distance from people labelled as mentally ill. Reducing stigma is an important component of a recovery orientation.

interviews to ascertain their perspectives on what a recovery-oriented service should look like and whether or not their team is currently offering recovery oriented services.

It is evident that there is a willingness to orient services toward a recovery orientation, albeit the conceptualization of recovery might be one that is focused on restoring functioning.

> *"Je pense que, de toute façon, on est en train de mettre la table pour vraiment entrer 100 milles à l'heure dans des services qui sont axés à soutenir le rétablissement chez les personnes. Pour l'instant, je ne peux pas… Mais je pense qu'on facilite." (M1)*

However, when discussing if the concept of recovery is part of organizational policy and procedures another manager replied:

> *"non. Peut-être plus dans les choses que tu vois du gouvernement, mais ici, c'est pas vraiement quelque chose qu'ils connaissent. Peut-être quelques uns, mais ça ne s'est pas beaucoup développé" (M2)*

One social worker described a paradox between the concept of recovery and the way that concept is manifested in the mental health care reforms, explaining that the recovery orientation is focused on satisfying administrative needs:

> *"Mais ce que le système veut, et ça c'est une impression, c'est très subjectif, mais ce que le système veut c'est que je fasse du rétablissement, mais pas pour le bien des personnes, pour le bien du système. […] Mais dans quoi on est vraiment, je ne sais pas. Je comprends très bien qu'il y ait des enjeux monétaires. Tout coûte cher, partout. C'est sûr qu'il faut faire le plus possible en dépensant le moins possible, ça je comprends. Que ça prend des gens responsables de la gestion des budgets. Il faut qu'il y aille des contrôles, on comprend très bien. L'impression que j'ai présentement, c'est que dans le mode de gestion qu'on a, ce n'est pas le rétablissement qu'on veut. C'est que ça coûte moins cher." (SW1)*

We continue to see a preoccupation with statistics and performance outcome measures. In a practice setting in which the managers do not act as a buffer between the professionals and the result orientation of the current health care system, we see a conceptualization of recovery by the CSSS that is constructed around statistical expectations. That is to say, recovery is valued by the organization because it serves a statistical end – the closure of a

file. When accessibility is measured by the number of files that are opened and closed (60 per year per professional is the requirement) then the conceptualization and relevance of recovery is affected:

> *"On prend pour acquis que si un client entre et sort, au bout de 15 rencontres, il est rétabli, mais ça c'est la statistique, ce n'est pas les faits. Comment vérifier s'il y a vraiment rétablissement, ça c'est autre chose. C'est pas parce que quelqu'un est sorti des services qu'il est rétabli. Il y a un épisode de services qui a été fermé, point" (SW1)*

In a practice setting in which recovery is discussed frequently as it related to the schema (Annex 11), recovery-oriented systems are seen by many of the participants as an approach particularly pertinent for clients that have 'severe and persistent' mental health problems. This is coherent with the discourse of rehabilitation models as well:

> *"beaucoup l'approche des troubles sévères, de ramener une position citoyenne, dans le sens que oui, vous êtes porteur de telle maladie, [vous prenez] tel médicament, mais maintenant, on travaille à reconstruire une vie pendant que ça va bien. En attendant un prochain épisode qui demandera peut-être des soins aigus à nouveau, on n'est pas obligé d'être toujours dans des soins très lourds au cas où. Quand ça va bien, on s'occupe d'autres choses." (CC1)*

> *"Le concept de rétablissement aussi. Je ne sais pas si c'est nouveau, mais ici au CSSS, les équipes cibles, c'est quand même nouveau. C'était des gens avant qui tombaient un peu dans les craques. Ça se chronicise. Là, moins. On ne fait pas de miracles, mais on est là […] Le SIV permet de rencontrer ces clientèles-là. Elles deviennent des clients à part entière et ont droit à recevoir une aide. C'est écrit dans le plan d'action.[…]. Le SIV prévient l'hospitalisation, l'internement. Je sais qu'ailleurs, dans d'autres CSSS, ça faisait longtemps que ça existait, mais ici, qu'il y ait une équipe qui fasse ça. Avant, ces clientèles-là étaient réparties un peu partout. Là, il y a vraiment une équipe qui fait du rétablissement." (SW6)*

> *"Quelqu'un qui est plus dans le continuum des troubles affectifs ou des troubles relationnels, c'est plus une offre de style psychothérapie. Quand on est au niveau des troubles sévères, c'est plus une offre de style suivi long terme, réadaptation, réinsertion." (M3)*

It seems that service delivery organized by continumms is a result of the idea that different interventions are needed in order to practice from a recovery orientation.

> *"Tout le monde est orienté rétablissement, mais c'est une offre de services différente parce qu'on ne travaille pas de la même façon avec la personne. Quelqu'un qui a un trouble relationnel pourrait être suivi dans le continuum des troubles sévères, mais l'offre de services qu'on va lui faire va être différente. C'est pour ça que c'est évalué selon le besoin de la personne. On regarde qui pourrait mieux répondre à son besoin" (M3)*

However, the clinical coordinator also discussed the first line mental health team's role in dispensing mental health services. The focus is placed on rehabilitation:

> *"…En première ligne, nous c'est de faire la réadaptation, de prendre les cas pour les stabiliser. C'est quand même du traitement, mais à un niveau où un intervenant, une fois par semaine, devrait tenir pour ce processus-là. C'est aussi une spécialité. " (CC1)*

We see therefore that a focus on developing a clinical specialization on the first line may push the importance of facilitating a recovery journey away from care; thus, marginalizing the experience of service users who are in recovery and promoting interventions that restore functioning, as was the case prior to the reforms. Nevertheless, as we will see in the following and final section of these results, despite the political transformations and the organizational perspectives, social workers' value base and preliminary training seems to be of great influence in practicing from a perspective that is coherent with the recovery literature.

6.3.3 Recovery-oriented practice

This section is dedicated to current social work interventions as described by the research participants. Although many of the items have been discussed through this paper, they will now be reconsidered specifically from the optic of recovery-oriented social work interventions. These items emerged not only as answers to questions on practice orientation, relationship with psychiatric medication, practicing from the perspective of stigma reduction, and the ability to intervene in a creative and autonomous manner, but also

from reflections on practice that appear throughout the interviews. As discussed by one participant the importance of critically looking at practices in order to ascertain if they are truly oriented toward recovery is important:

> *"…des fois, on pense qu'on est très axé rétablissement et dans le fond on l'est pas, alors ça va être tout ce travail là de conscienisation, d'amener les personnes à ce qui est et à ce qui n'est pas une pratique axé sur le rétablissement" (M1)*

Destigmatisation

Destigmatisation practice can take many forms. Practicing from a value base of respect as discussed in the section on social work values and recovery values can be a major tool in reducing self-stigma. Moreover, it is worthwhile to note that stigma reduction efforts are actually at odds with a biomedical conception of mental illness (Norman, 2011). This is because a biological causation increases society's perception of the seriousness and poor prognosis (chronicity) of mental health problems. Although the "age of the brain" campaigns have attempted to educate the public on mental health problems by citing the biological underpinnings of mental illness in order to decrease blame for exhibiting symptoms of mental illness, the result is an increased social distance. Goffman's (1963) discussed the social consensus to stigmatise with the results being a fundamental reduction in the identity of the person being stigmatized. One social worker discussed destigmatisation practice:

> *"Ça a toujours fait partie de la pratique. Je trouve qu'il n'y a rien de nouveau là-dedans. C'est quelque chose qu'on essaie de nous présenter, je pense, comme des nouveaux principes. Moi, en tant que travailleur social, ça a toujours été là. […] Et même je dirais en tant qu'être humain. Il n'y a rien de nouveau là-dedans. On ne travaille pas pour stigmatiser les gens. Au contraire. On a toujours voulu essayer de les inclure socialement..." (SW1)*

Thus, it would follow that in order to decrease social distance and increase social cohesion and inclusion, social workers would have to go beyond the task of restoring basic social functioning. Many social workers discussed their role in working with the community as not only part of the mandate of the mental health team, but also as part of the fundamental practice of social work.

However, some social workers described destigmatisation interventions in terms of psychoeducation and the discourse of a biomedical perspective is evident:

> *"… Quand je rencontre les gens, si les gens des fois ont des questions par rapport à leur diagnostic, pour moi, c'est bien important de normaliser ça, de dire aux gens que c'est comme avoir le diabète, c'est pas la fin du monde. De nuancer ça. […] Faire de la psychoéducation auprès des proches pour déstigmatiser, normaliser…"(SW6)*

> *"J'ai une dame qui vit […la stigmatization] actuellement de la part de sa famille et on est en train de considérer la possibilité de faire une rencontre de famille, ne serait-ce que pour donner de l'information, faire un petit peu de psychoéducation sur la maladie dont elle est atteinte, qui est la maladie bipolaire..." (SW4)*

Working in the community

Recovery-oriented practice was equated actually with working in proximity to a client's community:

> *"Pour moi, le rétablissement, je vais dire que j'ai toujours dosé là-dedans. Parce que j'ai été faire un DEC à Dawson où on était vraiment très communautaire dans nos approches pour assurer que la personne maintient son autonomie dans la communauté. J'y crois fondamentalement. Je pense que le CLSC a toujours ce mandat-là, en partant, même avant que la santé mentale rentre, le rôle du CLSC a toujours été ça. Permettre aux gens de rester dans la communauté, d'avoir une meilleure qualité de vie. Leur donner des moyens, les aider à faire des liens à l'entour pour maintenir et préserver leurs acquisitions. Pour moi, c'est la logique des choses." (SW7)*

Another social worker discusses what it means to practice from a recovery orientation, focusing on maintaining stability in the community:

> *"[…]c'est des interventions positives, centrées sur les forces, sur les solutions, où on ne parle pas tant de la maladie. On parle plus de ce qui va bien, on encourage ça. C'est ma réponse personnelle. Sinon, le rétablissement, ça va après. Il y a la phase de traitement, la phase de réadaptation, après le rétablissement. C'est aussi des interventions plus flexibles dans la communauté, aussi en CLSC, adaptées aux personnes, avec ses objectifs, ses besoins. C'est une façon d'intervenir psychosociale qui est flexible, qui est générale aussi. Adaptée aux besoins de la personne, dans un contexte où la personne est stabilisée, quand même. On veut maintenir ça" (SW6)*

The managers did not always sanction intervening in the life milieu of a client and interventions of this type (in the community) were reserved for specific clientele, especially when the mental health team was divided into client-specific continuums:

> *"[On] peut aller faire de l'intervention dans d'autres sites et dans la communauté et à domicile. Pour certains clients." (M3)*

> *"Sévère et persistant, on est encouragé à aller à domicile, mais juste sévère et persistant" (SW6)*

However, we see that some social workers, especially those with past CLSC experience, succeed in effecting community interventions:

> *"Il y a des choses que je ne suis pas mandaté officiel pour le faire, mais il y a des choses que je fais… Il y a des situations des fois où les clients sont mal pris, il faut agir, il faut que ça bouge. J'accompagne des clients par exemple dans certaines situations, […]Je prends la latitude de le faire. Je ne le fais pas souvent. Mais je le fais quand je sens qu'il faut que je le fasse." (SW1)*

> *"Il arrive parfois que lors d'une rencontre avec un client, on décide que cette journée-là, je l'accompagne, vais prendre un café au groupe d'entraide avec lui pour lui montrer les lieux, présenter des gens. Je pouvais le faire avant et je peux le faire maintenant… Tandis qu'ici on peut aller voir les gens à domicile si on juge que c'est requis… En autant qu'on fait nos heures et que la clientèle n'est pas pénalisée. On peut s'organiser comme on veut. C'est une belle latitude que je pense le plan d'action n'est pas venu changer." (SW4)*

An analysis of the interviews reveals an importance placed on creativity and innovation in order to offer a certain standard of service, but not necessarily a standardized service:

> *"Tout le monde n'a pas le même cheminement. Tout le monde ne fera pas le même circuit dans le réseau de nos services, parce que ça va être adapté selon le besoin de la personne. Mais l'objectif ultime, c'est qu'à un moment donné, la personne va être capable de ne plus avoir besoin de nous ou de pouvoir venir occasionnellement." (M3)*

> *"Si les voix sont angoissantes, menaçantes, et ils disent aidez-moi, on propose ce qu'on a de médicale. S'ils ne veulent pas prendre les pilules, on*

> *passe par ce genre de technique là, où ils peuvent, de façon cognitive, vivre avec les voix s'ils ne veulent pas être traités en psychiatrie et prendre des médicaments. Il y a toutes sortes de techniques pour ne pas les entendre, des bouchons, écouter de la musique, c'est plus de la diversion. Il y a aussi un autre travail plus tard de discuter avec les voix, de les intégrer dans la vie de la personne pour qu'au lieu qu'elles soient vécues de façon en dehors et contrôlante, que ce soit des parties d'eux qui se parlent et de négocier avec les voix, prendre moins de place, s'affirmer." (CC1)*

The effectiveness of these community interventions in terms of facilitating recovery, reducing stigma and increasing social cohesion is yet to be determined. However, social workers unanimously felt that autonomy, flexibility and reflexivity allowed them to intervene with their clients in a way that was stigma reducing and community-oriented. In brief, the interviews reveal that intervening in this manner was equated with facilitating recovery-oriented interventions. However, it is important to consider the research based on patient narratives (Rodriguez et al., 2000; Rodriguez et al., 2002; Rodriguez et al. 2006) that indicates the centrality of the time spent between professional and client. The importance of listening, allowing the person to have space to express himself and establish a new positive identity are identified as stronger facilitators of recovery than continuity of services. Moreover, the research in this area demonstrates the importance for a person to be connected to his community in an active and participatory way. Thus, community interventions or referrals to community or alternative resources must be done in order to facilitate a process for the client and not just to satisfy the bureaucratic need for service continuity.

PII

Previous sections have discussed the PII in terms of its development and in terms of its centrality to social work values. The discussion that follows emphasises the ways in which social workers use this tool in their interventions. The formalization of the PII is meant to support active participation of clients in their intervention plans; balance the power relationship between the client and the professionals; and change the status of service users from passive patients to active citizens. The way in which individual social workers intervene with respect to the items included in the PII and client projects, dreams,

and objectives that are not on the PII was discussed. The social workers discussed negotiating the PII in different ways with the clients. The theme of negotiation was prevalent in the interviews. The participants place value and importance on both the clients' perspectives and their professional opinions.

> *"Je le fais toujours avec le client, après je rédige ça et le montre au client. C'est à ce moment que je vais lui demander sa signature, s'il est d'accord, s'il y a quelque chose à changer. Dans un premier temps, je fais mon évaluation professionnelle et c'est suite à ça que l'on priorise les difficultés qu'ils veulent travailler." (SW4)*

> *"C'est la première chose que je vérifie dans mes rencontres, la demande du client en rapport avec la demande du requérant. Il y a toujours un écart. […] Le P.I.I., c'est toujours la dernière chose que je fais […] C'est de regrouper les principales choses sur lesquelles on va travailler. Je le rédige moi-même et je le présente au client. Je trouve que ça prend moins de temps faire ça comme ça. Le client est bien libre par exemple, s'il veut ajouter ou enlever n'importe quoi, on le fait" (SW1)*

> *"Ici, dans l'établissement, on est tenu par des plans d'intervention. Je trouve que c'est un outil que j'utilise, que je trouve vraiment intéressant. Surtout pour la clientèle sévère et persistante, les gens accrochent beaucoup, quand ils voient que ça va être concret. […]Des fois, il y en a qui peuvent demander de faire une photocopie et il l'a mise sur son frigidaire pour voir les objectifs. Je me suis fait une grille avec plusieurs thématiques, comme santé, loisirs, travail, relations interpersonnelles. Je vois avec la personne, qu'est-ce qui va bien là-dedans et qu'est-ce que vous voudriez améliorer. […] En même temps, qu'est-ce que je pourrais améliorer. La consommation, je pourrais peut-être diminuer un peu ou prendre moins de café ou me trouver une job. […] Après ça, je l'écris de façon formelle et on le signe." (SW6)*

> *"La plupart, c'est des plans d'intervention que je leur donne à faire. Je fais ma partie, eux font leur partie et on négocie, parce qu'on ne s'entend pas toujours... Moi aussi j'ai le droit à mon opinion professionnelle. Souvent, on est capable de négocier" (SW7)*

> *"C'est que la personne et l'intervenant doivent s'entendre ensemble sur des objectifs. C'est un travail conjoint. La personne vient consulter. […] Si la personne vient me consulter moi comme professionnelle, il y a une différence entre venir me parler à moi comme professionnelle, de parler à son voisin ou à son ami. Elle vient chercher quelque chose chez un professionnel. Mais je*

> *ne vais pas tout décider pour elle. Ce n'est pas parce que je suis un professionnel que je vais tout décider et que j'ai la vérité. La meilleure personne pour elle-même, c'est la personne elle-même, qui se connait mieux, qui sait ce qu'elle veut, veut faire ses choix comme un adulte. C'est sûr que moi, je peux l'éclairer, lui refléter des choses, mais on s'entend ensemble sur qu'est-ce qu'on va faire ensemble, qu'est-ce que moi je peux offrir" (M3)*

Naturally, during negotiations disagreements can arise. The interviews suggest that these are mostly due to limitations in the service offer in which referrals to the community are dispatched. Some social workers discussed supporting realistic client objectives and breaking down a life goal into smaller objectives:

> *"Je ne peux pas m'obstiner sur les objectifs d'un client, mais ce que je peux lui dire par exemple, c'est que je ne peux pas intervenir sur telle chose ou je ne peux pas vous aider par exemple sur tel besoin que vous voulez mettre au PII. […]. On a des limites dans le sens qu'on ne peut pas tout faire. À ce moment-là, on peut penser de référer ailleurs. On peut nommer à ce moment-là le besoin du client, sa demande, et dans les objectifs, c'est de référer aux services appropriés." (SW1)*

> *"C'était pas quelqu'un qui était psychotique. C'était plus un trouble de personnalité limite. Ça n'avait pas d'allure. Elle était d'un certain âge et voulait devenir une danseuse professionnelle. Elle a toujours voulu être ça et c'était son objectif. Oui, on peut aider la personne à rêver et travailler ses rêves, mais j'ai un peu de misère, personnellement, si quelqu'un me dit, je veux être astronaute, je n'embarque. Avec la cliente, c'était une négociation qu'on a faite. Elle a déjà fait de la danse, mais ça faisait 10-15 ans qu'elle avait quitté. […] Rendu là, elle le savait qu'être danseuse professionnelle à 50 ans… J'ai travaillé plus à regarder dans la communauté. Parce qu'il y a des organismes où la danse fait partie de la thérapie. (SW7)*

> *"[…]les gens savent qu'est-ce qui est bon pour eux. Des fois, les gens nous sortent des beaux objectifs que même moi, je n'aurais pas pu dire. Des fois, les gens se mettent peut-être la barre trop haute ou veulent se fixer des objectifs trop hauts, souvent, rendu à ce stade-là dans l'intervention, il y a déjà un lien de confiance qui est établi. Avec l'humour, des fois, je vais dire, vous n'êtes pas un peu ambitieux. Mais avec humour, pour que ce soit respectueux. La personne va dire, ah oui, tu as peut-être raison. Comme une fois, une dame était toujours sur l'ordinateur, c'était vraiment un peu obsessionnel. Elle ne s'occupait pas vraiment de sa vie. […]Je lui ai dit, voudriez-vous changer ça, qu'est-ce que vous en pensez? Elle dit, bien oui, ça*

> *n'a pas de bon sens, je suis toujours sur ça. Et quel serait votre objectif et elle répond, j'aimerais faire juste une heure par jour d'ordinateur, alors qu'elle en passait peut-être 10. Je lui ai dit qu'elle était ambitieuse. Alors, mettons trois heures. Des fois, je vais dire un petit mot pour mettre des objectifs plus réalistes, mais toujours dans le respect." (SW6)*

The PII is not always completed and the active participation that would indicate the centrality of the client in his treatment is marginalized regardless of past professional experience or current workplace:

> *"This is what we are going to work on, they see it and sign it. On the ones that are more difficult you show them, it is more verbal. Some you can actually work with, intellectually they understand, others is more difficult because they have deficience intellectual." (SW2)*

> *"Il y a des clients que j'en fais pas. Quand j'ai des clients paranoïdes, je me fais un plan pour moi, mais je ne lui fais pas signer un document. Quand ils ont un délire paranoïde, c'est trop envahissant pour eux. Mais je sais, je ne vais pas faire juste du social. Quand même, on va regarder ensemble et on va travailler certaines choses, comme comment mieux gérer son stress." (SW7)*

The reason for skirting the PII may be because many interventions are focused on symptoms, medication, and functioning. Social workers in both milieus were asked to discuss their practice with respect to psychiatric medication. We see the heavy weight of traditional psychiatric practice in some of the responses that indicate professional interventions in the first line mental health team as relating to :

> *"[…]symptoms, medication, budgeting" (SW2)*

Choice

The analysis has revealed that self-determination and choice are not imbued in participant discourses surrounding social work values. Moroever, we see that when describing interventions, the goals are related to compliance and controlling symptoms. Social workers dicussed their roles with respect to medication as focused on compliance in order to achieve stability of symptoms and avoid negative side effects:

> *"[…] Depuis assez longtemps, je travaille quand même dans une approche où on donne l'information au client sur sa condition et de l'intervention et du*

> *pourquoi de l'intervention. Entre autres avec la medication[..] parce qu'il y a beaucoup de gens qui ont plus ou moins de résistance ou des interrogations par rapport à la médication et s'ils ne sont pas bien informés, c'est difficile d'avoir une bonne adhésion à la médication." (SW1)*

> *"C'est sûr que je dois faire un suivi plus au niveau de la compliance, des choses comme ça. Si la personne prend bien sa médication ou si elle se sent inconfortable mettons avec telle ou telle médication, tel effet secondaire. C'est dans ces cas-là que parfois, je vais consulter mes collègues infirmiers ou encore le médecin ou le psychiatre. Mais oui, je suis appelée à jouer un rôle aussi de ce côté-là." (SW4)*

We see that in practice settings that do not have historical ties to a psychiatric institution, social workers still express the need to learn more about psychiatric medication. Some of these social workers articulated the importance of verifying that medications are adapted to client's life:

> *"[…] Je pourrais chercher à connaître les effets de cette médication chez le client. Ça l'empêche de fonctionner le matin, j'essaierais de voir avec lui, de l'amener à discuter de ça avec son médecin pour que justement, la médication soit adaptée à son fonctionnement à lui." (SW5)*

Nevertheless, it seems that tools such as the PII, a professional value base that upholds choice, and a stated recovery orientation have not yet resulted in practices that foster empowerment based on hopes and dreams. Practices seem to still be focused on compliance, avoiding adverse effects of treatment, avoiding adverse effects of the problematic, and controlling symptoms. This may be due to a practice context that requires service users to rapidly feel well enough to exit the service – professionals must open and close 60 client files per year. This may also be due to limitations in the social work field's description of its value base. Social work maintains a focus on problem solving (IFSW, 2000) and restoring basic functioning (OTSTCFQ, 2011) as well as the power to judge when a service user is capable of making choices (CASW, 2005). Thus, another paradox is revealed that directly influences practice: the prinicples of self-determination and choice are contingent upon larger working practices that remain deep-rooted in traditional approaches to care.

6.4 Changes in practice since the 2005 reforms?: a contested perspective

Participants discussed any changes in their social work practice, roles, and responsibilities in response to the questions 'Since recovery was named as an orientation in the 2005 MHAP, have your practices changed?'. The results show that managers and social workers have different perspectives and definitions of changes in practice. Some managers discussed how practice has changed regarding the use of the PII, practicing within an interdisciplinary team, and practicing with an approach that is focused on a client's autonomy. However, the managers' discourses were often focused on the changes related to services and continuity of care. They discussed practice changes in terms of improved referrals and liaison with community and specialised partners.

> *"[…] Une des choses qui m'avait frappée [au debut], c'est l'engagement et comment les professionnels étaient dédiés à la clientèle et tout ça. Mais en même temps, je dirais que le côté peut-être un peu pervers de ça, c'est qu'on était tout pour ce client-là. Des clientèles très vulnérables, en rupture de leur réseau social, beaucoup d'isolement et de pauvreté, on les prenait très en charge. On les avait pour amis. Petite anecdote, je me rappelle à un moment donné que j'avais une intervenante en congé de maladie et quelqu'un l'avait remplacée. On était en train de réviser son case load et je me rappelle un client, j'avais questionné parce qu'il me semblait que cette personne était rendue ailleurs, qu'on devrait penser à fermer le dossier. L'intervenante m'avait dit non, tu ne peux pas faire ça. Si on ferme le dossier, quand je vais revenir de congé de maladie, elle va être fâchée. On les prenait en charge, pas tous les clients, mais quand on parle de troubles sévères, de gens plus vulnérables, on les gardait dans nos services. Il a fallu vraiment travailler ça avec les professionnels, revoir comment on travaille." (M3)*

According to the clinical coordinator the main change in practice following the reforms and changes in work organization has been time for the professionals to reflect on their interventions and the client's needs. Again, this is articulated in terms of length of service offer:

> *"[…] Le gros changement, ce que j'ai beaucoup encouragé à instaurer, c'était de prendre du temps avant de se sentir, que les thérapeutes prennent en charge un cas pour la vie. C'est de prendre du temps, de dire dans quoi je*

> *suis. Est-ce que j'ai la collaboration, qu'est-ce que je vais lui offrir, du groupe, de l'individuel, court terme, moyen terme. […]. On va voir ce qui est possible de faire. Je trouve que c'est nouveau pour eux d'avoir cet espace-là pour prendre le temps de voir si j'ai un patient collaborant, prêt à travailler, ou si c'est pas mûr du tout." (CC1)*

Interestingly, almost all of the social workers stated that their practice approaches and interventions have not changed due to new policies or work organization. Some of the social workers say that their practice has not changed following the reforms and deny a renewal of practice toward recovery because they were already practicing from a recovery perspective. Only one social worker discussed how her practice has not been changed but rather facilitated by the transformation in the mental health system. She explains that the sense of team work, work climate, and developing partnerships with the hospital facilitate the recovery-oriented practices in which she has always been engaged:

> *"Je pense que ça a peut-être facilité. Je vais dire, dans le rétablissement, le fait que j'ai vécu 15 ans avec le milieu de l'itinérance, quand on a commencé dans l'itinérance, on venait juste de vivre la dernière vague de la désins. On avait beaucoup de clients qui étaient lâchés lousses dans la communauté et qui étaient psychotiques. On l'a fait. On était une petite équipe. On s'est battu beaucoup. On l'a fait le rétablissement, mais en ciel ouvert avec très peu de moyens. C'est là qu'on a été cherché un psychiatre qui s'est joint à notre équipe. Je pense qu'on était le seul CLSC dans tout le Québec à avoir un psychiatre qui faisait partie d'une équipe au CLSC. Pour moi, c'est faisable. Je ne vois rien de nouveau. Ce que je trouve qui est le fun là-dedans, c'est qu'on commence à ouvrir des portes avec les hôpitaux, que ce soit un peu plus un langage commun. Il y a de la job à faire, je pense qu'on est loin de notre profit, personnellement. Par contre, je me dis qu'on commence à s'asseoir aux mêmes tables. Parce qu'on ne parle pas le même langage." (SW7)*

Nevertheless, other social workers (SW4, SW5, SW6) discussed indirectly how new procedures have resulted in practice changes. In both sites social workers stated that a renewal of practice toward a recovery orientation had not taken place. There seems to be two principal reason for this: 1) social workers all felt that they have been practicing from a recovery perspective before the term became entrenched in policy and 2) the definition of recovery and recovery oriented practice was heterogeneous. However certain nuances exist

since social workers in both research sites acknowledged the change in their work organization due to new tools and procedures.

CONCLUSION

The general objective of this project was to explore the development of recovery-oriented practices in first line mental health teams in Québec. I wanted to find out if mental health social work practice had been renewed following an explicit governmental orientation toward recovery. This was important because the literature demonstrates that recovery-oriented practice can faciliate a person's recovery journey. As illustrated in the two previous chapters, the results of the present study reveal a complexity in the construction of recovery-oriented practice. By analyzing the two milieus links were made between service offer and work organization[58] that facilitate flexible, reflexive, autonomous, interdisciplinary, and client-centred interventions; the literature has also shown that these dimensions contribute to recovery-oriented practice. However, despite the influence of work organisation on changing practice, it is not a total determinant of practice renewal. In addition, this project has contributed to the confirmation of my intuition that social workers feel a strong rapport with the recovery model; albeit they have varying definitions of what recovery is. Notwithstanding, this project has demonstrated the importance of going beyond simplistic assumptions that social workers are unanimously ready to overturn a biomedical hegemony: The results suggest that practicing from a recovery orientation was a shared ideal among the participants but that the meaning and expression of this ideal was profoundly shaped by practice domain. Thus, despite naming recovery as a favoured orientation or naming structural or social issues as determinants of mental well-being, a certain chronicity in terms of mental health problems and trajectory in mental health services is evidenced. I initially expected participants to discuss the hegemony of the biomedical model and express a natural and immediate connection with the value base of the recovery model. I am surprised by participant's focus on the constraints related to results-oriented management models that evaluate practice interventions in a quantitative manner. I was also led to consider the gap that exists in the literature on recovery and recovery-oriented practice and the 'real-world' social work perspective of the latter. Social workers in both sites described recovery in terms of

[58] It is useful to remember that work organisation refers to the operationalization of strategic directives. For the purposes of this project, it refers specifically to the operationalisation of the major directives of the Mental Health Action Plan

functionality; this indicates a focus on something beyond a simplistic symptoms reduction but does not go as far as considering a larger societal functioning that considers the importance of social links and personal life journeys that are not related to the illness or problems at hand.

This report highlights two different service contexts and illustrates how the microprocesses of the operationalization of the MHAP and the overarching recovery orientation differed at each location. More precisely, this project shows how organizational service delivery influences work organization at the professional level and thereby affects practice. However, I am concerned about the way recovery-oriented practices are constructed; the way in which the word 'recovery' is used. As stated by Jacobson & Curtis (2000) in reference to the operationalization of recovery-oriented services in the United States:

> "Some states simply rename their existing programs: Community support services, vocational rehabilitation or housing support are now described as 'recovery-oriented' services. This renaming process demonstrates a lack of understanding of recovery; in particular, a failure to acknowledge the necessity for a fundamental shift toward sharing both power and responsibility" (p.335)

As public health policies and institutions begin to develop a stated recovery orientation, we must be wary of service delivery systems that pay lip-service to the term recovery. The participants described their current practice contexts as largely biomedically focused. This study confirmed that social work interventions and attitudes are affected by organisational contexts. Many participants acknowledged that organisational and systemic factors negatively affect their ability to practice in recovery-oriented ways. The results show that the manager can play an interesting role in acting as a buffer between the professional's role and the outcome-focused, adminstrative requirements.

As previously discussed, the social workers that participated in this project for the most part feel that they have always practiced from a recovery standpoint. Participants in this study feel that recovery might be the way for social workers to put words on something that is already done. Nevertheless, there were fluctuations in the understanding of the term recovery and recovery-oriented practice. It seems that social workers construct their

understanding of recovery based on their practice contexts that guide them in identifying which types of interventions they should use and in how to proceed. In order to create change and fulfill the profession's mandate to be agents of change, it is vital that social workers be able to read their institutional context and understand how it interacts with their professional context. This understanding will improve the ability to create changes within the institution, in their practice, with their clients and reduce the impact of the often opposing institutional and practice contexts.

The research findings suggest that not all social work core values are integrated into interventions and practice; values that espouse a global, humanistic approach. The recovery orientation has attempted to emphasize not only an alternative paradigm to the traditional biomedical model, but also allows for a broader perspective of mental health. Thornton and Lucas (2010), writing from the United Kingdom, state that the recovery model "has been linked to policies to promote social inclusion" (p.24). Like Anthony (1993, 2001), Slade (2009) and many others, these authors place values at the crux of the development of a mental health recovery model. The question remains, as can be seen by the participant responses, which values are to be favoured? The results of this study indicate that recovery-oriented systems and practices will be difficult to develop in a results-oriented paradigm. Social workers are in a position to influence the development of person-centred, citizen-led, strengths-based interventions. Although the recovery conceptualization is for the most part focused on restoring functioning, this may be due to the conceptualization of social work practice by the OTSTCFQ. This attention to restoring basic functioning is inappropriate with regards to the recovery orientation because it ignores the learning and meaning given to the experiences that a person with mental health problems has had. Is a focus on functionality at odds with a social work role of improving social cohesion and inclusion? Moreover, as we can see, at several levels (government, institutional and professional order) opposing messages are given to social workers in terms of how they should practice. A recovery orientation is to be favoured within a result-oriented managerial era; recovery is the driving force behind the mission statement of

organizations that seek out evidence-based practices; social work values are articulated in tandem with a job description focused on functioning.

Future studies would do well to focus more particularly on social work practices and on the service user perceptions of how these interventions in public mental health settings facilitate their recovery journey. Rodriguez et al. (2006) discuss the relationship between the service user and the professional, that is to say the professional's interpersonal abilities, know how, attitudes, and behaviours (p.149). The question remains how do we change practice. The recovery orientation and social work profession share a value base. This study revealed that social worker attitudes toward recovery were positive, yet practices have not changed significantly. New tools and procedures may have led to technical modifications in practice, yet participants report that the fundamental interactions between service users and professionals have not be altered.

I am nevertheless optimistic about the continued quality of social work interventions in the mental health field. Remaining critical not just of the biomedical model, but of the emerging recovery conceptualisation may shield social work practice from being reappropriated by 'community institutions'. In order to maintain a high level of practice quality, it will not be sufficient to change institutional norms and values; behaviours and interventions must also adapt. On the one hand, as we have seen this can be achieved to a certain extent, according to managers at least, through the use of tools and procedures. The social workers that participated were more focused on how positive work climate, increased flexibility, reflexivity and professional autonomy allow for more room to maneuver. However, how will social workers intervene with the additional time and space given to them? How can we ensure that practice quality is maintained? If a client feels valued and respected as a fellow human being this can be a major factor in a recovery journey and in regaining a sense of citizenship. This might be as straightforward and uncalculated as offering information and choice, having a conversation, or asking people about their day regardless of whether that is related to their mental health problems.

In 1971, Milton Rokeach conducted a widely cited psychological study that aimed at modifying values, attitudes, and behaviors. The researchers confronted participants with the inconsistencies within their own value/attitude systems; in other words they made participants aware of dissonance between an attitude they might hold and a value they might subscribe to. The researchers succeeded in creating long-term changes in which values such as equality and freedom became more important to the participants. Changing or maintaining values, both social work and recovery values, as well as changing behaviours might be done through patient narratives focused on not just the mental health problems of the service user, but also on the citizen that is at the heart of the matter. Changes in practitioner attitudes, perceptions, beliefs, and prejudices are at the heart of a true renewal of practice. The Government of Québec refers to this when discussing mental health recovery, stating:

> *"Il n'existe pas un modèle unique qui sous tende le rétablissement, mais des attitudes et valeurs qui donnent espoir aux personnes utilisatrices de services et maximisent leur qualité de vie" (MSSS, 2005a, p.19).*

Health policies are increasingly results-oriented; the State develops tools to measure outcomes of clinical practice. Recovery is a value-laden orientation; choice, hope and autonomy are difficult to measure in a results-oriented system. Moreover, mental health practitioners are intervening with issues that are socially constructed; the position of these issues as a medical illness is contested. Like mental illness, mental health, and the DSM, the concept of recovery is also a construct. However, due to its subjectiveness and heterogeniety perhaps it needs to be 'de-constructed' by the service users in particular territories. In the literature, the recovery approach calls for a user perspective at the centre of the value-base. How are social workers' experiences and practices affected when they are aware of service user perspectives of interventions and recovery? Considering the guiding narratives that Slade (2009) refers to as the knowledge base for a recovery-oriented service delivery system, it would be pertinent to consider how a change of practice might be supported by professionals being made aware of narratives focused on the person, rather than the illness. In a practice setting, this means that social worker evaluations would have

to move beyond an evaluation of social functioning toward a more humanistic and empathetic approach to mental health problems. The concern wth evidence-based practices is that creative interventions will be stifled if an intervention strategy has to be scientifically proven through randomly controlled trials before it can be used. Thus, professionals on the field who may have creative options based on their professional direct contact with service users may be unable to practice in a way that is helpful unless the scientific community has proved it.

The crucial matter however, is the centrality of the human factor in the development and implementation of policies and services; technocratic, neoliberal management models with the goals of improving efficiency by reducing social spending will not result in actions that would support recovery and participation. This exploratory study indicates that we are in the middle of the change; the paradigm shift is not yet complete. In order to ensure that recovery-oriented services and practices are indeed developed, a systematic evaluation of these would have to be implemented. There has been some work attempting to measure an organization's recovery orientation through various scales and methods such as the Recovery Enhancing Environment Measure (Ridgway et al., 2003 as cited in Armstrong & Steffen, 2009) and the Recovery Promotion Fidelity Scale (Armstrong & Steffen, 2009). The purpose of these measures is to evaluate the extent to which mental health agencies espouse a recovery orientation. In other words, this exploratory study confirms the need to pay more attention to the development and establishement of a recovery orientation in first line mental health teams in Québec. If a recovery orientation in policy is going to successfully be translated into practice, greater structural and organisational support of recovery is needed.

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ANNEX 1 – INTERVIEW GRILL

	OBJECTIVES	QUESTIONS	KEY WORDS
1	Determine participants' perceptions of user involvement in intervention planning, in overcoming mental health problems, and in working with partner organisations: • by describing the perception that participants have the problems faced by system users • by determining how user needs, satisfaction and goals are assimilated into practice • by describing the perception that participants have of the possible solutions to problems faced by users • by exploring if reforms have led to changes in the status of users from passive patients to active citizens THEME: active participation and centrality of the user	What are the principal problems that system users face? What do you think are the principal causes of these problems? Do you believe that users can eventually thrive and survive without psychiatric/mental health intervention? **Prior to the reform**, were users involved in intervention planning? In what way – please provide an example. How were mental health users perceived (as patients, clients, citizens)? What was the social workers role play in intervention planning? What was the role of the manager in facilitating intervention planning? How were psychiatrists or family doctors involved in the elaboration of an intervention plan? What items were typically included as goals in the intervention plan? **Following the reform**, can you describe a situation in which a user was directly involved in intervention planning? Can you describe a situation in which professionals did not agree with the users goals. How was this disagreement resolved? How are mental health users perceived (as patients, clients, citizens)? What is the social workers role play in intervention planning? What is the role of the manager in facilitating intervention planning? How are psychiatrists or family doctors involved in the elaboration of an intervention plan? What items are typically included as goals in the intervention plan?	Biological underpinnings, hereditary Mental illness Social and environmental factors Poverty Psychotherapy Medication Employment reinsertion Social reinsertion Community participation Partnership with community organizations Quality of life Centrality of psychiatric hospital Individualised intervention plans Individual/family input Power balance/power shift User committees, user-run services
2	Describe any variations that exist in the relevance of new recovery based interventions between social workers and managers in the first line mental health team • By describing how managers and social workers in first line mental health teams are experiencing mental health reform • By describing how participants understand the concept of recovery THEME: MHAP/recovery	What is your perception of the transformations in mental health policy in Quebec? What have been the positive aspects of the reform? What have been the negative aspects of the reform? **Prior to the reform**, where was your place of practice? What clinical approach was encouraged by your organization? Can you describe how your work was organized (schedule, relationship with coworkers and supervisors, organizational communication and culture, job design). What did the term recovery mean to you? **Following the reform,** how did your work place/environment change? How has the organization of your work changed? What clinical approach is encouraged by your organization? Do you think the reforms are resulting in recovery-oriented practice approaches? In what way? Is it relevant to your practice? What does the term recovery mean to you? What values are at the base of recovery?	Mental Health Action Plan, roles and responsibilities of team members, intensity of interventions, accessibility of services Empowerment, hope, motivation, agency, self-management, positive identity, personal meaning, individual goals, valued social roles, social justice, strengths-based practice, process-orientation
3	Determine the organization of the services • by examining the relationship practitioners have with service users • by determining the accessibility of services THEME: MHAP directives (accesibility, populational approach, hierarchy of services)	Prior to the reform, how were services organized? Were services accessible; what were the waiting lists like? Did a user have to see a doctor in order to obtain services? Please describe the typical pathway a service user will take to access services. Following the reform, how are services organized? Are services provided in greater proximity to the service users environment, an objective of the PASM? In what way? What factors hinder this? Are services accessible? What is the waiting list? Does a user have to see a doctor in order to receive obtain services? Please describe the typical pathway a service user will take to access services.	

	OBJECTIVES	QUESTIONS	KEY WORDS
4	Determine the management models favoured by the Québec Ministry of Health and Social Services and how these approaches influence work organization • By examining the professional background of the manager (including her clinical and managerial training) • By determining how long the individual has been in a managerial position • By determining a manager's perceived level of agency • By determining factors that facilitate or constrain the transformation of practice toward recovery • By determining the role of organizations/managers in creating changes in practice THEME: performance measures	How long have you been in a managerial position? What is your professional background? What is management? **Prior to the reforms,** How would you define the role of a manager of a mental health team? What management models were you expected to apply? Have these changed over the course of the last 5 years? 10 years? More? What type of statistical information is gathered? What objectives are you expected to measure? Did you have a choice in how you do your job? Did you have a choice in deciding what you do at work? Did others make decisions about your work? Did you have a good deal of say in decisions at work? Did your job require you to take the initiative and organize work creatively? **Following the reform,** How would you define the role of a manager of a first line mental health team? What management models are you expected to apply? Is there pressure on you to manage in a certain way? How do you experience results-oriented management? What type of statistical information is gathered? What objectives are you expected to measure? What are the positive aspects of this approach? Examples? What are the negative aspects? Examples? What are the effects of this approach? Examples? Is this management style in line with recovery and the other major orientations of the reforms (desectorisation, populational approach, centrality of user and family)? Do you have a choice in how you do your job? Do you have a choice in deciding what you do at work? Do others make decisions about your work? Do you have a good deal of say in decisions at work? Does your job require you to take the initiative and organize work creatively? What is your organisation's position vis à vis recovery? How is recovery included in the policies and procedures? Examples. Have your leaders or managers discussed recovery with you? How do/can leaders and managers reinforce recovery? Has your organization provided any educational opportunities concerning this subject? Can you describe a situation in which you were encouraged to manage from a recovery perspective? Can you describe a way in which you encountered obstacles in managing from a recovery perspective?	Results-oriented management, Treatment outcome Mission statement Team leader, DSM, professional responsibility Interdisciplinarity
5	Determine the makeup of the team structure • By examining the formal and informal rules and policies such as hiring policies and continuing education • By determining how roles and responsibilities are delegated and how information flows • By determining where the decision makers lie on the organizational chart THEME: work climate and professional practice	**Prior to the reform**, can you describe your team structure and your specific responsibilities? What competencies were favoured when hiring new staff? What was the influence of the unions and the collective agreements in hiring and organizing teams? Are you part of a social services department? Does your organisations' social services department have an official stance vis à vis the reforms in the mental health? **Following the reform,** how has the organisational structure and the composition of your team changed? How does this structure help or hinder the application of recovery oriented practice? Have your specific responsibilities changed? What competencies are you looking for when hiring new staff for the first line mental health team? What are the constraints that exist to hiring staff with a recovery orientation (budget, union, staff shortages)? Are you part of a social services department? Does your organisations' social services department have an official stance vis à vis the reforms in the mental health? How would you describe work climate? Do you have team meetings? How are different professional roles integrated? Differentiated? Do you have time to reflect on practice?	Organization values, staff training and team meetings Service process client description, cost of service Professional competency versus seniority

	OBJECTIVES	QUESTIONS	KEY WORDS
6	Determine the approaches/orientations used by the social workers and what influences the appropriation of these approaches • by examining how long the social worker has been practicing • by describing her past experience • by deetermining what are the factors that facilitate or constrain the transformation of practice towards recovery • by the examining the role of social workers in the evolution of mental health policy toward recovery • by determining how/if changes in mental health policy over the course of the last decades (movement towards empowerment, recovery, working with the community) is linked with this evolution THEME: social work practices	How long have you been practicing? What is your past experience? Which social work values are the most salient to you? Do you think that the social work field has been influential in the evolution and reform of mental health service organization and practice? In what way? **Prior to the reform,** what was your practice orientation? What model did you use? Had you heard of the recovery model? Were stigma and discrimination reduction a part of practice? Example. Do you have a say in choosing who you work with? Do you have a great deal of say in planning your work environment? What was your role in determining the duration and intensity of intervention? Typically what did this look like? How would you describe your relationship with the psychiatrist? What was your role with respect to psychiatric medication? What place did medical interventions take in comparison to other interventions in your work? Were you encouraged to take initiative? **Following the reform**, what is your practice orientation? What model do you use? What do you know of the recovery model as a practice model? How do you think interventions might have to be changed in order to practice from a recovery perspective? What are the constraints to practicing from a recovery perspective? What factors facilitate a recovery-oriented practice? Are stigma and discrimination reduction a part of practice. Example. Do you have a say in choosing who you work with? Do you have a great deal of say in planning your work environment? What was your role in determining the duration and intensity of intervention? How would you describe your relationship with the family doctors and/or psychiatric consultants? How has it changed? What is your role with respect to psychiatric medication (ie. do you help clients accept it, do you play a neutral role, do you encourage withdrawal, etc…). What place do medical interventions take in comparison to other interventions in your work? Can you describe a situation in which a social worker's contribution to the organization of work and practice approaches were retained by management? Can you describe a practice situation in which you intervened in the community in which system users live and assisted them with goals not directly related to their mental health concerns?	Psychotherapy, medical model psychosocial readaptation Client autonomy, client citizenship client involvement, recovery Psychosocial assessment Psychotherapy, physician's assistant, form filling (ie. welfare) administration of funds/cigarettes symptom management, socia justice/change, stigma reduction Social justice, psycho-socia rehabilitation, inherent value ir every person, community outreach process-orientation

ANNEX 2 – CONSENT FORM

CONSENT FORM

Research Project Title: Achieving a renewal of social work practice: an exploratory study of social worker and manager perceptions of recent mental healthcare reforms that embrace the recovery model

Researcher: *Emmanuelle Khoury, MSc (social work) candidate, Université de Montréal*

Research Director: Lourdes Rodriguez del Barrio, PhD., professeure agrégée, École de service sociale, Université de Montréal

A) PARTICIPANT INFORMATION

1. Research objectives

This study seeks to explore how the recent reforms in Québec Mental Health Policy are interpreted and applied by social workers and their managers. There is limited information in the literature that investigates how the organisation of work for first line mental health workers affects recovery-oriented practice. The aim is to develop a better understanding of how a renewal of practice toward recovery can be achieved and respond to the preliminary research question: how can social workers achieve a renewal of practice rooted in recovery concepts?

2. Participation in this research project

Your participation in this research project consists of the following:

- An interview of approximately one hour that will take place in your office or another convenient location.
- The interview will be tape recorded with your permission.

3. Confidentiality

The information obtained during the interviews, which will be audio recorded, will remain confidential. Each participant will be attributed a number and only myself and my research director will have access to the list of participants and the number that was attributed to each. Moreover, the information obtained in the interview and on the tape recorder will be kept in a locked filing cabinet. Participants can rest assured that no names of persons will be referred to in the final report. All information, transcriptions and audio recordings will be destroyed seven years following the completion of the research.

4. Advantages and inconveniences

By participating in this research project, you are not exposed to any particular risks or disadvantages.

You will have the opportunity to contribute to the understanding of the recovery model and of other practice models used by front line social workers. You will participate in the advancement of information on the social worker's and manager's role in the renewal of mental health practice, as well as, perhaps gain a clearer understanding of your professional role, your satisfaction with that role and the way in which your practice is shaped by personal, professional and organisational factors.

5. Right of withdrawal

Your participation is completely voluntary. You are free to withdraw from the study at any time with verbal notification, without prejudice and without justifying your decision. If you decide to withdraw from the research, you can communicate with the researcher at the telephone number indicated at the end of this document. If you withdraw from the study, the information that has been collected up until the moment of your withdrawal will be destroyed.

B) CONSENT

I declare to have become knowledgeable about the above information, to have received answers to my questions concerning my participation in this study, and to understand the goals, nature, advantages, risks, and inconveniences of this study.

After consideration, I consent freely to take part in this study. I understand that I can withdraw at any time without prejudice and without having to justify my decision.

I consent to having the data collected in this study be used
In subsequent research projects of the same nature, conditional ☐ YES ☐ NO
to approval by a research ethics committee, whilst respecting
the same principles of confidentiality and protection of information.

Signature : _____ Date : _____

Last Name : _____ First Name : _____

I declare to have explained the goals, nature, advantages, risks and inconveniences of this study and to have responded to any questions concerning this study to the best of my ability.

Researcher signature_____ Date : _____

Last Name : _____First Name: _____

For any questions relative to this study, or to withdraw from this research project, kindly communicate with Emmanuelle Khoury, MSc (social work) candidate, at the following telephone number: or at the following email address:

Any complaints relative to your participation in this research can be address to the ombudsperson at the Université de Montréal, at or at
(The ombudsperson accepts collect calls).

A copy of the signed consent form must be remitted to the participant

ANNEX 3 – ETHICS CERTIFICATES (CERFAS)

Université de Montréal

Faculté des arts et des sciences
Vice-décanat à la recherche

No de certificat : CÉRFAS-2010-11-169-A

COMITÉ D'ÉTHIQUE DE LA RECHERCHE DE LA FACULTÉ DES ARTS ET DES SCIENCES (CÉRFAS)

CERTIFICAT D'ÉTHIQUE

Le Comité d'éthique de la recherche de la Faculté des arts et des sciences, selon les procédures en vigueur et en vertu des documents qui lui ont été fournis, a examiné le projet de recherche suivant et conclu qu'il respecte les règles d'éthique énoncées dans la *Politique sur la recherche avec des êtres humains* de l'Université de Montréal :

TITRE : ***Achieving a renewal of social work practice: an exploratory study of social worker and manager perceptions of recent mental healthcare reforms that embrace the recovery model.***

REQUÉRANT : **KHOURY, *Emmanuelle, KHOU01517901, étudiante à la maîtrise en service social, École de service social.***

sous la direction de :

RODRIGUEZ DEL BARRIO, Lourdes, professeure agrégée, École de service social.

MODALITÉS D'APPLICATION
Tout changement anticipé au protocole de recherche devra être communiqué au CÉRFAS qui en évaluera l'impact au chapitre de l'éthique.

Toute interruption prématurée du projet ou tout incident grave devra être immédiatement signalé au CÉRFAS.

Selon les exigences éthiques en vigueur, **un suivi annuel est minimalement exigé afin de maintenir la validité de ce certificat**, et ce, jusqu'à la fin du projet. Le questionnaire de suivi peut être consulté sur la page Web du CÉRFAS.

Date de délivrance : 22 oct. 2010
AAAA / MM / JJ
Date d'échéance* : 22 oct. 2011
AAAA / MM / JJ
*correspond à la date prévue de fin du projet

Espace réservé en cas de prolongation

ANNEX 4 – ETHICS CERTIFICATE (CER CSSS)

Centre de santé et de services sociaux
[redacted]

Centre affilié universitaire

COMITÉ D'ÉTHIQUE DE LA RECHERCHE

CERTIFICAT D'APPROBATION ÉTHIQUE

Dossier no. : 2011-01

Titre du projet : Un renouvellement des pratiques en service social : une étude exploratoire des perceptions chez des travailleurs sociaux et leur gestionnaire des réformes en santé mentale et du modèle de rétablissement

Sous la direction de : Emmanuelle Khoury, étudiante, Maitrise en service social (dir. Recherche : Lourdes Rodriguez del Barrio, PhD., professeure agrégée) École de service social, Université de Montréal

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Les membres du Comité d'Éthique de la Recherche du CSSS [redacted] ont jugé le projet mentionné ci-haut conforme à l'éthique de la recherche sur les êtres humains.

Ce certificat est valide du 11 janvier 2011 et jusqu'au 10 janvier 2012.

[redacted]

Présidente
Comité d'éthique de la recherche
[redacted]

ANNEX 5 – ORGANIGRAM 1

LA DIFFICULTÉ RAPPORTÉE PAR LE CLIENT CORRESPOND-ELLE À UN PROBLÈME D'ORDRE TRANSITOIRE OU À UN TROUBLE DE SANTÉ MENTALE ?

Note : lors de votre référence à un programme, considérez la demande du client plutôt que le problème tel que vous le percevez (ex. Vous savez que le client a été abusé sexuellement par le passé, mais le client demande à recevoir de l'aide pour apprendre à s'affirmer davantage.)

PROGRAMME TROUBLES TRANSITOIRES – services généraux

Services psychosociaux répondant aux besoins des personnes qui risquent de voir leur équilibre psychique compromis parce qu'elles vivent des situations difficiles.

PROGRAMME SANTÉ MENTALE

Services visant à réduire la durée et l'intensité des principales manifestations des troubles mentaux. Le client doit avoir reçu ou être éligible à recevoir un diagnostic de trouble de santé mentale.

QUEL EST L'OBJECTIF DE L'INTERVENTION DEMANDÉE ?

MAINTIEN DES ACQUIS → **ÉQUIPE SÉVÈRES ET PERSISTANTS**

RÉHABILITATION → **PSYCHOLOGIE**

EXEMPLES DE PROBLÉMATIQUES ABORDÉS DANS LES DIFFÉRENTS PROGRAMMES

Trouble de l'adaptation
Difficultés conjugales
Stress, anxiété situationnelle
Affirmation de soi, communication
Violence conjugale
Dépendance affective

Deuil
Pertes (rupture, perte d'emploi)
Estime de soi et confiance en soi
Gestion de la colère, des émotions
Réaction face à la maladie
Survenue d'un trauma (sans état de stress post traumatique)

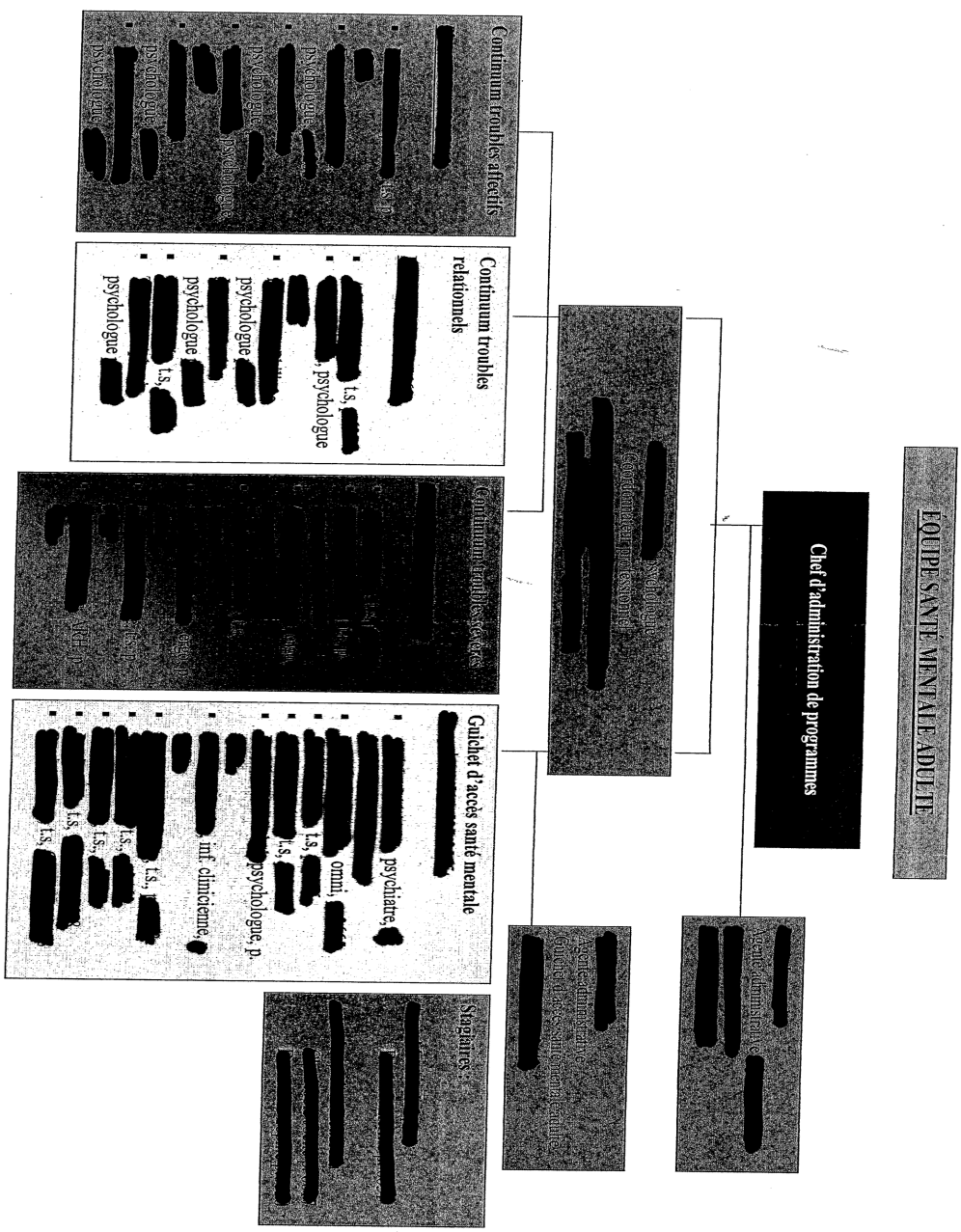
Troubles de l'humeur chronique
Troubles anxieux chroniques
Trouble psychotique stabilisé
Trouble de personnalité (maintien des acquis)

Troubles anxieux
Dépression majeure
Deuil pathologique
État de stress post-traumatique
Trouble de personnalité réhabilitable

Note :Pour l'instant ,il n'y a pas de psychologue dans l'équipe des troubles transitoires. Ne référez pas en psychologie pour ce type de problématique.

Note : Tout trouble de santé mentale qui est plus que modéré et qui est non stabilisé devrait être référé en psychiatrie.

ANNEX 6 – ORGANIGRAM 2



ANNEX 7 –CLIENT COMMITMENT FORM

Centre de santé et de services sociaux [redacted]

Name :

Chart # :

CLIENT COMMITTMENT FORM

Within the context of shared responsibilities concerning the procedure you are about to undertake and considering our mission to assure accessibility and continuity of services for our clients on the waiting list, we have elaborated the following steps concerning missed or cancelled appointments. We ask you to read the below indicated procedures and sign the form signifying your comprehension and commitment.

PROCEDURE CONCERNING MISSED OR CANCELLED APPOINTMENTS

- An appointment has been agreed upon between yourself and your mental health professional.
- The approximate duration of your appointment is 50 MIN
- Should you arrive late for your appointment, you mental health professional will not be able to prolong the duration of the session.
- Should you have to cancel an appointment, phone your mental health professional at (514) [redacted], extension [redacted], as soon as possible (24 hours in advance). Failure of recall on your part, following a 10 day delay, will signify closure of service episode.
- Should you be absent for three (3) consecutive appointments or if the frequency of missed appointments is elevated, your mental health professional will not contact you and will end your service episode.

  - *Closure of your request concerning services in our program does not prevent you from having access to other services in our CSSS*

Consent

I have read and understand the procedure concerning cancelled or missed appointments. I agree and consent to adhere to the above indicated procedure concerning appointments.

Client: _____ Mental health professional: _____

Date: _____ Date: _____

ANNEX 8 – PII

Centre de santé et de services sociaux [redacted]

PLAN D'INTERVENTION INDIVIDUALISÉ – SANTÉ MENTALE ADULTE

Nom, numéro de dossier

Description du problème / besoin Description of problems / need	Objectifs Objectives	Intervention et durée prévisible du service Intervention and duration of service	Personnes impliquées Persons involved

Plan d'intervention réalisé par

☐ infirmier(e) ☐ psychologue ☐ travailleur(se) social(e) ☐ autre, précisez _____

Nom _____ Téléphone _____

Signature de l'intervenant _____ **Date** (AAAA/ MM/ JJ) _____

Signature du client/ tuteur _____ **Date** (AAAA/ MM/ JJ) _____

ANNEX 9 – PII

Centre de santé et de services sociaux

Centre affilié universitaire

PLAN D'INTERVENTION - CLSC
(Autres que SAD)

Nom : _____

Prénom : _____

No de dossier : _____

Profil de l'usager : _____

BUT Le but visé par le présent plan d'intervention et d'allocation de services concerne :

Principalement pour l'usager
Le plan vise :

☐ Disciplinaire ☐ Interdisciplinaire

Élaboré le Année	Mois	Jour	Signature(s)	Révision prévue le Année	Mois	Jour	Intervenant(e) pivot

PLAN D'INTERVENTION - CLSC
(Autres que SAD)

N° de dossier

Date	N°	PROBLÈMES	OBJECTIFS
		Quelle est la manifestation et la source de difficulté ?	Quel est le résultat attendu de l'intervention

PLAN D'INTERVENTION - CLSC
(Autres que SAD)

N° de dossier

MOYENS/INTERVENTIONS	INTERVENANTS	SERVICES ALLOUÉS	ÉVALUATION	
Quelle intervention doit être effectuée pour corriger le problème ou la difficulté et atteindre l'objectif visé ?	Qui va intervenir	Nombre de fois ou fréquence de l'intervention	Date	Résultat A P M NA

PLAN D'INTERVENTION - CLSC
(Autres que SAD)

GUIDE D'UTILISATION

Profil de l'usager: Usager en phase postopératoire (110) ; Usager en soins palliatifs excluant usager atteint du sida (120) ; Usager atteint du sida (130) ; Usager ayant une déficience physique (210) ; Usager ayant une déficience intellectuelle (310) ; Usager présentant des troubles mentaux sévères et généralement persistants (410) ; Usager présentant des troubles mentaux transitoires (420) ; Usager présentant des problèmes de santé mentale (430) ; Usager en périnatalité (510) ; Usager ayant un problème d'alcoolisme – toxicomanie (610) ; Usager en perte d'autonomie (710) ; Usager enfant, jeune et famille à risque (810) ; Usager ayant tout autre profil (900).

But: Indiquer dans quel but est préparé le plan d'intervention. Généralement, on ne devrait indiquer qu'un seul but.

La détermination du but du plan d'intervention sert à préciser l'orientation poursuivie ou ce à quoi on tente de parvenir par le plan d'intervention. Le plan permet à l'usager et aux intervenants d'avoir une idée commune de la situation désirée et d'éviter les fausses attentes de sorte que les énergies de tous tendent vers un même résultat.

Élaboré le/révisé le : Inscrire la date de l'élaboration ou de la révision du plan.

Signature(s) : Signature de la personne qui rédige le plan. L'intervenant peut faire contresigner le plan par l'usager dans ce même espace.

Révision prévue le : Inscrire la date prévue pour la révision du plan.

Intervenant pivot : Inscrire le nom de la personne responsable de la coordination du plan.

Date : Inscrire la date de la formulation du problème et des objectifs. Lorsque de nouveaux objectifs ou d'autres interventions sont déterminés pour régler un problème, inscrire la date à laquelle le changement a lieu.

Problèmes : Il s'agit des problèmes prioritaires identifiés à la suite de l'évaluation des besoins et sur lesquels l'usager et ses proches sont d'accord autant que possible et qui font consensus auprès de l'équipe interdisciplinaire. Identifier la cause et la manifestation du problème : déficience, incapacité, handicap.

N° : Numéroter chacun des problèmes.

Objectifs : L'objectif exprime le résultat souhaité. L'objectif doit décrire un comportement observable ou inclure une norme de mesure. Indiquer le délai fixé pour la réalisation de l'objectif (ex. : d'ici 5 jours ou 3 semaines) sauf pour les objectifs dont le maintien des résultats dépend de la poursuite des interventions. Plus d'un objectif peut être fixé pour chaque problème.

Moyens/interventions : Décrire l'action à entreprendre pour résoudre les difficultés ou les problèmes et atteindre les objectifs visés. Plusieurs interventions peuvent être déterminées pour chaque problème ou objectif.

Intervenant : Indiquer le nom et la discipline de l'intervenant.

Services alloués : Indiquer le nombre total de fois (s'il s'agit de services ponctuels ou de courte durée) que seront alloués les services ou la fréquence (par jour, par semaine ou par mois) des services alloués en fonction de la disponibilité des ressources.

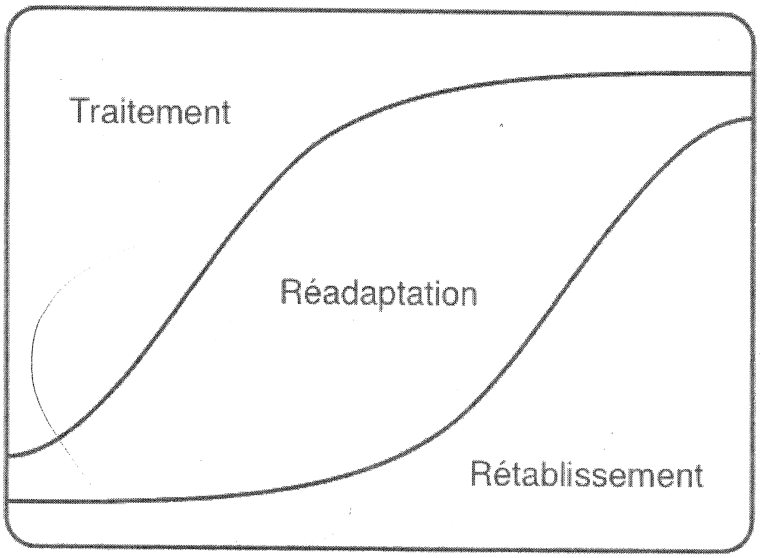
Évaluation : Évaluation conjointe de l'atteinte des objectifs avec l'usager ou son représentant.

Date : Inscrire la date de l'évaluation des résultats. Plus d'une date peut être inscrite lorsque la poursuite de l'objectif est maintenue.

Résultat : Indiquer les résultats de l'évaluation par **A**, **P**, **M** ou **NA**

Atteint :	L'objectif fixé est complètement atteint.
Poursuivi :	Les mêmes interventions doivent se poursuivre pour améliorer ou maintenir les résultats obtenus.
Modifié :	Les interventions planifiées n'ont pas permis d'atteindre l'objectif fixé. L'objectif ou les interventions doivent être modifiés et reformulés selon le même processus.
Non **A**tteint :	L'objectif fixé n'a pas été atteint et est abandonné.

ANNEX 10 – TREATMENT, REHABILITATION, RECOVERY SCHEMA



Phase de crise
Fontionnement faible

Phase de stabilisation
Fontionnement en consolidation

Phase de développement
Fontionnement optimisé