SOCIAL WORK AND THE MULTIDISCIPLINARY
MENTAL HEALTH TEAM

A Practicum Report
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ABSTRACT

This practicum report is a combination of my practice experience gained while completing a practicum at Prince Albert Parkland Health Region (PAPHR) Mental Health Services from May 2009 to July 2009 and the literature reviewed on the topic of multidisciplinary mental health teams. This report explores the strengths and challenges experienced by multidisciplinary mental health teams, including those that I observed while completing my practicum. Issues explored in the report include differences and similarities of ideologies amongst the different professionals that belong to the multidisciplinary mental health team, social work values and ethics and how they are similar and different to those practiced by other professions, strategies and skills that are utilized by the members of the multidisciplinary mental health team, and an examination of the relationships of varying levels by multidisciplinary mental health teams.

Throughout the paper I make connections between the literature and my observations and experiences from my practicum. I conclude that many of the strengths challenges that are discussed in the literature reflect similar strengths and challenges that exist at PAPHR Mental Health Services.
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1. INTRODUCTION

The following paper is an integrative paper which connects the literature available about social work in a multidisciplinary setting to the Master of Social Work practicum I completed from May 2009 to August 2009. The practicum took place at Prince Albert Parkland Health Region (PAPHR) Mental Health Services. Being a social work student in a multidisciplinary mental health team peaked my interest in finding more about how multidisciplinary teams worked. The PAPHR Mental Health team provided a place to explore such interests and a description of the setting will be provided.

Social work is one of the professions that are part of the multidisciplinary mental health team and in recent years there have been larger numbers of social workers belonging to such teams. Social workers have experienced a number of difficulties in the multidisciplinary team, although their presence in and contribution to such teams is valuable. Members of the multidisciplinary team often have differing ideologies about the view of mental illness and its treatment. Social work often has difficulty with the medical model of mental illness, which is often utilized by other professions and the mental health agency itself. Along with differences in ideologies amongst professionals, values and ethics vary as well. Though there are values and ethics that are shared amongst mental health professionals, social justice and advocacy are strong components of social work culture. These components are significant contributions of social workers to the multidisciplinary mental health team. Strategies and skills that social workers use in mental health settings also differ from other professions. Strategies rooted in the medical model such as diagnosing and evidence based practice do not often reflect the way social workers intervene with mental health clients. Social workers come from generalist education and have background in the areas of anti-oppressive practice, community development and
advocacy. Differences in ideologies, values, ethics, strategies and skills are correlated with relationships between social workers, other professionals, clients, community, society and the agency itself. Relationships in multidisciplinary teams can be affected by the role ambiguity felt by social workers, differences in professional ideologies, the lack of social work voice in influencing policies and programs, and the hierarchy that exists in such teams.

This paper aims to explore the dynamics of multidisciplinary mental health teams and the role of social work within such teams. Similarities and differences among social workers and other disciplines in the multidisciplinary mental health team, such as psychology, community mental health nurses and psychiatry will be explored in the context of ideology, values and ethics, relationships, strategies, and skills. Experiences from my practicum experience highlight some of the findings from the research on the topic of social work in multidisciplinary mental health teams.

2. DESCRIPTION OF THE SETTING

Prince Albert Parkland Health Region (PAPHR) outpatient mental health services are located in the lower level of the Victoria Square Building next to the Victoria Hospital in Prince Albert, Saskatchewan. PAPHR Mental Health Services is an agency that employs a number of staff from different professions who work together to deliver services to clients. Two primary terms are used to describe team with members of different professional affiliations providing service to clients in mental health settings: interdisciplinary teams and multidisciplinary teams. The two terms are often used interchangeably though they describe two different types of teams. Jessup (2007) explains the difference between the two types of teams in an allied health care setting. Both multidisciplinary and interdisciplinary teams are comprised of individuals from different professions that bring with them their own expertise. Professionals who are part of a
multidisciplinary team primarily work with the individual in isolation from each other and share 
information via case conferencing or comparing case notes. Interdisciplinary teams differ in that 
professionals from different professions meet with the client at the same time. Assessments, 
diagnosis and interventions are discussed in the meeting with the patient, exploring alternatives 
while still in the meeting with the client. The term multidisciplinary team more appropriately 
describes the type of service that was offered at PAPHR Mental Health Services. Thus, the term 
multidisciplinary team will be used in this paper.

The multidisciplinary outpatient mental health team is comprised of social workers, 
psychologists, community mental health nurses, psychiatrists and clerical/support staff. There 
are no physicians on-site at PAPHR Mental Health Services but they were part of the services 
provided to mental health clients via referrals and general medical care. Often, psychiatric 
medications are prescribed by family physicians as was follow-up care. For the purposes of this 
paper, the PAPHR Mental Health team will refer to outpatient practitioners in the Victoria 

square. This will exclude physicians, staff employed at the PAPHR inpatient psychiatric facility, 
and mental health practitioners from satellite communities.

2.1 Referral Process

Referrals come from a variety of different sources. Mental health clients are often 
referred by family members, physicians, schools, government agencies such as the Ministry of 
Social Services and the Ministry of Corrections, Public Safety and Policing, or individuals could 
refer themselves. Referrals are collected by two intake workers, both BSW social workers. 
Referrals come in via telephone, mail, fax or individuals walking in requesting services. 
Referrals are collected throughout the week and are divided up amongst staff at referral meetings 
that take place every Friday afternoon. Workers have much control over the referrals they take.
Referrals are sometimes divided on the basis of the number of clients on one’s caseload, interest and experience.

2.2 Programs and Services

There are a variety of programs and services available to those individuals who struggle with a mental health issue. These include psychiatric services, adult services, child and youth services, and forensic services.

Psychiatric services are primarily provided by the Psychiatrists and Community Mental Health Nurses. The following is a list of psychiatric services offered at PAPHR Mental Health Services: psychiatric consultation clinic for children and youth, adult psychiatric treatment and assessment services, community mental health nursing and rehabilitation services, consultative services, and decentralized clinics.

The majority of the adult mental health services are provided by social workers and psychologists. The following is a list of services that are provided to adults at PAPHR Mental Health Services: individual assessment and treatment, anxiety and depression groups, postpartum depression support, consultative services, psychogeriatric consultation, and individual and group grief counselling.

The child and youth team primarily consists of social workers and psychologists as well. The following is a list of the child and youth services provided by PAPHR Mental Health Services: individual assessment and treatment, cognitive disability strategy, eating disorders program, coordinated behaviour management program, grief counselling and the Healing Hurting Hearts Camp, School Plus services, child and youth development clinic, decentralized clinics, residential support and training consultant, clinical consultation, and child and youth clinical training consultant.
The forensic services are also offered mainly by social workers and psychologists. The following is a list of forensic services offered by the PAPHR Mental Health team: court ordered assessment under the Youth Criminal Justice Act, Adolescent Sex Offender program, individual and group counselling and treatment, New Choices for Men program, partner support programs for victims of domestic violence, High Risk Violent Youth Offender Program, and consultative services.

2.3 Staff Demographics

When I completed my practicum, based on my observations of the staff, there were forty-four staff in the Vic Square office, excluding those who were on leave or in satellite communities. Of those forty-four staff, sixteen were social workers, eight were psychologists, ten were community mental health nurses, six were psychiatrists, and four were administrative support. Of the forty-three staff members, five were male and thirty-nine were female. There were no male social workers on staff for the duration of my practicum. Both the nursing and administrative support units consisted exclusively of female staff. Traditionally, social work and nursing are professions dominated by females (Sands & Angell, 2002). As was the case at PAPHR Mental Health Services, female staff tend to outnumber male staff, yet there are often more males in management positions than there are females. The psychiatry team was a mix of male and female. There were two programs that consisted of social workers and psychologists, the adult forensic team and the child and youth team. Both of these programs were managed by male psychologists. The director of mental health was male had a community mental health nursing background.

The staff at PAPHR Mental Health Services come from a variety of educational backgrounds. Twelve of the social workers are BSW educated, two are working towards their
MSW, and two have completed their MSW. Four of the psychologists were PhD educated and four were MA educated in psychology. The psychiatrists were medical doctors and the community mental health nurses were trained in psychiatric nursing.

Of the professionals at PAPHR Mental Health Services, the majority are social workers. Cohen (2003) mentions that social workers are “preferred providers of nonmedical treatment, in large part because they are less-expensive sources of services compared with clinical psychologists and psychiatrists” (p. 35). The numbers of social workers compared to the other professions employed at PAPHR Mental Health Services may support this argument.

PAPHR Mental Health Services appears to have some difficulty with recruiting clinical psychology positions. In some instances, social workers are filling clinical psychology positions until a suitable applicant was found. Although there are similarities among the professions, there are distinct differences between the professions of social work and psychology. Having social workers fill psychology positions has the potential to leave social workers questioning their unique role within the team and feeling unsure about their job security. This also leads into the dangerous expectation that the two professions, though distinctly different, are expected to carry out similar tasks. It is made clear, however, that social workers are not educated to make psychological assessments. In these situations, it is possible that the role of social work can become blurred and aspects of the profession can be left behind.

Although the number of social workers employed at PAPHR Mental Health Services outnumbered the psychologists and psychiatric nurses, the managers of the Child and Youth Team, the Adult Forensic team, the Community Mental Health Nursing Team and the Director of Mental Health were not social workers. Without social work influence at the management level, the potential for the role of social work to remain blurred is imminent. It is possible that
management who come from different professional backgrounds may not fully understand the unique contributions of other professions, such as social work. Of the five male staff members that worked at PAPHR Mental Health Services, three are in management positions. There is one female in a management positions, who manages the community mental health nurse team. One of the individuals in the MSW position had a supervisory role of other social workers in the Child and Youth and Adult Forensic Teams but had less power than the other managers in terms of influencing programs and policies. For example, social workers would often go to this MSW social worker for consultation and support but final decisions about clients and policies are made by the managers of the Child and Youth and Adult Forensic Teams. Role ambiguity and a lack of social work in management can often be problematic for social workers that belong to the multidisciplinary mental health team. Problems can also arise for social workers when their ideologies are different from their managers and other members of the multidisciplinary mental health team.

3. IDEOLOGY

Multidisciplinary teams are designed to bring different professions together in order to provide the best service possible to the client population. Bringing together individuals from different professional backgrounds can often work very well but also comes with a unique set of challenges. Multidisciplinary teams come together to share expertise that is specific to each profession, though each profession comes with its own beliefs about the determinants of mental health issues. This allegiance to one’s profession can make integrated teams difficult to achieve (Norman & Peck, 1999; Onyett, Pillinger & Muijen, 1997; Reid et al, 1999a). Differences may include oppositional views of mental illness and its causes, specifically whether or not mental illness is an individual pathology that must be diagnosed and treated or if external factors affect
an individual’s mental health (Barnes, Carpenter & Dickson 2000, Bland & Renouf, 2001; Dane & Simon, 1991; Sands & Angell, 2002; Murphy & McDonald, 2004; Norman & Peck, 1999). Other differences include conflicting value systems and diverse views of client care and treatment (Barnes et al, 2000; Sands & Angell, 2002; Murphy & McDonald, 2004; Norman & Peck, 1999).

Historically, Mental Health has been a field that operates within the medical model when it comes to the identification of mental health issues and treatment options for clients. Mental health agencies have employed professions who are more likely to adopt the medical model, such as psychiatry and psychology (Norman & Peck, 1999). In recent years, there have been more social workers employed in mental health agencies. Social work often approaches clients in the psychosocial model, from a person-in-environment context (Barnes et al, 2000; Bland & Renouf, 2001; Dane & Simon, 1991). In viewing causes and treatment of mental health and mental illness, social workers who utilize the psychosocial model are searching for external contributors such as socio-economic status, housing, ethnicity, gender, age, relationships, as well as a variety of other factors. Some professionals who have been trained in the medical model of mental health such as in those who come from psychiatry and psychology have been known to view mental health as an individual pathology, focusing on the diagnosis and treatment of that individual (Barnes, Carpenter & Dickson 2000, Bland & Renouf, 2001; Dane & Simon, 1991; Sands & Angell, 2002; Murphy & McDonald, 2004; Norman & Peck, 1999). Due to this diversity in ideology, social workers in multidisciplinary mental health teams are likely to experience difficulty (Renouf & Bland, 2005). Differences between the medical model and a more psychosocial approach can include whether or not diagnosis is necessary, whether or not
treatment is aimed at the individual or includes external factors such as socio-economic status and relationships, and differing ideas about brief therapy and evidence based practice models. A social worker in Murphy and McDonald’s (2004) study described the challenges different training and philosophies can have in the workplace:

It’s professional isolation because, as much as you might work in a multidisciplinary team, there is no one else in the team who understand the way you’ve been trained and your code of ethics and the way the workers think…of course I’m going to look at a situation differently than someone who has trained under the medical model” (p. 132).

Differences in language and approach can also be a source of frustration and communication difficulties among team members (Bland & Renouf, 2001). The CASW Code of Ethics (CASW, 2005) and the profession of social work itself stress the importance of changing policies and practices to minimize social injustice and create better services for clients. Professions with a more elite status, particularly those who adhere to the medical model, prefer to continue to provide services in the same way that services have been provided for many years (Peck & Norman, 1999). Psychiatrists, in particular, have been identified as resistant to change (Peck & Norman, 1999). Other professions such as occupational therapists and social workers have expressed their concern with the medical model (Peck & Norman, 1999). Often each member of the multidisciplinary mental health team identifies very strongly with their individual professions, which can lead to problems with a unified vision and philosophy. With differing opinions and approaches to mental health treatment, clients may receive conflicting messages from team members regarding their treatment (Rabin & Zelner, 1992).

Miller (2002) adds that in the medical model, clients are seen as passive and recipients of the “expert” recommendations of professionals. Rather than a view of pathology, diagnoses and
treatment, the social worker views strengths and weaknesses of the client in terms of their environment (Barnes et al, 2000; Miller, 2002; Bland & Renouf, 2001; Carpenter, Schneider, Brandon & Woooff, 2003; CASW, 2001; Dane & Simon, 1991; Mitchell, 1993; Murphy & McDonald, 2004; Rabin & Zelner, 1992; Renouf & Bland, 2005; Swenson, 1998). Some authors question the ethics of the medical model, arguing that ignoring the role of structural oppression that exists in society further contributes to that oppression (Barnes et al, 2000; Swenson, 1998).

The image of the client population at PAPHR Mental Health Services and view of mental illness from an agency perspective is primarily medical in nature. Referral meetings at PAPHR Mental Health Services are held on Friday afternoons and I was able to attend many of these meetings as a student. During these meetings I made several observations. Referrals are required to have a clear mental health issue or diagnosis stated by the individual who referred the client to PAPHR Mental Health Services. The presenting problem needs to fit into diagnosable criteria of the DSM-IV-TR in most cases, although exceptions could be made if services could not be provided by another agency in the community. Those referrals that do not meet this requirement are referred to other counselling agencies in the community or are returned to the referring person or agency.

The image of the client population varies amongst professionals and disciplines. Those professions and individuals that are trained in a more medical model are more likely to view mental health or mental illness, as an individual pathology. Social workers at PAPHR Mental Health most often adopted a more social model of mental health and mental illness, which looks beyond the individual, recognizing that mental health is also influenced by family relationships, social networks, community, and society. Social workers who adopt a more social model of practice also recognize the impact of other various factors on mental health: housing, ethnicity,
family functioning, culture, resilience, socio-economic status, vulnerability, gender, age, support networks, strengths, stressors, and employment.

This is not to say that all practitioners at mental health chose to practice within the medical or social model exclusively. One strength of the PAPHR multidisciplinary mental health team is the frequent meshing of the medical and social models, creating a more balanced view of mental health and mental illness. Community mental health nurses, sometimes trained in a more medical model, do a large amount of community outreach and support. Individual practitioners, regardless of educational background, are involved in different projects that are often outside the realm of the medical model. Examples of utilization of the social model include a bus ticket program to increase accessibility to mental health services, a child development clinic that focuses on the child, family and community, and the incorporation of outside influences on mental health and mental illness into one to one counselling sessions with clients. I would argue that the majority of these projects were initiated by individual practitioners based on their own values and ideologies, rather than the overarching ideology of the agency.

Multidisciplinary mental health team members bring differing theoretical frameworks and ways of thinking that are unique to his or her profession. Each individual member of the team also comes with a set of values and ethics that are unique to the profession from which he or she comes.

4. SOCIAL WORK VALUES AND ETHICS

It has been identified that one of the challenges of multidisciplinary mental health teams is the difference in ideologies amongst professionals in a multidisciplinary team (Norman & Peck, 1999; Onyett, Pillinger & Muijen, 1997; Reid et al, 1999a). Social workers in
multidisciplinary mental health teams face the unique struggle of adhering to their values and ethics while being a member of a team where less emphasis is on a psychosocial approach.

Social justice is a core value and ethical expectation that differentiates social work from other professions (Bland & Renouf, 2001; Renouf & Bland, 2005; Swenson, 1998). A unique characteristic of social work practice is that, “social workers have, simultaneously, ethical responsibilities to address both private troubles and public issues” (CASW, 2001, p. 4). Giles, Gould, Hart and Swancott’s (2007) completed a study aimed to gather social workers’ understanding of their priorities within their work in multidisciplinary teams in health settings in hopes to clarify the role of social work in multidisciplinary teams, identify their choice of interventions and its core priorities for practice. Data was gathered through a survey tool, which thirty-six social workers completed and focus groups, which were attended by seventeen social workers. In this study, social workers emphasized advocating for the rights of both the client and the community to ensure equal access of suitable resources. There are components of PAPHR Mental Health Services’ practices which could be potentially problematic for those who require mental health services: lack of social policy and individual not having equal access to services, the lack of cultural friendliness, and the high numbers of clients who did not attend appointments.

Aboriginal people account for approximately 34% of the population in Prince Albert and are overrepresented in systems such as the legal system, the social services system and the health care system (Statistics Canada, 2010). During my practicum at PAPHR Mental Health Services, based on my observations Aboriginal clients did not appear to access mental health services. There were few Aboriginal clients on the caseloads of mental health workers that I spoke to and of the clients I counseled during my practicum, only one of them was Aboriginal. The
atmosphere at PAPHR Mental Health Services did not appear to be overtly culturally friendly. For example, clients cannot directly access traditional Aboriginal practices such as sweat lodges, sweet grass or elders directly through PAPHR Mental Health Services, rather such practices have to be sought out by individual practitioners. Also, there is no Aboriginal art or aspects of Aboriginal culture on display in common areas of PAPHR mental health services and there are few mental health resources such as pamphlets and handouts available in languages such as Cree or Dene. At staff meetings that I attended, there was little focus on how to make services more culturally friendly. A step in the right direction is an Aboriginal Liaison position, which is held by one of the social work positions at PAPHR mental health services, which will hopefully address some of the aforementioned issues.

The rate of clients who do not show up for their initial appointment with a mental health worker is informally estimated by some of the workers at PAPHR Mental Health Services at about fifty percent. This held true for the referrals that were assigned to me throughout my practicum, where about one-half did not access services at PAPHR Mental Health Services, despite the referral person or agency feeling they could benefit from such service. There are negative and positive aspects of such a high “no show” rate. One such positive aspect is the manageability of caseload size. With fewer people attending their appointments, workers were more able to concentrate their efforts on clients who did attend. If all of the individuals referred to PAPHR Mental Health Services were accessing services, there would likely be a significant waiting list for clients to access their initial appointment with the number of staff that was currently employed. However, a high number of clients who do not attend their scheduled mental health appointments may have negative implications. Clients were referred by a physician or agency for the purpose that an individual was struggling with a mental health
problem. If approximately one-half of those individuals did not end up accessing services, there were a large portion of clients who were not getting the assistance they needed in regards to their mental health issues.

Social workers have traditionally embraced the role of the practitioner who empowers those who are disadvantaged in society (Harries, 1999). Social workers look beyond the needs of the individual to an ecological model, identifying the needs of the family, community and society as a whole (CASW, 2001; Dane & Simon, 1991; Giles et al, 2007; Harries, 1999; Peck & Norman, 1999). Self-determination, advocacy and empowerment are some of the core beliefs in social work (CASW, 2005; Giles et al, 2007; Peck & Norman, 1999). In the context of mental health, social work has included the family in treatment, included the social impacts of mental illness, and has emphasized follow-up care (Rabin & Zelner, 1992). Due to the differences in values and ethics of the social work profession compared with those of psychiatry, psychology and nursing, social workers may be compelled to support organizational practices that differ from their ethical and professional standards (Bransford, 2005).

Working as a social worker in a multidisciplinary mental health team is rewarding but also has some challenges. Sometimes the values of the individual and the profession are not always the same as other professions or the agency itself. Social workers in a multidisciplinary mental health team struggle with the medical model versus the psychosocial approach. Traditionally, social work has been a profession that focuses on people and their environments and social work education and training is often modeled on an ecological, humanistic framework (Barnes et al, 2000; Bland & Renouf, 2001; Dane & Simon, 1991).

Social workers themselves often struggle with the place of their values and ethics within the multidisciplinary mental health team. It is a daily struggle to figure out whether a social
worker is to adopt the more medical approach and treat a mental health problem using various psychotherapy approaches or to look beyond the individual and adopt a more psychosocial approach. Often, the social workers at PAPHR Mental Health Services do both. Psychotherapy approaches such as individual counseling are used at PAPHR Mental Health Services but social workers also look beyond the individual and take other factors that affect the individual’s mental health, such as informal support and housing into consideration.

Within PAPHR Mental Health Services, each member of the multidisciplinary team has a code of ethics, specific to their profession. Issues such as confidentiality and equal treatment of clients are clearly important to the organization and expected of all workers, regardless of profession. In order to be a social worker employed with the PAPHR Mental Health team, a social worker must be registered with the professional association, the Saskatchewan Association of Social Workers (SASW) which requires all social workers to adhere to the *Standards of Ethical Practice for Social Workers* (SASW, 2001). Social workers are also required to follow the Canadian Association of Social Workers (CASW) *Code of Ethics* (CASW, 2005). The social justice component of social work is clearly emphasized in both of these documents, which stresses the importance of the responsibility of social workers to advocate for equal access to resources, particularly those who are disadvantaged, marginalized or have special needs (CASW, 2005; SASW, 2001). This specific contribution to the mental health field and the ethical responsibility that social work has to offer is not overtly supported by PAPHR Mental Health Services. This is not to say that the agency encourages or even tolerates unethical practice, but social workers are not always encouraged by the agency or given the tools necessary to practice competently or fully adhere to the *Code of Ethics* and *Standards of Practice*. For example, neither social workers nor the other professionals at PAPHR mental health services were
permitted to meet within their respective disciplines to discuss how their values and ethics could be better incorporated into services provided for clients. Allowing social workers to do so would provide a collective voice to social workers to better incorporate values and ethics into daily practice. This is particularly important due to the weak social work voice at the management level. Individual practitioners often took it upon themselves to find ways to incorporate specific ethical components of the social work profession into daily practice. For example, social workers advocate for clients within and beyond the doors of PAPHR Mental Health Services, are involved with the SASW, and continue to expand their knowledge about mental health and the social work profession.

Due to the fact that social workers are often fewer in numbers in multidisciplinary mental health teams or have few members of their profession in positions of power, social workers are either forced to defend their profession (Peck & Norman, 1999), leave the organization (Dane & Simon, 1991), or compromise values in order to continue to be a part of the team (Dane & Simon, 1991; Peck & Norman, 1999). An example of one such compromise that social workers make is the shift toward brief interventions and evidence based practice, which can stray social workers from outside their professional boundaries (Dane & Simon, 1991). Bransford (2005) expresses concern about compromising values in order to belong to the dominant group, resulting in a loss of knowledge and unique contributions social workers have to offer to the mental health field. Social workers strongly feel that an understanding of social work values is very important to be a distinct and esteemed part of the multidisciplinary mental health team (Carpenter et al, 2003; Peck and Norman, 1999). When members of the multidisciplinary mental health team do not feel their values and ethics are not clearly understood, relationships at varying levels of the agency are likely to be affected.
5. RELATIONSHIPS

The following section will discuss some of the ways relationships were developed and the obstacles that stood in the way of relationships between: worker-client, worker-agency, worker-worker, worker-profession, worker-community, client-community, client-society, client-agency, and worker-self.

5.1 Worker-Client Relationships

There are some obstacles that hinder the development of an effective helping relationship between worker and client. There is emerging overlap in training between professionals such as social workers and mental health nurses, which contributes to role ambiguity (Barnes et al, 2000; Peck & Norman, 1999). If role ambiguity was resolved in multidisciplinary teams, clients would be assigned to the professional or individual that would be most suited to the client’s needs (Rabin & Zelner, 1992). Not only do other professionals and social workers themselves appear to have a lack of clarity about their role in the multidisciplinary mental health team, clients appear to share in this lack of understanding about social work in mental health.

The large numbers of social workers in multidisciplinary mental health teams is a fairly recent phenomenon (Bland & Renouf, 2001). Society continues to view social workers in the more familiar role of child protection. Some clients who need to access mental health services, for example, expect to be treated by more familiar mental health professionals such as psychiatrists, psychiatric nurses and psychologists. Some clients inquire about the role of social work in the multidisciplinary mental health team and question the ability for social workers to provide mental health services. This issue, compounded with the fact that social workers often question their own role in the multidisciplinary mental health team, can create an obstacle for an effective helping relationship. This can be particularly true when clients have had previous
negative experiences with social workers. When this occasional situation would arise, the PAPHR multidisciplinary mental health team handled it effectively. If the client was uncomfortable with seeing a social worker or any worker for that matter, the referral would simply be assigned to someone the client would feel more comfortable with.

Other obstacles that can inhibit the client-worker relationship include individual counselling styles, personality conflicts, and different values of the worker and the client. As mentioned previously, multidisciplinary mental health teams have traditionally focused on the medical model of treatment. The argument has been made that social workers often feel uncomfortable with the medical model and prefer a person-in-environment approach. Some clients may expect, or even prefer, the medical model. When the social worker attempts to employ a more ecological model, clients may have a difficult time adjusting to the alternate ideology. Other conflicts may arise in differences between the counsellor’s style and the client’s preference. Some clients prefer a more non-directive approach whereas others benefit from a confrontational style of service. Personality also has an impact on the creation of a helping relationship. In some instances just the personality of the mental health professional does not fit well with the client’s expectations or needs. Differing values can also put a strain on the therapeutic relationship. The values that either the client or the worker have do not always match each other, potentially creating friction in the therapeutic alliance.

There are some factors that facilitate a positive therapeutic relationship between worker and client. Regardless of the ideology, medical or otherwise, therapists are working toward the same goal – helping the client improve. This desire to help people is paramount in creating an effective working relationship with the client. Many of the therapists at PAPHR Mental Health Services strive to create an effective rapport with their clients and establish a positive working
relationship in the early stages of the mental health intervention. The professionals who belong to the multidisciplinary mental health team work at the clients’ pace and ensure the clients feel heard and respected. Interventions are client-driven so the client feels empowered to make changes necessary to improve their mental health.

5.2 Worker-Agency Relationships

The relationship between the worker and the agency can be positive or negative depending on a variety of factors. Role ambiguity seems to be the strongest barrier for social workers feeling like they are being an effective and valued member of the multidisciplinary team. Mitchell (1993) points out that multidisciplinary mental health teams are often underusing and undervaluing the contributions of the social work profession.

All members of the team seem to share their concerns with the blurring of disciplines and roles (Barnes et al, 2000; Norman & Peck, 1999; Onyett, et al, 1997; Rabin & Zelner, 1992; Reid et al, 1999a). Reid et al (1999a) conducted a qualitative study that explored the stress and job satisfaction among mental health staff in community based multidisciplinary mental health teams. The goal of the study was to explore three things: emotional exhaustion and poor physical health among mental health staff despite reports of high levels of satisfaction and personal accomplishment, why community based staff appeared to be more burnt out than hospital based staff, and why social workers were more burnt out in comparison to their cohorts from other professions. The study consisted of a purposive sample comprised of community psychiatric nurses, ward nurses, psychiatrists, psychologists, occupational therapists, and social workers. Staff, regardless of discipline, commented that having a clearer more significant role in the team would make their jobs more satisfying. This study also states that in the United Kingdom, multidisciplinary mental health teams consist of professionals that are required to be
generic team members who have to provide a broad range of service to client groups. The roles of particular members of the multidisciplinary team, such as social workers and psychologists are ever expanding while psychiatry appears to becoming more restricted due to their ability to prescribe medication (Onyett et al, 1997). Since members of the multidisciplinary team have concerns with role blurring, it is important that the agency itself takes steps to address the issue to make the team run more effectively. No intervention from the management levels of multidisciplinary mental health teams is likely to cause resentment from the staff toward the agency itself.

The social workers in some studies argue that social work is not understood and sometimes not respected by other professions (Peck & Norman, 1999; Rabin & Zelner, 1992). Further to this, social workers often feel their professional values and obligations differ from those of the system (Giles et al, 2007; Dane & Simon, 1991). Renouf and Bland (2005) add to this stating:

Multidisciplinary teamwork is almost inevitably the site of inter-professional tension, productive or otherwise, and this tension is likely to be felt most painfully by members of professional whose values, knowledge and skills are least well-aligned with the dominant operating paradigm (p. 424).

Onyett, Pillinger and Muijen (1995) completed a study in which they sent out postal questionnaires to multidisciplinary community mental health teams to identify what community mental health teams do, how they work as a team, what helps or hinders the functions of the team when dealing with people with mental health problems, and how team membership is experienced by different professions. The sample of 445 professionals comprised community psychiatric nurses, other nurses, social workers, administrative staff, occupational therapists,
clinical psychologists, consultant psychiatrists, other doctors, generic/support workers, specialist therapists, and other staff including voluntary staff, employment workers, care managers, a counsellor, a student nurse, a support worker and a worker on information technology. The majority of the sample included in the study was psychiatric nurses, social workers, and administrative support. The social workers in this study reported negative feelings about working in a multidisciplinary mental health team. These social workers reported feeling highly emotionally exhausted, were unsatisfied with their working relationships, had less job satisfaction than any other profession, had a lower sense of personal accomplishment and had a high level of depersonalization. In addition, social workers in this study were very confused about the vision of the team and their role within the team.

Carpenter et al (2003) carried out a study that explored the relationships in multidisciplinary community mental health teams. The study specifically explored professional and team identification, team functioning, psychological well-being of staff, and job satisfaction. Questionnaires were completed by 113 participants comprised of community psychiatric nurses, social workers, support workers, psychiatrists, psychologists, and occupational therapists. Social workers in the study indicated that social workers are not happy with their role in the multidisciplinary mental health team. These social workers reported lower professional identification, lower team participation, lower support for new ideas, lower levels of working as part of the team, and higher levels of role conflict in comparison with the other professionals in the study. Interestingly, Carpenter et al found no differences in professions regarding role clarity, which conflicts with many other studies. One of the social workers interviewed in the study indicated that front line workers tend to work well together but difficulties with
management and administration issues is a primary source of problems in multidisciplinary teams.

There is often a hierarchy of staff that exists in multidisciplinary mental health teams (Murphy & McDonald, 2004; Norman & Peck, 1999; Onyett et al, 1997; Peck & Norman, 1999; Reid et al, 1999b). Professions who practice from the medical model are noted as being on the top of the hierarchy (Murphy & McDonald, 2004; Peck & Norman, 1999; Rabin & Zelner, 1992; Reid et al, 1999a). Social work is one of the professions at the bottom of the hierarchy and rarely has influence over policy and program decisions (Murphy & McDonald, 2004). An example of this during my practicum was the lack of social work presence in management at PAPHR Mental Health Services. Although the social workers are supervised by one of the MSW social workers, supervisory decisions are primarily made by the managers of the Child and Youth Team, the Adult Forensic Team and the Director of Mental Health. It can be challenging to go to a supervisor from another profession regarding work issues, depending on what the issue is. This is not a reflection of the approachability of the supervisor in those positions; rather having a manager from a different educational background can simply be the barrier. A lack of understanding about the social work profession and its unique contribution to the multidisciplinary mental health team can contribute to such feelings. There is also the potential for social workers to have different ideas about their role in the multidisciplinary mental health team than the views of management. The hierarchy that exists in multidisciplinary mental health teams has a societal base as well. Managerial positions are often occupied by white males, which can leave women and individuals from different ethnic groups, often in social work and nursing positions, feeling devalued and powerless (Sands & Angell, 2002).
PAPHR Mental Health Services is a positive work environment with a solid multidisciplinary team. Although there are some challenges, all members of the multidisciplinary mental health team appear to be happy in their jobs and provide quality service to mental health clients. Multidisciplinary team members are encouraged by the agency to utilize their breaks, which create opportunities to network with individuals both in and out of the team. Due to the flexible work environment, such as influence over which referrals team members take, autonomy over areas of specialization and flexible work hours as well as a solid team approach, the relationship between the workers and the agency is more often than not a positive one.

5.3 Worker-Worker Relationships

The relationships between professionals who belong to a multidisciplinary team can be strained simply because professionals work as a team rather than in isolation from each other. Along with the commonly noted differences in opinions and personality conflicts that arise in most work environments, multidisciplinary team members also struggle with role ambiguity, professional hierarchy and differences in ideologies, values, and ethics.

A commonly cited frustration of individuals who are part of a multidisciplinary mental health team is the hierarchy that exists among staff (Murphy & McDonald, 2004; Norman & Peck, 1999; Onyett et al, 1997; Peck & Norman, 1999; Reid et al, 1999b). This hierarchy affects the sense of achievement, value and professional growth among mental health staff (Onyett et al, 1997). Since medical staff members are at the top of the hierarchy, often a medical model approach can dominate the multidisciplinary mental health team (Murphy & McDonald, 2004; Rabin & Zelner, 1992). Allied health professionals and those outside of the medical professions tend to be at the lower end of the hierarchy (Murphy & McDonald, 2004).
Differences in level of education, status and rates of pay undoubtedly leads to unsettled feelings by staff who are seen to be at the bottom of the hierarchy (Norman & Peck, 1999) as well as disempowerment (Reid et al, 1999a). In Murphy and McDonald’s (2004) study, one social worker provides an example of how this hierarchy impacts practice: “the psychologist’s input is viewed as more valid (more scientific) even though we are saying the same thing” (p. 133).

The hierarchy in multidisciplinary teams contributes specifically to difficulty of team members identifying with the team. Barnes et al (2000) note the difference in social class and gender between social work and psychiatry, reflecting the hierarchy that exists and the difficulty in the professions relating to each other. Another barrier to team identification is the members of each profession “protecting their turf” and trying to define a distinct role (Cohen, 2003; Dane & Simon, 1991). This contributes to the individualization of professions rather than the development of a team approach. Fear of loss of power and one’s own professional identity within the team may contribute to negative stereotypes and competitiveness that can exist amongst members of multidisciplinary teams. As Barnes et al (2000) state, “professions have traditionally achieved power, status and the rights to practice by claiming their areas of knowledge as their specialism” (p. 568). Team identification is most likely to be achieved when individuals in the team are socially valued and able to achieve a sense of self-esteem (Onyett et al, 1997). The best outcome will be achieved for the multidisciplinary team when staff members are clear about their role within the team but are still able to hold on to their professional identity (Onyett et al, 1997).

Some social workers feel their values and roles are often misunderstood by other professionals (Carpenter et al, 2003; Reid et al, 1999b). Social workers in Murphy and
McDonald’s (2004) study believed that they were at the bottom of the hierarchy which left them feeling subordinate and unappreciated. Carpenter et al (2003) also report social work’s marginalized position in the multidisciplinary mental health team.

Although team members can struggle with their roles as a member of their profession and as a member of the team, Carpenter et al (2003) found that staff in their study actually identified more strongly with the team than their individual professions. This led to clearer and more effective objectives for the team. Barnes et al (2000) found that there were more similarities than differences amongst the attitudes and values of professionals in a multidisciplinary team.

One obvious benefit to multidisciplinary teams is the convenience of members of each profession operating under one roof, which was the case at PAPHR Mental Health Services. This opens the door for a team approach to tackle organizational problems (Norman & Peck, 1999). Being part of a multidisciplinary team encourages team members to collaborate and communicate with each other, which can lead to healthier working relationships. Other benefits include greater opportunities for communication as well as more effective communication. By having professionals from different professions working as part of a team, clients have access to better quality care. Though each profession has its own unique qualities and attributes, one of the benefits to multidisciplinary teams is knowledge overlap that leads to a breakdown of interprofessional boundaries (Sands & Angell, 2002, Rabin & Zelner, 1992).

Team members who participated in the study by Onyett et al (1995), including community psychiatric nurses, other nurses, social workers, administrative staff, occupational therapists, clinical psychologists, consultant psychiatrists, other doctors, generic/support workers, specialist therapists, and other staff cited positive aspects of being part of a multidisciplinary mental health team. Fifty-two percent of team members participating in this
study cited the team itself and multidisciplinary work was a principal source of reward in their work. Generally, the members of the team described a supportive team environment that worked well together. The study conducted by Carpenter et al (2003) showed that multidisciplinary mental health teams are generally working well. Onyett et al (1997) also stress the importance of management in providing additional support, education and training to multidisciplinary teams in order for them to function effectively and efficiently rather than simply assuming these teams can work effectively..

Overall, the relationships between all staff members, regardless of professional affiliation, at PAPHR Mental Health Services were positive. Staff members, from all professional backgrounds, who had been in the mental health field for a long period of time graciously mentored newer members of the multidisciplinary mental health team. Relationships were strengthened through interactions during coffee and lunch times and in situations where workers supported each other about issues both in and outside the workplace. When having difficulty with a particular client or issue, it was not uncommon to see staff members of different professions in and out of each other’s offices sharing resources and techniques. Most team members had an informal open-door policy that was inviting. For the most part, professions did not appear to be segregated and workers were able to utilize the unique attributes of the other professions in the agency.

5.4 Worker-Profession Relationships

Maintaining one’s professional identity in a multidisciplinary team can be challenging, particularly when the dominating paradigm does not easily align with the values of one’s profession.
Studies have found that social workers had the least professional identification of any profession in a multidisciplinary mental health team (Onyett et al. 1995; Onyett et al., 1997; Carpenter et al., 2003). Other findings from research also noted that certain members of the team feel a loss of professional identity (Onyett et al., 1997; Reid et al., 1999a). Members of the multidisciplinary mental health team have another struggle that is unique to the team environment. Since each member comes from a different profession, individuals have difficulty balancing their roles as a member of the team and a member of their professional identity (Barnes et al., 2000; Onyett et al., 1995; Onyett et al., 1997). Occasionally, a conflict between the values and practices of the team and one’s own professional identification will arise, leaving the team member torn and confused, which can contribute to job dissatisfaction (Barnes et al., 2000; Onyett et al., 1995).

According to Peck and Norman (1999) social workers feel like they are often compared with other professionals in regard to the similarities among professions and this is a threat to the social work profession. More overlap amongst duties of professionals working in the mental health field may also contribute to the strong identification with one’s own profession. There is the increasing threat that one’s duties may soon be replaced by other professions (Norman & Peck, 1999). Additionally, in this study social workers felt like they were less able to differentiate themselves from other members of the team, resulting in a lack of professional identity. Due to a lack of social workers in management and administrative positions, social workers felt as though they have been less able to define their specific contributions to the mental health team (Peck & Norman, 1999). Conflict can arise when different professions carry out a duty that another profession has already identified as their own (Sands & Angell, 2002).
It is difficult to remain connected with one’s profession in a multidisciplinary team without effort on behalf of the individual worker. This individual effort was displayed at PAPHR Mental Health Services. There was little agency support for clarifying the unique contribution of social work to mental health services and little support from upper management to incorporate social work values and ethics into the services. Without overt support and encouragement of the utilization of social work values and principles, it is easy for such unique attributes of the profession to be lost to the team, leading to the adoption of values, ethics and ideologies of the other professions in the multidisciplinary mental health team. Social workers continually face the challenge to incorporate the principles of social justice into their mental health practice, which is not an overarching mandate of PAPHR Mental Health Services.

Social workers must be registered with the SASW to be a mental health social worker at PAPHR Mental Health Services; this condition also applies in most other mental health agencies in the province. Social workers from PAPHR Mental Health Services are affiliated with the SASW and some have a strong connection with the social work profession. Many of the social workers employed at PAPHR Mental Health Services were involved with the SASW through committee work or responsibilities with their local chapter.

5.5 Worker-Community Relationships

Social workers in mental health can face an array of barriers to creating effective relationships with the community. One of the most prominent barriers at PAPHR Mental Health Services is its physical location. PAPHR Mental Health Services are located near the hospital, which is not located centrally along with many of the other helping agencies in the city. Due to this isolation, PAPHR Mental Health Services are not as visible in the community and networking with community members and other agencies can sometimes be challenging.
Transportation for some community members can pose a problem and limits the number of individuals who enter the agency requesting services on their own behalf rather than being referred by another individual or agency. Barriers to physical access to PAPHR Mental Health Services by community members leave the potential for community members to be unaware of the services that they could be taking advantage of. These challenges directly relate back to the social work ethics and values, particularly the social justice component and social workers should be continually striving to reduce these barriers.

PAPHR Mental Health Services is increasingly developing strategies to facilitate connections between mental health services and the community, such as becoming more involved in the schools and networking with referring agencies. Community mental health nurses are excellent examples of professionals who are active in the communities and Reserves surrounding Prince Albert, making mental health services visible and accessible. More could be done in the area of mental health promotion and encouraging the utilization of mental health services. Social workers in the mental health field should be continually striving to strengthen the relationship between the profession and the community.

5.6 Client-Community Relationships

It has been argued in this paper that social workers adopt a more social, ecological view of mental health rather than the medical model of mental health, which tends to focus on individual diagnosis and treatment. It is important to look at all areas of an individual’s life that affect their mental health and this means looking past the individual, to their family, social networks, community and larger society. It is important to strengthen supports in the community to help individuals sustain good mental health over a longer period of time. Looking beyond the individual can avoid the common problem of “fixing” the individual without changing the
environment and potentially setting the client up for failure. Strengthening communities and increasing the role community members and informal supports in mental health recovery plans has potential benefits such as reduced need for mental health services, a decrease in inpatient psychiatric hospital stays, a reduction in the use of psychiatric medications, and decrease the need for formal services.

5.7 Client-Society Relationships

The relationship between the client and society in the area of mental health services can be strained at times. There continues to be an over-arching stigma about mental illness and the mentally ill that is quite disheartening. Social workers can help improve this relationship by engaging in anti-oppressive practice and utilize skills such as advocacy and social justice. This may include abolishing myths and stigma associated with mental illness (Sands & Angell, 2002). Strategies associated with such a client centred approach include: avoid talking to the client in terms of their mental illness, (e.g. a schizophrenic rather than a person with schizophrenia); not expecting a person with a mental illness to be less capable of tasks than others and to be grateful when offered opportunities; and including the person in case conferences and meetings about their well-being rather than deciding what is best for him or her (Sands & Angell, 2002).

5.8 Client-Agency Relationships

There may be various obstacles to creating a healthy relationship between the client and the agency. Some of the difficulties with the medical model of mental health have been discussed. If the medical model does not fit well with the particular client one is working with, it becomes difficult for the client to achieve sustainable change. As mentioned previously, changing the individual without changing the environment can often set clients up for failure. On example of how the medical model ideology was problematic at PAPHR Mental Health
Services is the clear mental illness distinction that was necessary for clients to access services. This brings about the debate of how “mental health” is defined in such a way that it turns away some clients who may need to access services. Although referrals were sent to other agencies in most of those cases, it is uncertain of whether or not the clients followed up with those agencies.

Location and transportation are once again barriers to access for many individuals who could benefit from mental health services in Prince Albert. Child care is also can be problem for clients who have children. Mental health services have some differences in comparison to other health agencies such as medical offices due to the nature of the topics being discussed as well as the attention required by the patient in therapy. In most cases, bringing children to appointments is not appropriate and lack of child care may prevent some individuals from accessing services. Mental health services are not always culturally friendly, which may also be a relationship barrier between the client and the agency.

Despite these obstacles, PAPRH Mental Health Services attempts to make services as client-friendly as possible. Client referrals are all treated equally by the agency if the referrals meet the mental health mandate. There was no wait list during my practicum at PAPHR Mental Health Services, which ensured clients received prompt service. Having intake workers who responded to referrals in a timely manner definitely helped to improve the relationships between the clients and the agency. Clients were treated with respect from every agency staff member from reception to management.

5.9 Worker-Self Relationships

Working as part of a multidisciplinary mental health team requires individual social workers to have a strong sense of personal identity and to adopt self care practices. Social workers are a group of professionals that have lower levels of job satisfaction and higher levels
of stress when compared with professionals in multidisciplinary mental health teams (Carpenter et al, 2003; Dane & Simon, 1991; Onyett et al, 1995; Onyett et al, 1997; Prosser et al, 1999; Rabin & Zelner, 1992; Reid et al, 1999b). They also have one of the highest levels of burnout amongst mental health professionals (Carpenter et al, 2003; Onyett et al, 1995; Reid et al, 1999b). Social workers in multidisciplinary teams have more role ambiguity and role conflict than their professional counterparts (Carpenter et al, 2003; Dane & Simon, 1999; Onyett et al, 1995; Onyett et al, 1997; Rabin & Zelner, 1992; Reid et al, 1999b). Being a part of a multidisciplinary team can also bring upon oneself the internal struggle of conforming to the dominant ideology used by the team or staying true to one’s values and profession. With all of these struggles social workers may have due to belonging to part of a multidisciplinary mental health team, it is very important to take care of one’s personal mental health.

Self care practices are one of the most important aspects of the relationship between the worker and him or herself. It is important for the worker to be aware of some of the struggles that are unique to a multidisciplinary team and to adopt strategies to lessen the effects on the individual. Although the responsibility of self care often lies within the individual, the agency does promote some aspects of self care. At PAPHR Mental Health Services, utilization of scheduled breaks and Earned Days Off (EDOs) are encouraged. Workers are supported to leave work at work and an Employee Family Assistance Program is readily available. Self care is part of a balanced work-life relationship in the human services and it is important for individuals to adopt strategies that will work for them.

Relationships can be both negative and positive in multiple levels of the multidisciplinary mental health team. Ideology has been noted as having an effect on relationships, as can be the
strategies utilized by various professionals who belong to the multidisciplinary mental health team.

6. STRATEGIES

Although social workers bring many contributions to the mental health team that are unique to the profession, it is not always easy to incorporate them into practice. Social workers in mental health settings are continually working toward addressing and changing the challenges they face in multidisciplinary mental health teams. One of the biggest challenges for social workers in these settings is to “carve out a large enough role for themselves that is consistent with their competencies” (Sands & Angell, 2002, p. 276). Social workers are forced to come up with ways of adapting existing practices in multidisciplinary teams to make them more social work-friendly or striving to find ways to incorporate the unique contributions into their day to day work. Some of the contributions utilized by the social workers at PAPHR Mental Health Services include using a psychosocial approach by looking at factors outside the individual that influence his or her mental health, meeting basic needs of clients and providing practical support as well as psychotherapy.

Working within the medical model has been identified as a unique challenge social workers face in the multidisciplinary mental health team. Adapting to or altering existing strategies that are an expectation of the mental health setting to a more psychosocial model can be an effective way to practice within the multidisciplinary mental health team.

The medical model focuses on diagnoses and treatment on the basis of observable symptoms and behaviours, which ignores the social and environmental causes of mental health (Barnes et al, 2000; Bland & Renouf, 2001; Carpenter et al, 2003; CASW, 2001; Mitchell, 1993; Rabin & Zelner, 1992; Renouf & Bland, 2005). The psycho social model of practice that is often
utilized by social workers in multidisciplinary mental health teams views all aspects of the individual in their environment that could potentially affect their mental health, including socio-economic status, housing, age, gender and relationships. There is a debate amongst social workers in the mental health field regarding diagnosing. Some social workers in the mental health field mention concerns with diagnosing, while other social workers feel diagnosing mental illness is important to client treatment and that the social work profession should be entitled to diagnose along with other professions such as psychology and psychiatry (Miller, 2002).

Diagnosing is a common practice in multidisciplinary mental health teams. Miller also explains that social work professionals can sometime be reluctant to diagnose, as labelling can further stigmatize and oppress the client who has a mental illness. Miller suggests that once a diagnosis is made, a “one size fits all” treatment plan typically follows that often neglects to acknowledge the unique circumstances of the individual and external factors that may contribute to their mental illness. Such an approach can easily set the client up for failure. There is often a stigma attached to having a mental health diagnosis, which can be problematic for the client. However, a mental health diagnosis has the potential to open doors for clients to access services and financial assistance they may not have access to otherwise. Perhaps social work will have to adopt a role that advocates for access to services that would make a diagnosis unnecessary.

When social workers do diagnose, clients are seen as participants in the diagnostic process and are asked questions about what they think the problem is, when they noticed a change and what those changes are, as well as incorporating the individual and cultural aspects that are unique to the client (Miller, 2002). Miller also suggests that when social workers are diagnosing clients, external and societal factors should be given great consideration and social work diagnoses should be fluid and ongoing rather than rigid and fixed.
Effective social work practice in the mental health setting requires a shift away from seeing recovery as reducing the impact of symptoms or compliance with treatment, to separating oneself from the mental illness, to increasing personal control, and surrounding oneself with support and positive relationships (Miller, 2002). Within this framework, clients create their own goals and concepts of change, they are the expert on themselves, and they are active participants in their case plan. Client empowerment is key for successful client outcomes (Miller, 2002; Mitchell, 1993). Social work practice in mental health also moves away from diagnosing, as is characteristic of the medical model. Miller indicates that diagnoses can often label and stigmatize and often uses a “one size fits all” approach. Miller also suggests that social work practice in mental health attempts to view client issues through a holistic lens, attempting to balance both psychological and social factors. Although the medical model is alive and well in multidisciplinary mental health teams, the professions that have often followed this approach are much more accepting of the psychosocial approach in recent years (Mitchell, 1993).

In recent years, there has been an increasing demand for mental health interventions. In 2002, it was estimated that one in five, or 20% of Canadians will experience some form of mental illness in their lifetime and every Canadian will be affected by mental illness through mental illness in a friend, colleague or family member (Health Canada, 2002). Due to the prevalence of mental illness in Canada, mental health agencies have shifted toward brief therapy and evidence-based practice approaches to meet the demand of an increasing client populations. One of the new approaches that mental health and other human service agencies are taking is the brief therapy approach (Cohen, 2003; Swenson, 1998). Often times, the brief therapy approach tends to be cognitive behavioural in nature and is often “goal-and present-oriented, behaviourally specific, symptom-directive, advice giving, educational, collaborative, and aimed toward the
resolution or amelioration of symptoms in relatively brief periods” (Cohen, 2003, p. 38). In addition to the brief nature of this approach, the new trend is toward evidence-based practices, using primarily those approaches that are deemed effective by research studies (Cohen, 2003; Giles et al, 2007; Murphy & McDonald, 2004). Social work as a profession can sometimes struggle with the concept of evidence-based practice (Murphy & McDonald, 2004; Renouf & Bland, 2005) and there appears to be division regarding its usefulness among social work researchers, practitioners, educators and policy makers (Murphy & McDonald, 2004). Some of the arguments against evidence-based practice are: it discounts clinical judgment, particularly if there is no research base for a presenting issue; it has a strong medical orientation; and it marginalizes evidence other than that which was collected through randomized controlled trials (Murphy & McDonald, 2004). Social workers felt that evidence-based practice ignored issues such as power and disadvantage (Murphy & McDonald, 2004).

Some areas of social work, such as case-management, advocacy, family work, and community development do not always fit well into the evidence-based practice framework and the effectiveness of such approaches are not always easy to demonstrate (Renouf & Bland, 2005). The example provided by Renouf and Bland helps demonstrate this point. Perhaps there is a high rate of depression in a community that also has a high rate of unemployment. Cognitive Behavioural Therapy (CBT) is an approach is definable and has proven to be affective for people with depression. Social workers working with this population of clients may feel a broader, community development approach such as empowering community members to take social action or advocating on behalf of clients to social services agencies and government may assist with the clients’ mental health. Although these social work interventions may be helpful to
clients, due to the difficulty to define the concepts or demonstrate their effectiveness, they may be deemed as less valuable or less important.

Murphy and McDonald (2004) conducted a study using qualitative and quantitative data via structured interviews with rural practitioners in hospital and community settings. The sample comprised of 50 participants from such teams, from 11 different disciplines, one of which was social work and the others were not identified. The social work portion of the sample comprised of only 6 social workers. Just over half of the social workers in the sample did not have a negative view of evidence-based practice, however, they did not feel they belonged to a profession that should use evidence-based practice. One social worker commented, “many of the skills/competencies in social work cannot be tested through evidence-based practice” (Murphy & McDonald, p. 131). Social workers in this study felt that their profession was non-scientific and that evidence-based practice models were incompatible with the philosophy and practices of social work. Despite negative feelings toward evidence-based practice, there is a weak voice advocating against its use in multidisciplinary mental health teams (Renouf & Bland, 2005). Since evidence-based approaches are already evident in many multidisciplinary mental health teams, resistance to the concept by social workers may not be productive. Rather, social workers could explore broader terms of “evidence” or determine ways to developing some sort of evidence in the psychosocial aspects of mental health (Renouf & Bland, 2005).

Adapting the more medical model approaches to mental health such as diagnosing and evidence-based practices can be an effective way to incorporate social work ideology into multidisciplinary teams. Another strategy is to promote the unique contributions, such as the utilization of the psychosocial model, advocacy, and community development skills that social work can offer the multidisciplinary mental health team. Social workers have a unique
contribution to bring to the mental health field and hold multiple areas of expertise that can contribute to the multidisciplinary mental health team. Although social work offers this unique contribution, Rabin and Zelner (1992) point out that this contribution is not always understood or valued. Often times the unique contributions social workers in mental health have to offer are not given the opportunity to be practiced. The contributions that are most often mentioned in the literature are the strong social justice component that is immersed in social work tradition, advocacy skills for clients, families and communities, the ecological approach to mental health, community development, and a client centred approach (Bland & Renouf, 2001; CASW, 2001; Dane & Simon, 1991; Giles et al, 2007; Harries, 1999; Peck & Norman, 1999; Renouf & Bland, 2005; Swenson, 1998).

Some authors are critical of social work in mental health being limited to psychotherapy, when the profession has much more to offer (Bentley & Floyd Taylor, 2002; Bland & Renouf, 2001). The ability of social work to assist clients with practical tasks that enhance their wellbeing is a unique contribution that social work can offer the multidisciplinary mental health team. Bland and Renouf (2001) draw attention to the fact that consumers of mental health services have generally valued the practical support received by social workers such as accessing housing and financial resources. Renouf and Bland (2005) stress the importance of social workers understanding the lived experience of the clients and their families or carers outside the mental health office.

Other professions such as nursing and psychology have increasingly taken on a more social perspective in recent years but social work appears to be a leader in looking at the broader issues related to mental illness (Walsh, 2002; Bland & Renouf, 2001). Peck and Norman (1999) point out that there are core skills that are not unique to the social work profession but the
The approach that social workers take to their work is different than other professions. Although many social workers in mental health settings have a variety of expertise, social work has often been seen as a generalist profession (Sands & Angell, 2002; Harries, 1999). As generalists, social workers can often conduct a wide range of individual, family and group interventions (Sands & Angell, 2002; Harries, 1999).

Advocacy is one of the most commonly cited contributions specific to social work in the mental health field (Sands & Angell, 2002; Bland & Renouf, 2001; Bransford, 2005; CASW, 2001; Dane & Simon, 1991). Social work advocacy is usually centred on providing support, information, and expanding resources for clients (CASW, 2001; Dane & Simon, 1991). Bland and Renouf (2001) add that it is important that social workers also advocate for the basic human rights of mental health clients to ensure they are not treated like second class citizens. Assisting clients in improving service delivery and work toward problem solving through collective action can prove to be an effective strategy that stems from social work values and traditions (Renouf & Bland, 2005).

Social justice has been a longstanding social work tradition and has a strong presence in social work practice, literature and education (Bland & Renouf, 2001; Bransford, 2005; Swenson, 1998; Walsh, 2002). Social justice is such an integral part of social work culture, that it is included specifically in the CASW Code of Ethics (CASW, 2005). Social workers have used social action in clinical roles to achieve social justice in mental health and other social work fields (Swenson, 1998). Social work “looks beyond illness and treatments to broader issues of individual and family welfare, to such concerns as identity and relationships, housing, work and income security” (Bland & Renouf, 2001, p. 238). According to Bland and Renouf (2001) the
capacity social workers have to link mental illness with social issues is the single most important
contribution of social work to the mental health field.

Social justice has its own meaning in a clinical setting. According to Swenson (1998) social justice is achieved using a client-centred approach and unique individual characteristics such as race, culture, gender, and class are seen as a focal point for work with clients. Empowering clients and acknowledging their social realities assists social workers in clinical settings, such as mental health, in attaining social justice (Walsh, 2002; Renouf & Bland, 2005; Swenson, 1998). Achieving social justice through empowerment is an important social work contribution to mental health:

"The goal of effective practice is not coping or adaptation but an increase in the actual power of the client or community so that action can be taken to change and prevent the problems clients are facing. Because the effects of powerlessness can occur on many levels, efforts toward change can be directed at any level of intervention or can include multiple levels of intervention" (Gutierrez, Glen Maye & DeLois, 1995, p. 250).

Social justice appears to be a priority for those social workers who are working in the mental health field. A study completed by Giles et al (2007) posed the topic of workload priorities to social workers who worked in health settings, some of who worked in mental health and were part of multidisciplinary teams. The social workers identified five workload priorities, which were a reflection of their social justice background:

(a) all forms of violence; (b) adjustment for client and carers across the life cycle to health status, particularly terminal illness, mental health and suicide, and disability; (c) trauma; (d) family and social relationships; and (e) disadvantage and inequity of access to
services and resources, particularly housing, legal services, rural, income and employment, and medical services (p. 156).

These workload priorities were centred on the common themes of safety, poverty, resources, advocacy, and social justice; ideas that are central to social work values and ethics. Community development is also a contribution that social work can offer the multidisciplinary mental health team.

Social work is cited as specifically contributing expertise in community development (CASW, 2001; Dane & Simon, 1991; Swenson, 1998), seeking and utilizing community resources (CASW, 2001; Dane & Simon, 1991; Swenson, 1998), rallying for organizational change (Swenson, 1998), and accessing financial assistance (Dane & Simon, 1991). The ecological and systems perspective is a strong component of social work education and the social work profession and benefits multidisciplinary mental health teams (Walsh, 2002; Bland & Renouf, 2001; CASW, 2001). Social work recognizes the strong correlation between person and environment and how the social well-being of clients drastically impacts their physical, mental and spiritual well-being (Bland & Renouf, 2001; CASW, 2001; Renouf & Bland, 2005). Since the ecological model is a strong influence in social work service delivery, social work shifts from focusing solely on the cognitive aspects of mental health to include emotional trauma, relationship difficulties, stress and crisis (CASW, 2001) as well as personality, resilience, strengths, support networks, class, ethnicity and gender (Bland & Renouf, 2001). Just as the environment influences the individual with the mental illness, the person with the mental illness will have an impact on his or her environment. Not only does the mental illness impact the individual but also his or her family members, personal relationships, and the community (Bland & Renouf, 2001). In addition, mental illness has an impact on life opportunities, the ability to
support oneself and one’s family, which in turn can affect housing, economic security and quality of life (Bland & Renouf, 2001). Interventions are not centred on the individual exclusively and often include individual, couple, family and group counselling or intervention (CASW, 2001). Although social workers have an array of expertise to offer the multidisciplinary team, these strategies are not always overtly supported and encouraged by the agencies or team members.

At PAPHR Mental Health Services, many of the unique social work contributions are not an expectation of the job, but rather an achievement that individual practitioners would take upon themselves. There seems to be little discussion in staff meetings about how to make services more accessible to reach a greater portion of the population. During my practicum there was a comment made by a supervisor in a meeting about being busy enough and not seeking to expand resources beyond those who were already being serviced. Some staff members, social workers, as well as other psychologists and psychiatric nurses are progressive in their thinking and put forth initiatives that make mental health services more accessible. Once the ideas are formulated, they often receive management support, but access to services and improvement of services do not seem to be a regular agenda item at staff meetings. For example, one social worker in the agency began a bus ticket program, which clients could utilize to assist with transportation to and from their appointments. Another program that increased access to services by youth was the direct mental health services provided to the students at the Prince Albert public high schools. Mental health workers were present in the schools 1-2 days a week to provide youth with on-site access to mental health services. There were numerous other initiatives that addressed the needs of diverse populations such as the child and youth
development clinic, in training therapeutic foster parents, and the coordinated behaviour management program.

Social work in mental health settings moves away from the traditional medical model and takes a more client-centred approach (Bentley & Floyd Taylor, 2002; Bland & Renouf, 2001; CASW, 2001). The client centred approach views clients as participants in their own changes (Bentley & Floyd Taylor, 2002; Bland & Renouf, 2001), who practice self-determination (Bentley & Floyd Taylor, 2002), work toward mastery over their environment (Bentley & Floyd Taylor, 2002), become conscious of their situation and recognize they have power over it (Bentley & Floyd Taylor, 2002; Bland & Renouf, 2001), with the help of the social worker have influence over decision makers and policies (Bentley & Floyd Taylor, 2002). Social workers in mental health can also recognize the value of the relationship of the client-worker and carer-worker relationship (Renouf & Bland, 2005). Strengthening the relationships with the people that are receiving mental health services has a tremendous impact on recovery.

The social worker in the mental health field sees the client as an equal partner in the change process. Clients are seen as competent adults that can make informed decisions rather than someone with an illness that needs to follow the strict instructions of the clinician (Bentley & Floyd Taylor, 2002). Interventions and treatment plans can be moulded and shaped around client perspectives (Bentley & Floyd Taylor, 2002). Honesty, trust, mutual respect and equal power are all integral parts of the social worker-client relationship (Bentley & Floyd Taylor, 2002). Both the social worker and the client acknowledge each other’s strengths and weaknesses (Bentley & Floyd Taylor, 2002). The therapeutic relationship is centred on the belief that change is possible and growth can happen (Bentley & Floyd Taylor, 2002). The ultimate goal of the work that happens between the social worker and the client is quality of life and this goal is
possible with planning, support and utilization of coping skills and resources the client possesses (Bentley & Floyd Taylor, 2002; CASW, 2001).

There are many examples of the client-centred, ecological approach to practice at PAPHR Mental Health Services. Clients are seen primarily in the office by the majority of the clinicians and were largely responsible for their own transportation. One of the social workers recognized that transportation could be an issue for many clients and the previous example of the bus pass system one such example of a client-centred approach. Individual counselling is the primary focus and individual practitioners rarely incorporate family members into treatment plans or counseling and usually refrain from gathering information from anyone but the client. This is not to say this does not occur; only that it is not common practice. One of the MSW counsellors was able to incorporate family work into her counselling practices in certain cases.

Prevention is another key contribution that social workers bring to the multidisciplinary mental health team. The CASW (2001) indicates that “prevention occurs on many levels and includes a focus on early intervention, individual and public education, advocacy and improving access to services, resources and information” (p. 4). Taking a preventative approach can reduce the numbers of people accessing mental health services rather the reactionary approach typically utilized currently when mental illness has escalated.

PAPHR Mental Health Services offers a variety of approaches to help assist those who are affected by mental illness. Psychotherapeutic approaches are the primary services that are offered at PAPHR Mental Health Services but other services are sometimes needed to support clients who are seeking help. Workers act as liaisons to other agencies and advocate on behalf of their clients when necessary. This is particularly true when clients are mandated to services by agencies such as the Ministry of Social Services or the justice system. Couple or marriage
counselling is rarely offered at PAPHR Mental Health Services. Under unique circumstances, if this type of service fell under mental health services mandate, couples counselling could be provided. There are four general categories in which the mandate of mental health services was able to reach those in need: individual approaches, group approaches, community-based approaches and family approaches.

Individual approaches are provided primarily in the form of one to one counselling with either a social worker or psychologist. Both adults and children and youth receive individual services but there are distinct differences in how those services are delivered. Adults are, for the most part, able to consent to their own counselling and are able to make decisions about the services they receive. The child and youth team must obtain consent from the parent or guardian if the child is under the age of sixteen. In emergency and special circumstances, children and youth under the age of sixteen can be seen once by a counsellor but parental consent is required thereafter. The child and youth counsellors work closely with the parents or guardians, though services to children and youth are still provided on an individual basis.

Individual psychiatric services are also provided by psychiatrists and community mental health nurses, which focused primarily on medication management and psychiatric support. Individual adults and youth are also able to utilize the forensic services at PAPHR Mental Health Services, which includes court ordered assessments, the adolescent sex offender treatment program, and the high risk youth offender program. Individual counsellors within the PAPHR multidisciplinary mental health team have expertise in a range of areas at mental health, including but not limited to: eating disorders, grief, geriatrics, depression, anxiety, post-partum depression and trauma.
There are numerous group approaches that were utilized at PAPHR Mental Health Services. Group services can be an effective way to reach a large number of clients who are exhibiting the same types of mental health difficulties. Some individuals benefit more from the group process than from individual counselling. There were only two psychotherapy groups in existence while I was completing my practicum at PAPHR Mental Health Services. One of the groups focused on education about and treatment of anxiety and depression and the other group focused on grief issues. There is also a child camp that is offered one weekend of the year that assists children who have lost a loved one called *Healing Hurting Hearts*.

The Adult Forensic Services at PAPHR Mental Health Services also provides treatment to clients through the group approach. The *New Choices for Men* program focuses on male perpetrators of domestic violence and presents them with alternatives to violence. A more recent program was developed to run concurrently with the *New Choices for Men* program called the *EVE* program. This program is intended to present alternatives to violence for the women who have been abused by their partners. Women who participate in the *Eve* program are required to have a partner who is attending the *New Choices for Men* program.

The approaches that are more integrated into the community could easily fall under the umbrella of individual approaches but deserve distinct recognition, as they open up services to people who may otherwise be unable to access mental health services. Mental health counsellors are available at the public high schools in Prince Albert and individual counselling is the primary focus. The Community Mental Health Nurses do provide a lot of service in Prince Albert and the surrounding communities providing psychiatric support and assisting with the delivery of medication. PAPHR Mental Health Services also had the opportunity to partner with the Ministry of Social Services to assist in the delivery of therapeutic foster parent training.
Family counselling is not a traditional service that is offered by PAPHR Mental Health Services but if special circumstances meet the mandate of PAPHR Mental Health Services, this type of service is offered by one of the MSW clinicians. The behaviour management program also works intensely with families. Although the focus is on managing the child or youth’s behaviour, it is imperative that the family is involved in the process. Focusing only on the child would get little positive results, as the family needs to make changes as well. The child and youth development clinic is also a program that works with the family rather than the child specifically.

Strategies used by social workers can vary greatly from their professional colleagues in a multidisciplinary mental health team. The skills that social workers bring to the multidisciplinary mental health team can also vary significantly from the skills utilized by other professionals such as psychiatry, psychology and psychiatric nursing.

7. SKILLS

Social workers bring a variety of skills that can benefit the multidisciplinary mental health team. Some skills that may be of particular use to the team are advocacy, an anti-oppressive knowledge base, knowledge and skill in community development and a psychosocial ideology. Though these contributions are seen as important by the social work profession, they are not always given such importance in a multidisciplinary mental health team setting. Due to a lack of acknowledgement of such skills, social workers must adapt these skills to be effective in their work in the multidisciplinary mental health team.

Social work is generally recognized as a generalist profession. Although this can be seen as a strength, it can also be noted as a limitation. Social work education generally lacks any specific training in the mental health field. Members of multidisciplinary mental health teams
struggle with the pressure to provide high quality and effective models of treatment (Onyett et al, 1997; Reid et al, 1999b). Staff members have noted gaps in training and that they feel would benefit their work (Reid et al, 1999b). Professional training most often takes place in isolation from other professions, which may contribute to team members identifying so strongly with their individual professions (Barnes et al, 2000). This may also contribute to ignorance among members from other professions about the roles and values of the other team members. Interprofessional education and training has been noted as a possible solution to work toward collaboration among multidisciplinary teams.

Multidisciplinary teams have a range of skills available to the client which can lead to more innovative treatment options (Bentley & Floyd Taylor, 2002; Norman & Peck, 1999). There are a variety of skills that were developed throughout my practicum as a result of being part of a strong multidisciplinary mental health team. The skills include: individual counselling skills, assessment skills, facilitation skills, critical thinking skills, and skills related to working as part of a multidisciplinary team.

The majority of my time at PAPHR Mental Health Services was dedicated to individual counselling with persons with mental health issues. Engagement and rapport building are initially the most important counselling skills. Throughout my time at PAPHR Mental Health Services, I was able to see my growth in these two areas. Some of my initial clients did not come back for their appointments but as the practicum went on, I noticed more of my clients returning for services.

There are a variety of counselling approaches that are used by practitioners at PAPHR Mental Health Services. Advice that was given to me as a student who had done little formal counselling was to learn one or two approaches well and apply them in sessions. I used two
counselling approaches throughout my practicum: cognitive behavioural approach and solution focused approach. These counselling theories are widely used by mental health services provincially and were successful with some of the clients I worked with throughout my practicum. I was more familiar with the solution focused approach than with the cognitive behavioural approach due to my work in other areas of social work. I did research on cognitive behavioural therapy and was interested in the focus various aspects of the approach. Those who did not respond well to one approach usually responded well to the other.

When we hear the words assessment and diagnosis in mental health, we frequently think of the services that are offered by psychiatrists and psychologists. Social workers are not trained to perform psychological assessments and do not possess the skills that are used to label someone with a psychiatric diagnosis. Social workers do, however, have the skills and training to complete psychosocial assessments, which take a more ecological approach by looking at the factors outside the individual that contribute to their mental health. I feel I was equipped with this knowledge prior to my practicum and was able to apply the knowledge to my work with mental health clients. This type of assessment is valuable information in the treatment of mental health clients. Although social workers do not label clients with a psychiatric diagnosis, it is still important to be aware of the symptoms of mental illness that the client is presenting. This information may be valuable to a psychiatrist or physician that is currently working with or will be working with the same individual in the future. Thus, it is important for mental health professionals, regardless of their educational background, to be familiar with mental illnesses and their symptoms in order to effectively work with the client. This was a skill that was deemed to be important by PAPHR Mental Health Services and one that I developed over the course of my time there.
Although I did not participate in some of the therapeutic groups that were offered at PAPHR Mental Health Services during my practicum, I was able to gain some group facilitation experience. I was able to take part in training therapeutic foster parents in conjunction with the Therapeutic Foster Home Workers at the Ministry of Social Services. This was a unique experience, as I was able to learn with the participants while I was assisting with delivering the material.

Being part of a multidisciplinary team throughout my practicum enabled me to think critically about a variety of things. I began to question the role of social work in mental health and some of the practices at mental health that have been the same for a long time that needed to be altered, such as various aspects of the medical model and evidence-based practices. I also questioned how to better incorporate social work values and ethics such as social justice and community development into mental health practice. I specifically questioned how services could be delivered differently to reach a wider client base.

This paper has discussed many of the challenges social workers face and the benefits social workers gain as being members of a multidisciplinary team. From my experience, it is clear that changes need to be made to ensure social workers have a clear and effective role within the multidisciplinary mental health team.

8. VISION FOR THE FUTURE

As the number of social work positions in multidisciplinary mental health teams increase, the need for social work to strengthen and clarify its role in these settings becomes increasingly important. Continuing education and developing and mastering skills specific to the mental health field is also a fundamental task in becoming a valued addition of the multidisciplinary mental health team. Though there is a social work presence in mental health, social work has to
make a substantial effort to become an indispensable member of the multidisciplinary mental health team. Harries (1999) identified a desired situation for social work in mental health:

The desired situation for social work is that it has a recognised and valued place in the delivery of service to people with a mental illness and their carers and that it can make a difference to the lives of these people in a way that they report to be beneficial (p. 61).

If social work demonstrates to mental health agencies that social workers are essential members of the multidisciplinary mental health team, they may begin to be treated as such (Bland & Renouf, 2001; Harries, 1999). According to Harries (1999), this can only be done when social work is represented in adequate numbers to demonstrate their unique contributions and their value to the organization.

Harries (1999) also asserts that the social work profession needs to clarify the role of social work in mental health and “advocate for itself as it claims to advocate for others” (p. 62). Social work has a distinct background and set of values and traditions. It is important that the profession push to have those values and traditions recognized and practiced in multidisciplinary mental health teams (Harries, 1999; Rabin & Zelner, 1992; Renouf & Bland, 2005) and to ensure that social work itself defines its own roles rather than other professions defining them (Rabin & Zelner, 1992). However, Bentley and Floyd Taylor (2002) encourage the social work profession to move away from consistently defending what the role of social work has been in the past and move toward a vision of what role social work can play in multidisciplinary mental health teams in the future. Social work needs to promote social justice in mental health settings as well as practices that are consistent with the values, ethics and traditions of social work (Bransford, 2005; Renouf & Bland, 2005).
Further to this, Giles et al (2007) recommend that social work should continually develop and revise a set of clinical priorities that would help define their role in the multidisciplinary mental health team. These priorities should be broad and reflective of social work practice as well as the social issues mental health clients are facing. Clinical priorities should reflect current and best practice and incorporate research and social work values that understand the relationship between mental health and social factors. In relation to multidisciplinary teamwork, social workers could use the clinical priorities as rationale to respond to certain types of referrals that are received by the organization.

Social work needs to promote an environment in which different points of view can be heard and respected, even when that view differs from the dominant paradigm (Harries, 1999; Rabin & Zelner, 1992). Social workers need to be clear about what they are able and unable to do, be willing to continually negotiate the conditions of their work, and become comfortable with taking and using power (Harries, 1999). Assertiveness is a key component of social work satisfaction on the multidisciplinary mental health team. Assertiveness skills would assist workers in clarification and changes to job description, confront lack of clarity, and promote healthier inter-professional relationships (Rabin & Zelner, 1992). Using power and authority is not always an easy task and often social workers and other professionals find themselves feeling helpless when policies are enforced by management positions. Bransford (2005) reminds professionals that policies are maintained only when workers collaboratively uphold those policies and refrain from advocating for alternatives. In order to change this pattern, Bransford suggests that social workers need to take a more distinct and active role in staff and organizational meetings. Social workers can also make a contribution to the mental health team by educating other professionals about social work values and ideologies, particularly social
justice, and supporting them in their practice of such an approach (Bransford, 2005; Swenson, 1998). Bransford (2005) mentions socialization as a problem for social workers in multidisciplinary mental health teams. Social work is a professional primarily made up of female practitioners. Bransford states that women have been socialized in most cultures to submit to the authority of men. She recommends that social work practitioners aim to empower themselves and empower and support each other. Men are more likely than women to be in supervisory and management positions, which can further marginalize the place of female social workers. It may become important then, for more female social workers in management positions when possible, and when not possible to collectively advocate for changes in work environments that would benefit themselves and their clients. Continuing education and training is also important for social workers to maintain current and competent.

Social work graduates often come out of their undergraduate education with a lack of specific clinical mental health skills and therefore adopt the practices of other professional colleagues (Renouf & Bland, 2005). Renouf & Bland (2005) indicate this marginalizes the position of the social worker in the multidisciplinary team further. Since social work education is often generalist based, it is important that social workers take the initiative to continue their education and expand expertise in the mental health field (Harries, 1999). Education can include in-services and workshops as well as graduate and post-graduate studies. Social workers in the multidisciplinary mental health team need to connect knowledge and practice, which makes their work accountable (Renouf & Bland, 2005). Giles et al (2007) suggest social workers strengthen their social work practice by engaging in research that is relevant to their practice.

Harries (1999) participated in a project aimed at improving mental health services in Australia by developing a set of standards to improve social work practice in the mental health
field and develop guidelines to work under. Social workers who participated in workshops identified the important role of the project to gain support from the Australian Association of Social Workers (AASW) to develop a Standard of Practice for social work practice in mental health settings. Giles et al (2007) criticize the AASW for not having a strong influence for social work in health care settings. Harries (1999) suggests that clients and caregivers could be involved in such standards by being involved in reviewing and evaluating mental health social workers and programs. There is currently no specific Standard for Practice for mental health social workers published by the SASW, only a Standard of Practice for Health Care Workers. This type of support from the SASW could contribute to the role clarification of mental health social workers in Saskatchewan.

9. CONCLUSION

Individuals who work as part of a multidisciplinary team and the managers and agencies that bring these individuals together can often have the best of intentions, but challenges emerge nonetheless. There have been several challenges identified that are particularly problematic for social workers in multidisciplinary mental health teams. One such challenge is the difference in professional values and ideologies, specifically the medical model that focuses more on individual pathology and treatment versus the psychosocial model that tends to look at external factors to mental health and utilizes the person-in-environment approach. Values and ethics differ amongst professionals as well and social workers sometimes feel that they lack the capacity incorporate ideas such as social justice and advocacy. Another challenge can be the differences in strategies and skills used by members from different professional backgrounds. Social work strives to incorporate community development and anti-oppressive practice while struggling with ideas such as diagnosing and evidence based practices. Relationships amongst
varying levels of the multidisciplinary team can also become strained. Role ambiguity and the hierarchy that exists in such teams can contribute to relationship difficulties.

These challenges exist in the multidisciplinary team at PAPHR Mental Health Services. Not only are staff members dealing with differences of opinion due to personality and value systems, such as in any workplace, but staff members are also dealing with differences in professional values and ideas. The hierarchy that exists in this multidisciplinary team was a difficult concept to cope with, as it remains hidden. Many of the social workers feel the hierarchy but feel they have little ability to change the system, as is true of most marginalized groups.

Despite the challenges that multidisciplinary teams face, there are many positive aspects of this unique type of collaboration that can rarely be found in other types of mental health settings. Members of a multidisciplinary team seem to find working with members of other professions rewarding and supportive (Onyett et al, 1997; Reid et al, 1999a). The strengths of multidisciplinary teams include the convenience of having staff members of different professions in a shared work environment, a strong team mentality, healthier work relationships between professions, and better care for mental health clients. Benefits of working in a multidisciplinary team were also evident at PAPHR Mental Health Services. Although there were challenges to working in a multidisciplinary team, the benefits were many. It was refreshing to be surrounded by a wealth of knowledge at my fingertips and a supportive team that was willing to answer questions at a moment’s notice. Watching team members of different professions have a close working relationship and combining expertise to meet the needs of a diverse client base is a unique benefit of a multidisciplinary team.
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