Mental Health and Addiction Services Administration: A Field Practicum Report

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Abstract

This report reflects my practicum experience with the Regina Qu’Appelle Mental Health and Addiction Services Administrative Leadership. The practicum took place between September 5, 2010 and December 13, 2010. This report follows the Direct Practice Framework recommended for Integrative Practicum Reports as outlined by the University of Regina, Faculty of Social Work. This framework includes the areas of: Ideology, Theory and Models of Practice, Values, Ethics, Relationships, Strategies, Skills and Vision. This report is a synthesis of my observations, research, participation and personal experience of my practicum. Its purpose is to highlight critical thinking, and experiential and reflective learning.
# Table of Contents

1. **Introduction**  
   1

2. **Ideology**  
   5
   - 2.1 Image of the Client  
     7
   - 2.2 Beliefs about Client Worker Status  
     11
   - 2.3 Determinants of Problems  
     12

3. **Values**  
   15
   - 3.1 My Value Base/Social Location  
     16
   - 3.2 Value Base of Client Constituencies  
     17
   - 3.3 Potential Value Clashes Between Self and Client  
     18
   - 3.4 Potential Value Clashes Between Client and Society  
     18
   - 3.5 Potential Value Clashes Between Client and Agency  
     19
   - 3.6 Potential Value Clashes Between Agency and Worker  
     20

4. **Theory & Models of Service Delivery**  
   21
   - 4.1 Systems Theory  
     22
   - 4.2 Recovery Model  
     23
   - 4.3 Client Responsive Approach to Service Delivery  
     25
   - 4.4 Stepped Care Model of Service Delivery  
     29
   - 4.5 Social Determinants of Health/ Population Health Approach  
     31

5. **Ethics**  
   32

6. **Relationships**  
   35
   - 6.1 Clinician/ Client Relationship  
     35
   - 6.2 Clinician/ Agency Relationship  
     36
   - 6.3 Clinician/ Clinician Relationship  
     37
   - 6.4 Agency/ Community Relationship  
     37
   - 6.5 Client/ Community Relationship  
     38

7. **Strategies**  
   39
   - 7.1 Quality Improvement Strategies  
     39
   - 7.2 Development of Guiding Principles  
     42
   - 7.3 Change Management Strategies  
     44
   - 7.4 Re-organization/ Integration of Services  
     46
   - 7.5 Organizational Leadership and Commitment  
     49
   - 7.6 Knowledge Exchange  
     50
8. Skills
9. Visions
10. Conclusion
11. References
1. INTRODUCTION

Mental Health and wellbeing contribute to our quality of life and to our ability to enjoy life. Good mental health is associated with better physical health outcomes, improved educational attainment, increased economic participation and rich social relationships. In fact, good health is not possible without good mental health (MHCC, 2009, p.10).

The Regina Qu’Appelle Health Region (RQHR) Mental Health and Addiction Services leadership team have a vision. The vision is that all people achieve the best possible mental health and well-being. In order to achieve this vision, Mental Health and Addiction Services portfolio are exploring ways to be more collaborative and responsive, as a system, to client needs. This vision was realized after the Mental Health Commission of Canada (MHCC) put out a call to action for all of Canada to participate in the development of a Mental Health Strategy for Canada. The RQHR has made commitments to this process by engaging in strategic planning, conducting research, engaging the community, providing leadership; and most importantly, acknowledging the need for change. As a middle manager in the organization, I had a desire to improve my knowledge and skill in the area of administration and I saw the opportunity that this call to action offered. Although currently employed by the RQHR in a leadership role, the challenge of participating in system transformation at a senior level both excited and intrigued me.

My career to date has included 8 years in direct clinical contact with children and youth at Child and Youth Services as a clinical social worker. Two years ago I was appointed to the Program Manager position the Randall Kinship Center and more
recently, the Kids First Program. In this position I manage a staff of 15 clinicians who provide services to infants, children, youth and their families. After consulting with Dr. Douglas Durst of the University of Regina - Faculty of Social work, I applied to complete a field practicum with the administrative office of the RQHR Mental Health and Addiction Service. Dr. Durst provided me with support and advice regarding the process involved in the practicum placement. My practicum placement with the Mental Health and Addiction Services Administrative Office was a full time practicum from September 2010 to December 2010. I was under the supervision of Lorri Carlson, Executive Director of Mental Health and Addiction Services. I was given the opportunity to be involved in a number of exciting opportunities throughout my time with Lorri that contributed to achieving my learning goals. My specific learning goals were as follows:

1. **Improve my knowledge in the area of administration within the Regina Qu'Appelle Health Region, with a specific focus on change management strategies and strategic planning.**

2. **Complete a literature review and environmental scan on the concept of centralized intake with the outcome of making recommendations to facilitate a discussion regarding implementation of this system change.**

3. **Participate in the development of a community strategic plan for mental health and addiction services.**

4. **To draw on existing social work skills and apply them in a new role.**

In order to meet these learning goals, I was provided with a variety of learning opportunities. The following summary provides a brief overview of each of the activities
I participated in over the four-month practicum. Each of these activities challenged me in different ways, but all of them were very worthwhile contributions to my development.

- **Lean Kaizen (small change process):** I had an opportunity to work with the RQHR’s Quality Improvement Team and staff and leadership of the Adult Mental Health Clinic’s Intake program on a *Lean* initiative. The process intended to improve standardized activities and processes, while eliminating waste within the system. A *Kaizen* is a continuous improvement exercise within the *Lean* model that “increases the effectiveness of an activity to produce more value with less waste” (Sayer & Williams, 2007, p. 339).

- **RQHR Leadership Retreats:** I had the opportunity to participate in the design and organization of two leadership retreats for the senior leaders in the mental health and addiction portfolio. The goals of the sessions were the development of vision, mission and values for the portfolio, information exchange, priority setting and the identification of action items.

- **Provincial Integration of Mental Health and Addiction Services Committee:** I was a member of this committee; participating in research and writing of a document that outlines recommended actions for the successful integration of Mental Health and Addiction Services. This provincial committee included representation from all of the other health regions in the province.
• **Centralized Intake Literature Review:** To complete this review, I spent time consulting with the entire intake staff of the various RQHR Mental Health and Addiction Service sites. I reviewed model programs in Saskatchewan and Canada and completed a comprehensive literature review. I submitted a written report for circulation to all managers within the portfolio. This report provided recommendations, based on the literature, for the implementation of a centralized intake program.

• **Mental Well-Being Strategy:** The *Mental Well-Being Strategy for Regina and Area (2011)* is a multi-sectoral and collaborative process designed to improve the mental well-being of our community. The strategy began when a working group was struck to begin identifying emerging practices and evidence from the current literature. I was fortunate enough to sit on this working group and participated in the research and writing of a foundation paper. Key stakeholders from the community were identified and asked to sit on a Steering Committee for the purpose of creating a shared vision for an improved future through priority setting and the creation of an action plan. As Lorri Carlson’s student, I was permitted to sit on this committee and participated in the development of the *Mental Well-Being Strategy for Regina and Area (2011)* document that is to go out to the community for consultation. From the beginning, the work of the strategy sought out the expertise, innovation and experience of community based service providers and management in the RQHR.
This report follows the direct practice framework developed by the Faculty of Social Work, University of Regina for writing a comprehensive integrative Master of Social Work practicum report. The paper is intended to integrate theory with the experience of the direct practice of the practicum. This report includes eight specific components: ideology, values, theory and models of practice, ethics, relationships, strategies, skills and visions. This report considers appropriate social work literature as it relates to my practicum experience with the administrative office of Mental Health and Addiction Services.

My learning was a combination of observation, participation, consultation and research. I was specifically requested to participate in a number of initiatives that support organizational transformation and change. Although I was not involved in direct practice with clients during this practicum, I reflect on my previous experience as a clinical social worker throughout the paper. Due to the nature and scope of this document, definition and greater understanding of mental health, mental illness and addiction will not be included. What is included is my experience and critical analysis of system transformation in a large organization.

2. IDEOLOGY

The objective must be to ensure that people of all ages living with mental health problems and illnesses are treated with the same dignity and respect as their fellow citizens, are actively engaged and supported in their journey of recovery and well-being, and are able to enjoy meaningful lives in their community while striving to reach their full potential (Mental Health Commission of Canada, 2009, p. 14).
Ideology is what drives the work we do; it is directly related to our meaningful belief system. In the context of my practicum experience, the call to action from the Mental Health Commission of Canada’s document *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada* (2009) is the main ideology that drove the experience I had. I spent a considerable amount of time immersed in this document throughout my practicum. This document provides a framework for the development of a mental health strategy for Canada, including seven high-level goals that are presented to emphasize areas within the mental health and addiction system that require attention. These goals have been adopted by the Steering Committee of the *Regina and Area Mental Well-Being Strategy* and the RQHR Mental Health and Addiction Services leadership team, as the ideological foundation for necessary change within the system. The Goals are:

- **Goal One:** People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being.

- **Goal Two:** Mental Health is promoted, and mental health problems and illnesses are prevented wherever possible.

- **Goal Three:** The mental health system responds to the diverse needs of all people in Canada.

- **Goal Four:** The role of families in promoting well-being and providing care is recognized, and their needs are supported.
• **Goal Five:** People have equitable and timely access to appropriate and effective programs, treatments, services, and supports that are seamlessly integrated around their needs.

• **Goal Six:** Actions are informed by the best evidence based on multiple sources of knowledge, outcomes are measured and research is advanced.

• **Goal Seven:** People living with mental health problems and illnesses are fully included as valued members of society.

*(Mental Health Commission of Canada, 2009)*

The Mental Health Commission of Canada encourages the nation to develop a plan of action for participation in the transformation of the mental health and addiction system. As a result, there are a number of regional, provincial and national initiatives taking place with a vision of improving the mental well-being of Canadians. In the RQHR, these initiatives include the participation in a community owned well-being strategy for Regina and area, quality improvement strategies, strategies to improve client responsiveness and activities related to the integration of mental health and addiction services. These initiatives are in the early stages of development, but are considered drivers of system change based on ideologies set forth by the Mental Health Commission of Canada.

2.1 **Image of the Client**

*Stigma refers to beliefs and attitudes about mental health problems and illnesses that lead to the negative stereotyping of people living with mental health problems and illnesses and to prejudice against them and their families. These are often*
based on ignorance, misunderstanding, and misinformation (Mental Health Commission of Canada, 2009, p. 91).

The image of the clients served by the RQHR’s Mental Health and Addiction Services is representative of all people; for it is safe to say that almost everyone in Canada will be affected by a loved one’s or their own mental illness, mental health, or addiction problem. Mental health and addiction problems cut across all socio-economic backgrounds, cultures, age groups, and genders.

To provide a sense of the volume of mental health and addiction clients, the following statistical data is presented. It is estimated that “each year, about one in every five Canadians will experience a diagnosable mental health problem or illness” (Mental Health Commission of Canada, 2009, p. 10). For the purpose of this document, national prevalence data is used to estimate the proportion of people in Regina and area that are suffering from a mental health/ addiction illness or disorder. In 2009, the RQHR had an estimated population of 253,809, with 190,117 of these being over the age of 20 (Regina Qu’Appelle Health Region, 2010). From the data we can estimated that in the RQHR, more than 38,000 adults and 12,000 children will experience a mental illness in a year (based on national prevalence rates and population, 2009). In addition to this, a National survey conducted in 2002, reveals that 10% of Canadians aged 15 or older reported symptoms consistent with alcohol or illicit drug dependence (Health Canada, 2002). Based on this information, we can estimate that 21,000 Regina and area residents aged 15 or older have symptoms of substance dependence. While mental illness is the second leading cause of disability and death in Canada, Saskatchewan spends only five percent of the provincial budget on Mental Health (Saskatchewan Ministry of Health, 2010). This
disparity between the need for services and the resources available is not only a problem in Saskatchewan. It is estimated that only one third of those who require mental health services in Canada actually receive them (Statistics Canada, 2003).

In Canada, mental illness is the second leading cause of human disability and premature death, and it is estimated that every day, 500,000 Canadians are absent from work due to psychiatric problems (Centre for Addiction and Mental Health, 2010). A lack of investment in mental health and addiction services produces substantial financial, societal, and personal costs. Businesses lose productivity or cannot find employees; communities experience higher rates of poverty, trauma and crime; and individuals and families fail to reach their potential and suffer unnecessarily.

Despite the prevalence and high cost of mental illness and addiction problems, there continues to be mistaken beliefs regarding people living with mental illness, mental health and/or addiction problems. They are often viewed as fundamentally different, and are often labelled by their diagnosis or illness. Mental illness can be portrayed in the media through sensationalized stories of violence, creating fear and misunderstanding. The result can be discrimination against individuals with mental problems or illness. Although we have come a long way from locking up the mentally ill, there is still a significant amount of work to be done to improve the image of our clients. There is a stigma attached to mental illness and addiction, a lack of understanding that needs to change. Stigma has been identified as a primary reason two thirds of people living with mental health problems do not seek help (Mental Health Commission of Canada, 2009).

As a result of the impact of mental health and addiction problems in our community, the RQHR’s Mental Health and Addiction Services portfolio have developed
a number of programs to work with different client populations. These include, but are not limited to the following programs. *Child and Youth Services* provide services to children, youth and families experiencing significant mental health problems. There are several distinct programs offered within Child and Youth Services, including the Autism Program, Children’s Program, Youth Program, Young Offender Program, the Randall Kinship Centre, Early Psychosis Intervention Program, Cognitive Disabilities Program, Kids First and Child and Adolescent psychiatry. The *Adult Mental Health Clinic* provides a wide range of community-based services for adults who are having significant problems related to their mental health and well being. The distinct programs within the Adult Mental Health Clinic include Individual Counseling, Alternatives to Violence Program, Alternatives to Sexual Offending Program, Rehabilitation Program, Vocational Services Coordination and adult Psychiatry. There is also an *Inpatient Mental Health Program* at the Regina General Hospital for both Adults and Adolescents. *Addiction Services* provides a wide range of community-based programs for people with addictions. Some programs are specifically for people dependent on alcohol or drugs, and include support, education and counselling for their family members. These programs include out patient, in-patient and day patient addictions programming as well as the SGI Safe Driving Program, the Harm Reduction Methadone Clinic, Detox and Stabilization, and Problem Gambling Programs. *Rural Mental Health and Addiction Services* are also available across the age spectrum under this portfolio.

During my practicum placement, I had the opportunity to meet with the intake teams within each of these five respective programs. This gave me first hand exposure to the breadth of the services provided as well as insight into the clients who access these
services. It has been reported to me that although there are a number of services available, there are still many who go unserved by this complex system. It was also reported to me that those with mild to moderate symptoms are often screened out completely. It was my observation that the system does not have the capacity to meet the needs of these individuals, and many wait an unacceptable length of time for services.

2.2 Beliefs about Client Worker Status

The staff and leaders of Mental Health and Addiction Services are exceptional and their work deserves recognition and value. The staff work from a client centered perspective which is reflected in the passion that each of them display in the way they work with people living with mental health and addiction problems. Clinicians incorporate respect, self-determination and evidence-based treatments in a non-judgemental way on a daily basis. I had the opportunity to observe excellence in the development of community partnerships on behalf of clients and/or identified gaps in services. The intake staff demonstrated exceptional skill in responding to crisis and those most in need of services. Overall, leaders and clinicians provide a high standard of care for clients and demonstrate skill in assessment, diagnosis and treatment. Staff manage multiple requests from multiple sources, and provide responsive care with limited resources. RQHR Mental Health and Addiction Services are voluntary, so the relationship is based on what the client is willing to work on. There is an underlying belief that the therapeutic relationship is a partnership and the goals of this partnership are defined by the client. There are many in our community who would say that they are thriving today because of the support offered by these clinicians.
Throughout my practicum experience, I was asked to identify limitations within our current service. The limitations identified here are not reflective of individual clinician limitations, rather they are system limitations. A number of other problems identified within the system are identified in the following section. In regards to limitations in the client/worker status, there are few identified by the clients themselves. This may be due to the fact that there is little opportunity for clients to share their perspective and provide feedback regarding this relationship. It is unknown whether clients experience a genuine partnership and it is difficult to find examples of where clients are involved in the system in ways that affect services. When client issues are brought forward, they are usually of a serious nature and are not reflective of the day to day client worker status. Clients are often happy to receive a service after a long search for help or wait for service. Clients rely on individual clinicians to be the expert, often not even being aware of the services that are available to them. These limitations in the client worker status can be viewed as drivers of change, and areas for focused system improvement.

2.3 Determinants of Problems

*In a transformed system that is orientated towards recovery and well-being, it will be everyone’s responsibility to ensure that every door is the right door. People will no longer be told, after a lengthy wait to try one service, that they came to the wrong place and need to start over elsewhere. Instead, providers will ensure that people are engaged with the right service as quickly as possible through improved system navigation and user-friendly information technology. This will mean that no matter where individuals first seek help, there is no wrong door and they will*
get connected to the appropriate part of the system, without having to tell their
story over and over again (Mental Health Commission of Canada, 2009, p. 72-73).

It has long been recognized that changes to the Mental Health and Addiction
System need to occur. “What generally exists is a fragmented patchwork of programs and
services, many of which face a constant struggle to find adequate resources to meet
ongoing demands” (Mental Health Commission of Canada, 2009, p.13). The following
section identifies some of the current challenges facing Mental Health and Addiction
Services within the RQHR.

One of the biggest challenges faced by the system is that there are insufficient
resources to meet the needs of those with mental health and addictions difficulties. The
system only has the capacity to see a limited number of individuals and the majority of
those seen are experiencing significant distress as a result of their current difficulties. As
a result, those with mild to moderate presentations, or those who would benefit from
prevention activities are unable to access service. The Mental Health Commission of
Canada (2009) suggests that Mental Health promotion and illness prevention has the
potential to improve the overall mental health and well-being of the population.

The services that are provided are disjointed and lack coordination. Each of the
programs listed previously has a separate intake system, data base, telephone number and
management structure. Clients access each service separately and clinicians are
sometimes unaware of clients’ involvement with other services within the portfolio. In
addition to the lack of formal coordination, several informants commented that there are
substantial ‘turf battles’ or resource protection, which interfere with cooperation across
networks. There is no mental health and addiction roadmap for clinicians to follow to
ensure a continuum across the service. Transition of care between services can be uncoordinated and complex. Disruption of care during transition has the potential to adversely affect the health, well-being and potential of vulnerable groups. Ideally, transitions should be planned and orderly, through communication between sites. Currently, communication between service providers during transition is limited and the services are not aligned in a way that allows for seamless transfer. These are considered system barriers that prevent information sharing across service providers and prevent clients moving seamlessly through a complex system. This also means that there a number of access points for clients, with no defined process for ensuring that they are connected with the appropriate service.

There is a lack of standardization within the current system as well. There are no commonly agreed upon standardized tools for screening, assessing risk, or prioritizing services in a consistent, objective and measurable manner. Each separate program has its own complex, paper driven health record system. Electronic communication and transfer of information is limited by a lack of automation within the system. Sites have developed their own process, often in isolation from the other services. As a result, there is no overarching framework under which these programs can collaborate care, access or resources, and there is no integrated structure or communication mechanism to support information sharing, joint planning or priority setting.

Services lack accessibility, and it is not uncommon to wait six months or longer for services (Saskatchewan Ministry of Health, 2010). The current wait times for access to mental health and addiction services ranges from 2 weeks to 9 months, depending on severity, demand and service required. There are also limitations in relation to clients
having access to services at times and in ways that are convenient to them. For people with serious mental illness, and for those experiencing substance abuse and homelessness, having to wait for a psychiatric appointment can mean the difference between regaining stability and relapse, crisis hospitalization, or even suicide attempts. Postl (2006) suggests that “wait times are a symptom of a larger problem…Canadians need to support a transformation that puts patients at the centre of the system” (p. 9). Culture also plays a role in access to mental health and addiction services. Often, the current system does not reflect the culture of those served. There is a recognition that mental health and addiction policies, programs, services and supports need to be oriented, organized and delivered with a foundation of cultural safety. Cultural safety “encourages service providers to communicate and practice in a way that takes into account the social, political, linguistic and spiritual realities of people with whom they are working” (Mental Health Commission of Canada, 2009, p.120).

3. VALUES

In Social Work, values can be understood as broad preferences concerning appropriate courses of action or outcomes (Sachs & Newdon, 1999; CASW, 2005). As such, our values are a reflection of what we believe to be right and wrong or what ‘ought’ to be. Our values should influence our attitudes and behaviours and guide all decision making. Sachs and Newdon (1999) suggest that values are the basis of our clinical work, advocacy and public policy agenda. They go on to suggest that we must be “explicit about our values to make clear what we believe and how what we believe is related to the selection of theory base and practice goals and methods” (Sachs & Newdon, 1999, p. 16).
As people, we cannot act separately from our values and beliefs, and it is important for all social workers to understand their personal values and the values of the agency to reduce conflict. The following sub-sections highlight the current values of the system, and how they are influencing the changes in mental health and addiction services portfolio.

3.1 My Value Base/
Social Location

I am a Metis Woman who was raised in a single parent family from the age of five, after my father was killed in a car accident. My mother is a teacher and worked hard to ensure that her three children were all given opportunities despite financial and emotional challenges. Values of family, generosity and independence were instilled in my life from a very early age and are strong values that I hold to this day. I, like so many others, have family members who experience difficulties with mental health and addiction problems. I know first hand how this can impact a family, a community and an individual. I understand that my upbringing has impacted the way I interact with clients and co-workers. I strive to be non-judgmental, generous and I have a genuine belief in the change process.

From September 2010 to December 2010 I was on a leave from my position at Child and Youth Services where I am employed as the Program Manager of the Randall Kinship Centre and the Kids First Program. I supervise and support 15 clinicians including psychologists, speech and language pathologists, mental health therapists, social workers, and a community development coordinator. Prior to this, I was a clinician with the Randall Kinship Centre for eight years. I completed a Bachelor of Human Justice in 2001, a Bachelor of Social Work in 2007 and applied to the Master of Social
Work program that same year. I have always worked full time and completed my studies part time.

My work experience has exposed me to a wide range of opportunities in leadership, community collaboration, therapeutic relationships, clinical skill, case management, program development and new learning experiences. I have had the opportunity to work closely with cultural brokers, Elders and Aboriginal staff and have been able to share these experiences with the families that I have the opportunity to work with.

3.2 Value Base of Client Constituencies

There is a growing consumer movement in Canada and these consumers (clients) want to be heard. The literature has begun to reflect information about what clients need from a mental health and addiction service, rather than focussing on what the ‘literature’ tells us they need. Like all people, individuals with mental health and addiction problems want to be contributing and valued members of society. They want to be treated with equality and be given opportunities. The Mental Health Commission of Canada (2009) has made an effort to include the voice of those with lived experience in all of the work that they do. From these voices, the value base of our clients becomes clear.

Clients value the hope of a better future; they value not being discriminated against based on their illness; they value their culture, their families, and contributing their own thoughts and ideas about what they need to be well. Clients value having choice regarding the services they receive and they would like to set goals and be supported in reaching these goals. They value access to much needed service in times of crises. They value an agency that is welcoming and warm and is available in the
community in which they live. They value having their families and support networks included in their treatment (Mental Health Commission of Canada, 2009).

3.3 Potential Value Clashes Between Self and Client

Potential clashes between self and client are present in the relationships I have with clients who entrust me with their care. The way that I know I should deliver services is through a mutual partnership with the client. My role should be to listen to the needs of the client, motivate the client to reach self identified goals, coach the client and family through difficult transitions - mentoring individuals through role modeling and support. This is not always the way that I actually end up providing services. It has happened that I have found myself making assumptions about what clients need. I end up being a teacher or teller, and direct people about what they need to do in order to reach their goals. Sometimes I even “do for” clients, rather than trusting them or challenging them to do for themselves. The challenge with self-determination is watching people you care about make choices that negatively impact on their recovery goals.

As a manager there is also the potential for value clashes between myself and my staff regarding the pressures of limited resources, increased expectations for direct client care, and an expectation for increased evidence-based treatments. Clinicians can feel overwhelmed by the pressure to deliver quality evidence-based services, while maintaining client responsive care for a large caseload. There are limited resources to support this and it has the potential to impact the staff and the clients they serve.

3.4 Potential Value Clashes Between Client and Society

There is a potential value clash between the client and society when it comes to the perceived safety of the community versus self-determination of clients with mental
illness or addiction. Many people believe that society should be able to use social control to ensure that treatment is adhered to and that social workers/clinicians can and should take away the rights of those that they feel are not making good decisions about their lives. These beliefs clash with the value of self-determination. There is also a lot of moral judgement in society regarding the mentally ill and addicted individuals. There is an attitude of ‘us versus them’ that result in lack of understanding, stigma and discrimination. There are also values of status, power and privilege that reinforce the notion that those without mental illness or addiction are better than those who have a mental illness or addiction.

3.5 Potential Value Clashes Between Client and Agency

The programs provided by Mental Health and Addiction Services are free of charge and are for the most part voluntary. There is potential for value clashes to occur when services are mandated under the Mental Health Act or other legislations. This has the potential for conflict again between the value of self determination and the value of keeping individuals safe from harm. Another potential value clash is the value that clients have regarding their families involved in their treatment. Agencies often have significant policies around confidentiality of health information (Health Information Protection Act). This can be frustrating for families and clients as they are not included in treatment and often feel helpless watching their loved ones struggle. Yet another potential clash is in regards to the accessibility of services. Everyone has the right to accessible and effective mental health care, yet as I have learned, this is not always offered in a timely manner. There are even times when those with mild to moderate services are not provided with mental health care at all.
3.6 Potential for Value Clashes between Agency and Worker

The values of the Regina Qu’Appelle Health Region are the foundation upon which all actions are measured within the Mental Health and Addiction System. The values of the RQHR include: Compassion (show you care and be people focussed), Respect (respect for others), Collaboration (be a team player, communicate effectively, show recognition, be solutions focused, contribute to organizational success), Knowledge (be open to continuous learning, protect privacy and confidentiality) and Stewardship (safeguard people and resources, be accountable for our actions, use information systems and internet responsibly, advocate a safe and healthy lifestyle). The Living Our Values Document (2007) suggests that “by living our values, we will achieve a safe, supportive, quality workplace” (Regina Qu'Appelle Health Region, 2007, p. 11).

The potential for conflict occurs when staff are asked to take on new tasks or increase their workload. This often results in the clinician stating that this is in conflict with their values pertaining to the quality of their work. They will sometimes suggest that the request of the agency limits their ability to be compassionate and knowledgeable as they do not have time to devote to clients in their care. There is an expectation that the clinician’s primary function is to see clients and be there to meet their mental health and addiction needs. However, there are also numerous other requests put on staff regarding community development and collaboration, and personal development expectations.
4. THEORY & MODELS OF PRACTICE

Theory suggests that services provided in the right way have the potential to improve outcomes. Models of practice are approaches or concepts that can be viewed as levers of change, influencing action that will take place. Both are important to consider when embarking on large organizational change. There are a number of theories and models that can be applied to the activities and adopted goals of system transformation within Mental Health and Addiction Services in the RQHR. In the literature, theory and models are often referred to as promising practices or approaches that have the potential to improve the mental well-being of individuals and communities.

Through my social work education, I learned about the concept of systems theory, and how it can be applied to the individual, family, and larger systems. The following section will provide a brief overview of systems theory, and how it can be applied to the concept of change in large organizations. Through my practicum experience, I had an opportunity to learn about a number of models of practice, and how they might be applied to improve the system. Examples of these models are also included in the following sub-sections. Application of any of the models listed here would require and result in a philosophical shift from the current state.

It was clear from what I learned that no one theory or model can provide a road map for system transformation; yet together, these theories and models have the potential guide leaders in the quest to improve outcomes. For the most part, these models have not yet been fully implemented within the system; however, they are being explored as the theoretical underpinning of change. These models seem simplified in their description, but I observed them to be much more complicated as the leadership team attempted to
sort out how these models of practice and theory will impact day to day business in the field of mental health and addictions.

4.1 Systems Theory

The overarching practice framework that I most readily identify with in relation to my practicum experience is systems theory. When looking at transformational change within an organization, a systems theory or systems approach appears to be most relevant to understanding and effecting change. Systems theory reminds us that we must look at the experience of individuals and organizations within the context of their environment (community, family, politics, economy, etc.). Vickery (1974) suggests that a systems approach “can help social workers to organize and integrate a multitude of perspectives and methodological approaches that may be used in attempts to achieve change of various kinds” (p. 390). Systems theory also attempts to explain the resistance to change that is often faced in large complex systems. Meenaghan, Gibbons and McNutt (2005) state that “systems theory contends that individuals, institutions, communities, and other living organisms dread disequilibrium” (p. 98). They go on to suggest that “systems in disequilibrium will scramble to return to a previous state even when it is not in their best interest” and that “any change causes defensiveness or restraint” (Meenaghan et al., 2005, p. 98).

This is an important concept to be aware of and manage as the system attempts to implement change. Systems theory is a macro approach to the transformational change I observed within the Mental Health and Addiction Services portfolio. The following subsections will provide examples of models of practice that have the potential for
change within the system. These models must be implemented through a systems theory lens, in order to understand why the organization may not embrace change readily.

4.2 Recovery Model

Recovery is understood as a process in which people living with mental health problems and illnesses are empowered and supported to be actively engaged in their own journey of well-being. The recovery process builds on individual, family, cultural and community strengths and enables people to enjoy a meaningful life in their community while striving to achieve their full potential (Mental Health Commission of Canada, 2009, p.122).

Until recently, the term Recovery was used mainly in the field of addiction. In the field of addiction, Recovery is understood as a life long process that is more than just the absence of substance use. Recovery is about creating a new life that makes it easier not to use alcohol or drugs. The idea of Recovery is a major philosophical shift for the way mental health systems have thought about mental illness. Mental health services have traditionally used an institutional or medical model; which suggests that people with mental illness should be cared for to ensure their illness is managed. Recovery can be understood as an attempt to restore hope and meaning in life, and positively identify with personal responsibility and control. The model suggests that hope and restoration of a meaningful life is possible, despite serious mental illness. The philosophy of Recovery “refers to the lived or real life experience of people as they accept and overcome the challenge of disability” (Deegan, 1998, p. 11). Recovery does not necessarily mean cure as one would use the term in relation to a physical illness. What recovery does
acknowledge is that a cure is ‘possible’ for many people facing mental health problems and illness.

Another way to understand the concept of Recovery is to compare the two notions of Clinical Recovery versus Personal Recovery. Clinical Recovery is a concept that is readily identified with by those working as mental health professionals in the system. Clinical Recovery involves “getting rid of symptoms, restoring social functioning, and in other ways getting back to normal” (Slade, 2009, p. 2). Personal Recovery is different in that it has emerged from the expertise of people with lived experience of mental illness. Personal Recovery is defined as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/ or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Slade, 2009, p. 2). Slade (2009) argues that most mental health service systems would be prepared to meet the goals of clinical recovery, but need to make changes in order to meet the goals of personal recovery. This sentiment would be supported within the RQHR’s system.

Fostering Recovery for people living with mental health and addiction problems is central to the approach being taken in the Regina and Area Well-Being Strategy (2011) and the strategic planning process of the Mental Health and Addiction Services leadership team – both as a philosophy and practical approach to working with people in distress. The community and the leadership team are committed to aligning services with the key components of the Recovery Model. The Mental Health Commission of Canada (2009) suggests that there are four key components of recovery: find, maintain and repair
hope; re-establish a positive identity; build a meaningful life; and take responsibility and control.

In a transformed system that adopts a recovery model:

- individuals are offered meaningful choice regarding treatment;
- services offered are recovery orientated;
- services are geared towards sustaining people in their recovery by maintaining self-determination and dignity;
- people living with mental health problems and their families are actively involved in the planning, design, delivery and evaluation of services; and
- programs are available in the community in which the individual lives; and services are organized and operated by individuals living with mental health problems.

(Mental Health Commission of Canada, 2009).

4.3 Client Responsive Approach to Service Delivery

Being person centered means that the measure of success will be the actual impact of the treatments, services and supports on the health and well-being of the people themselves (Mental Health Commission of Canada, 2009, p. 15)

Both the Mental Well-Being Strategy for Regina and Area (2011) and the Mental Health and Addiction Services portfolio in the RQHR are working towards defining what a client responsive system means for the clients and families that they serve. The goal of such exploration is to improve the quality of service delivered to people with mental health and addiction problems. One of the tasks during my practicum placement was to
do a literature review and attempt to define client responsive service. I wrote a summary definition of client responsive services and shared it with the leadership team as well as the Steering Committee of the Well-Being Strategy. The document was given full endorsement and was shared in a formal presentation to all of the managers in the Mental Health and Addiction Services Portfolio. The following is the definition of client responsive services that I compiled.

Services are primarily organized and delivered around client needs and interests; and the role of the service provider is to meet the needs of clients and foster empowerment and choice to clients and their families as they move towards recovery. This approach to service delivery supports client self-sufficiency, dignity and respect, through a process of listening to clients and fostering meaningful participation in planning and decision making. Services are provided in a context of collaborative relationships with clients, caregivers, and other service providers in the community. It also means that clients have access to information in order to effectively participate in self-management and decision making. A client centered service is comprehensive and meets people’s needs across the lifespan. Services are coordinated and provided in a timely and convenient manner. (Slade, 2009; Saskatchewan Union of Nurses, 2010; Mental Health Commission of Canada, 2009)

Within this task, I also provided examples of what a client responsive service might look like for clients. Based on what I had learned, I summarized that providing client responsive services mean that the client can expect to:
• Be heard and have their needs and interests respected,
• Be treated as an individual, and be offered choice regarding treatment,
• Have access to information to assist in decision making regarding their well-being and self management,
• Access services in ways/ times that are convenient to them,
• Obtain services that are prompt, dependable and accurate,
• Know who to call if they have suggestions or concerns with the service,
• Transition smoothly through a coordinated system,
• Experience an equal partnership with service providers,
• Receive services that are evidence informed and accountable, and
• Participate in continued quality improvement through contributing suggestions, concerns and expectations.

It became clear through the literature that providing a client responsive service was more than just providing a definition and recommending specific actions. Most important to this approach is the adoption of principles or concepts that clinicians, leaders and policy makers must measure all decisions and actions against. The Saskatchewan Union of Nurses (2010) spent time considering the concept of client centered services as well. They suggest that the core concepts of client centered [responsive] care include:

• Respect and dignity: listen to and honor client and family perspective and choices. Client and family knowledge, values, beliefs and culture are incorporated into care.
• Information sharing: Service providers communicate and share complete and unbiased information with clients and families in ways
that are affirming and useful. Clients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.

- Participation: clients and families are encouraged and supported in participating in care and decision making at the level they choose.

- Collaboration: clients and families are also included on an organization wide basis. Policy, program development, implementation and evaluation; facility design, professional education as well as in the delivery of care.

(Saskatchewan Union of Nurses, 2010)

A common and overarching principle of patient focused or client-responsive service delivery needs to be commonly accepted and promoted. In the literature, this approach suggests that services are organized and delivered around client need; and ensures that clients receive the right care at the right place at the right time. It also means offering clients the opportunity to participate in, make choice, and influence services provided to them at the point of access. Postl (2006) suggested that the patient and the patients’ needs should be the focus of decisions regarding system change.

The adoption of these concepts and behaviours would be considered a paradigm shift for the organization. Staff and management acknowledge that on an individual level, they are able to identify the work they do individually with clients within this definition. Less apparent was how the system is reflected in this description. Many of the managers agreed that working in this way does not come naturally to the mental health and addiction system and it was agreed that the system
had a lot of work to do before they can truly say that they are offering client
responsive services across the service. I observed that the system will have greatest
difficulty in the area of involving the client in decision-making and service delivery.
There is much to be learned from our community partners, who do a much better job
of this than the formal system.

There are a number of action items being considered in an attempt to begin to
align with this approach. These include seeking to increase access to services,
ensuring system responsiveness to unique needs (e.g. gender, culture, Aboriginal),
ensuring urban and rural equity, and better coordination of services for families.

4.4 Stepped Care Model of Service Delivery

The stepped care model of service delivery was a relatively new concept for me
when I began working in my practicum placement. As I learned more about the model, I
realized that it was more than just a way to deliver services, and that it was actually a
model that supports prevention, recovery and client responsive approaches. It also
provides a framework for creating a continuum of services to a mental health and
addiction population.

The application of a stepped care model to a system means having a range of
different services or ‘steps’ depending on what strengths people have and how much
treatment people need– more intensive treatment services are reserved for those who do
not benefit from less intrusive first line treatments. People may move in and out of steps
to support their goal of recovery. It also means delivering services that increase strengths
and may prevent people from needing treatment at all. Components of this approach
include treatment matching service intensity to need, availability and accessibility of
services, a coordinated continuum of care, flexibility, collaboration, and measures used to determine level of care. Bower and Gilbody (2005) suggest that adoption of this approach ensures that the recommended treatment is the least restrictive (while still providing gains) and that the outcomes are monitored systematically to identify ongoing treatment needs (Bower & Gilbody, 2005). While many mental health and addiction programs are using stepped care as an organizational structure to deliver services, it remains unclear how many steps are optimal. The model discussed in this paper will focus on five different levels of intensity. The following is a list of examples of stepped care in a mental health and addiction services system:

- Step 1: Prevention, health promotion, community supports and self-help
- Step 2: Screening and brief intervention
- Step 3: Short-term clinical intervention and support
- Step 4: Intensive, longer-term treatment, rehabilitation and support
- Step 5: Specialized treatment, rehabilitation and associated supports

(Fraser, 2009, p. 5)

The adoption of this model has implications for the way that clients are assessed and triaged for services. It is also important to note that, within the RQHR’s Mental Health and Addictions Services, the majority of resources are dedicated to Step 4 and Step 5. There are a number of action items being considered by the community and the RQHR in an attempt to begin to align with this model of service delivery as well. These include identifying and solving gaps and overlaps in the system, creating a mechanism to ensure clients receive the appropriate services (based on intensity or need) and increased
efforts to improve awareness and education (stigma reduction, health promotion, illness prevention, early intervention and determinants of well-being). One of the identified benefits of stepped care is that clients will have options regarding treatment, based on a continuum of care, and outcomes will be monitored to determine level of care.

4.5 Social Determinants of Health/ Population Health Approach

It is widely accepted that health, including mental health, is determined by much more than biological or genetic endowment. Social, economic, environmental and cultural factors – such as income, place within a social hierarchy, level of education, access to adequate housing, experience of inequity – are major contributors to health outcomes. The impact of many of these factors is often only identifiable when outcomes are examined across large segments of the population and these factors are often best addressed at a societal, rather than individual level (Mental Health Commission of Canada, 2009, p. 123).

There is a growing recognition that the determinants of health need to be addressed in order to achieve overall well-being in our community. The Social Determinants of Health are defined by the World Health Organization (2011) and include the “circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics” (p. 1). It is clear that our overall well-being; which includes our mental well-being; is shaped by our life circumstances. It is also evident that our well-being can be increased or diminished by the quality of these circumstances. According to the World Health Organization (2004),
Community belonging and social support may play a bigger role in overall well-being than socio-economic determinants such as education and income.

A Population Health approach is one strategy to create the conditions that support the best possible well-being for everyone in our community. Population Health focuses on the root causes that determine well-being and uses health promotion and illness prevention strategies to create healthy communities. The World Health Organization (2004) suggests that effective promotion and prevention strategies have been found to reduce the onset of some mental illnesses (p. 14). Examples of population health promotion strategies include: creating supportive environments, assisting people in developing personal skills and resilience, and strengthening the community’s will and capacity to take action. By addressing the determinants of mental well-being, professionals can hope to ensure real and lasting success by promoting protective factors and resilience and, thereby, preventing the onset or severity of mental illnesses and addiction.

5. ETHICS

The leadership team within Mental Health and Addiction Services is made up of diverse professionals from different backgrounds, all bound by the Ethical Guidelines and Codes of Conduct of their respective professional associations. Approximately half of the staff and leadership within Mental Health and Addiction Services are Social Workers and, therefore, adhere to the Canadian Association of Social Work Code of Ethics (2005). Due to the fact that I was not involved in direct clinical practice, I did not observe any ethical dilemmas or concerns during my practicum placement. I did, however, reflect on
the impact of proposed system changes within the ethical responsibilities of social workers and managers under the Code of Ethics.

Ethical dilemmas for managers are often different than those faced by clinicians. Ethical dilemmas brought to the attention of management are often issues that require a system-based response. The CASW (2005) has defined responsibilities of managers and suggest that leadership positions are guided by additional ethical responsibilities. These include responsibilities towards: acquainting others with the ethical responsibilities of social workers, promoting effective team work and communication, participating in social action, advocating for client base, engaging in action to ensure full access to resources, advocating for changes in policy and legislation to promote social justice, and expanding choice and opportunity for all people. These additional responsibilities are applicable to the work of the Mental Well-Being Strategy (2011) and the work of the leadership team.

One of the underlying principles outlined in the CASW Code of Ethics (2005) states that “Social workers uphold each person’s right to self-determination, consistent with that person’s capacity and with the rights of others” (p. 4). Social workers have a responsibility to promote the self-determination and autonomy of clients. This principle should be one of the ethical guidelines against which all decisions are measured. This statement resounds with me as I reflect on my experience, as self-determination is so integral to the idea of Recovery and the stated values of the organization. Another principle that is important to Mental Health and Addiction Services is the principle that states: “Social Workers uphold the right of society to impose limitations on the self-determination of individuals, when such limitations protect individuals from self-harm
and from harming others” (CASW, 2005, p. 5). Mental health and addiction staff play an integral role in upholding this principle in our community, as they are often the service provider when people are un-well or are early in their recovery process.

The *Mental Health Services Act* (1986) is a Saskatchewan piece of legislation that also gives form to the ethical behaviour of those employed in Mental Health and Addiction Services. The Act ensures that all people can expect to be treated fairly and equally and ensures that any person may ask for and receive mental health services. It also highlights individual rights to accept or refuse services, and ensures that individuals provide consent before they can be examined or treated. The Act also provides legislation regarding times when an individual can receive care and treatment without their consent, and how they can protect their rights if this does occur (The Mental Health Services Act, 1986).

Other ethical considerations fall under the *Health Information Protection Act* (HIPA) (2003) that provides legislation regarding rights of individuals and their personal health information. The *Health Information Protection Act* (2003) applies to all forms of health information including paper and electronic health records. It ensures protection for individuals, but also identifies situations in which information can be shared when required. *The Mental Health Act* (1986) and the *Health Information Protection Act* (2003) are Saskatchewan Acts that protect the rights of individuals and provide guidelines/ criteria for working with individuals who experience a mental health and/or addiction disorders. These Acts can also provide barriers to those accessing or providing mental health/ addiction services. Examples of this include; the individual’s right to refuse treatment under the *Mental Health Act* (1986); and restrictions on the sharing of
information between service providers and family members under HIPA (2003). These legislations are intended to protect individuals, sometimes at the cost of that individual getting the services they need, being well, or providing support to those who have the best interests of the individual in mind.

6. RELATIONSHIPS

Relationships are the foundation for all social work actions. Relationships have the potential to foster change and result in positive outcomes for individuals, families, groups and communities. Troubled relationships often signify problems that require the attention of those involved. This portion of the paper will highlight the potential for relationships in transforming the system, as well as the pitfalls of leadership when not paying attention to relationships while implementing change. The Mental Health Commission of Canada (2009) suggests that transformation will require all stakeholders to work together. The following sub-sections will illustrated that specific relationships involved and will illustrated how these relationships will contribute to the success or failure of change within the system.

6.1 Clinician/Client Relationship

One of the main components of the proposed changes in the mental health and addiction system is the relationship between the client and the clinician. The potential for this relationship to improve overall well-being is the reason that most people enter this field of work in the first place. For this to happen, the relationships must be built on equal partnership, positive regard, respect, and dignity. Clients must be viewed as individuals with individual needs and goals. The role of the clinician is to meet these
needs through engagement, creating motivation, and building trust. This must be considered the most important relationship because if clinicians are doing this well, they will see an improvement in the overall well-being of the clients they serve.

My fear, for the process thus far, is that the RQHR and the community have not included the voices of those with lived experience. This will limit the success of the process if leaders in the RQHR do not include client and families in the development and delivery of programs and services. There must also be a process established in order to incorporate a feedback mechanism to ensure continuous quality improvement.

6.2 Clinician/Agency Relationship

To implement the mission of an agency, an organization develops policies, structures, and procedures that serve to control how people connected with the agency will behave (Sachs & Newdon, 1999, p. 96).

I believe that change can only occur when individuals in an agency (both leaders and staff) share common goals and purpose. For this to happen, it appears that clinicians must be able to envision how the proposed changes will benefit both the clients and the clinicians themselves. Leaders in the agency must work to ensure that the vision for change is a shared vision. This can be achieved through transparency, communication, and support for commonly agreed upon principles. Leadership must value the opinion of front line staff and ensure that change is an inclusive process. By supporting innovation and listening to new ideas, staff will feel like their needs and feelings are being heard.

Change often results in stress, anxiety, and fear. If these emotions are not addressed, workers will not feel supported or valued. Workers can take an identified
need for change personally, so motivations for change must be clearly understood by everyone.

6.3 Clinician/Clinician Relationship

The system is currently made up of a number of different professions including psychiatrists, psychologists, social workers, mental health therapists, psychiatric nurses, addiction counsellors, speech and language pathologists, occupational therapists, and paediatricians. First Nations Elders are also an integral part of the system, providing leadership and guidance to the development of cultural competency amongst the staff. Within each of the service sites (e.g., Child and Youth Services, Addiction Services), this multi-disciplinary setting provides an opportunity for cross training, sharing discipline-specific knowledge, and improved outcomes for clients. The relationships between clinicians have the potential to assist clients through a complex system, offering them a wide range of expertise and knowledge.

On the other hand, when a large system is not integrated, it can make it more difficult for clients to access services and receive the care that they require. The reality is that there is little integration between staff from different site locations. This is the case, despite the portfolio and leadership being completely integrated. There is mistrust and lack of understanding about what each other does and is competent to do. Of all the relationships that I am most concerned about, this one is the one that worries me the most in regards to the proposed transformation of the system.

6.4 Agency/Community Relationship

Because there are a lack of resources within the formal mental health and addiction system, the RQHR will need to rely on our partners within the community to
support our work with our clients and their families. Partnerships allow for shared services, shared resources, and opportunities to learn from each other. There are numerous examples of strong collaboration and networking, and there are multiple organizations and agencies that deliver quality services to the community.

As mentioned previously, there are many individuals who require mental health and addictions services that are not receiving them. To meet these needs in the community, there is a need to work together with other organizations and agencies to identify and problem solve around service delivery gaps. The *Mental Well-being Strategy for Regina and Area (2011)* is one example of creating relationships to address this situation.

**6.5 Client/ Community Relationship**

The community is ‘the’ support network for all of the clients served. If this relationship is not healthy, and there are not enough resources or they are inaccessible, we can predict that the outcomes for our clients will be negative. Clients often find the formal mental health and addiction services to be a complex and daunting system. The community often provides services that are located within their own community, are inclusive of people with lived experience, and are accepting of clients as they are. These can be valuable resources to a population that is often stigmatized and discriminated against.

Mental well-being is everyone’s business. It requires a coordinated effort from inside and outside the mental health and addictions sector to ensure mental well-being for the entire population. To ensure that clients with mental illness and addictions are not misunderstood, clients and their advocates require a stronger voice in our community.
7. STRATEGIES

The following strategies were identified in the literature as having positive impacts on improved service delivery in the field of mental health and addiction services. Some of these strategies have already begun to be implemented within the Mental Health and Addiction Services portfolio (LEAN), while others are presented here as suggestions for improving service delivery. This section will provide examples of quality improvement and change management strategies. It will also provide an overview of the importance of the development of guiding principles, re-organization/integration of services and knowledge exchange in transformational change.

7.1 Quality Improvement Strategies

In health care, quality improvement is directed toward increasing patients’ satisfaction and improving outcomes. Quality improvement focuses on all processes of healthcare. The method is most often applied to problems in service delivery, such as access problems. When applied directly to the clinical product, continuous quality improvement methods can further the considerably broader goal of medicine and of mental health care; to improve health (Keller, 1997, p. 821).

In the literature reviewed, improved access to services is often referenced in the context of quality improvement (Keller, 1997; Chovil, 2009; Williams, Latta & Conversano 2007; Bichel, Erfle, Wiebe, & Conly, 2009; and Smith, 2008). Quality improvement is a process of culture change, driven by data and a client centered philosophy. It is a long-term approach to creating improved quality within a system by working towards small changes. Chovil (2009) adds that “Continuous Quality
Improvement involves the use of assessment, feedback and application of information as a way to improve services (Plan-Do-Study-Act)” (Chovil, 2009, p. 22). Williams et al. (2007) suggest that recent calls for improvements have highlighted the importance of quality improvement and systems change for the benefit of customers. Innovation and adoption of modern management practices was also identified in the literature.

Innovation is defined as any new idea for change in the system (Rogers, Maher & Plsek, 2009).

Barnette and Clendenen (1996) suggest that implementing quality management involves: preparation; setting forth the vision, purpose, mission, and goals; planning; establishing blueprints for excellence; establishing strategic indicators and forming teams; training leaders; and conducting assessments. Chovil (2009) advises that staff involvement in quality improvement is integral and suggests that it is a way to honour the expertise, that each of them bring to the organization. She states that “staff need to own the quality improvement initiatives and embed them into everyday practice” (Chovil, 2009, p. 23). Keller (1997) found that collecting data on productivity appeared to increase productivity and access. They were able to increase customer satisfaction, manage productivity, and work standards which resulted in more effective and efficient care for the clients they serve. At one of the RQHR Mental Health and Addiction Services sites, direct client contact is being measured in an attempt to ensure that client care is the focus of the services provided.

Lean is the quality improvement model that has been adopted by the Saskatchewan Ministry of Health and the Regina Qu'Appelle Health Region. Lean is defined as “an improvement methodology based on customer-centric definition of value,
and providing that value in the most effective way possible, through a combination of the elimination of waste and a motivated and engaged work force” (Sayer & Williams, 2007, p. 339). In partnership with the Quality Improvement Team (RQHR), the leadership team identified areas within the service to apply quality improvement strategies. ‘Access to intake’ was one of the identified areas. The goals were to simplify the intake process by reducing steps for clients to access an intake worker; increase capacity of intake workers to match service to client need through triage/assessment of clients referred by general practitioners; eliminate waste (wait/tag phone calls); and automate the intake process where possible. Implementation of this process has begun, and clients can now access intake workers directly (on three telephone lines) and now intake staff input intake information into an electronic form so that other intake clinicians can access the data.

I had the opportunity to participate in this quality improvement process from the identification of problems to the implementation of solutions. Creating a clear vision of a client centered intake took a considerable amount of time and commitment from staff that are often already overwhelmed by their current workload. It has been acknowledged by the leadership team that this process requires the development of a team of individuals who will be responsible for assessment, feedback and application of information that improves service delivery. This process acknowledges change management principles, knowledge exchange and Lean methodology (Plan-Do-Study-Act). The leader’s role in this process is to support the system in making positive changes for client-responsive care and promote a vision of improved service delivery.

The Mental Health and Addiction Services Provincial Committee also participated in a Lean initiative; the result was the development of a provincial screening tool for
mental health and addictions to be utilized at the point of intake. The main objective for the development of this tool was to assist frontline staff in prioritizing services in a consistent, objective and measurable way. This tool is being piloted in Mental Health and Addiction Services and implementation began on February 7, 2011.

7.2 Development of Guiding Principles

Principles were another strategy commonly identified in the literature that can guide decision makers implementing system change and/or integration of systems. Principles are understood as collective standards which assist in decision making and policy development (Suter, et al., 2009). The Mental Health and Addiction Services leadership team believe that the adoption of a clear set of principles to guide the change process is required. These standards will assist in creating a client-centered approach to developing accessible, available and effective programs, treatments and service. They believe that these principles need to align with the vision, mission, and values of the Mental Health and Addiction Service portfolio and Regina Qu’Appelle Health Region. Principles must inform the way that services are provided, and create a change in the way staff think about the work they do.

Barnette and Clendenen (1996) presented a case study on quality improvement and highlighted principles that guided the process. These included: establishing a customer-centered focus; making data-based decisions, using teamwork and empowerment; being leadership driven; providing intensive training; and paying attention to the infrastructure. Axelrod (2002) also presented a compilation of system change principles. These included: widening the circle of involvement to create a critical mass of people who design and support necessary changes; connecting people to each other
and to different perspectives, information and ideas creation and action; creating communities for action to implement the change; and embracing democracy so issues of self-interest versus the common good and minority versus majority opinion are balanced to ensure support.

The *Mental Well-Being Strategy for Regina and Area* has developed a set of principles to guide the community process, and the RQHR Mental Health and Addictions Services leadership are principles. They believe in order to be successful in system transformation the following principles must be supported:

- **Collaboration** – Working together to ensure services to meet the needs of our community
- **Accessibility** – Everyone has access to effective mental health and addictions care as part of universal access to basic healthcare.
- **Evidence-Based** – Programs and services are informed by evidence-based practices from multiple sources including science, personal experience and knowledge in diverse cultural traditions.
- **Responsive and Appropriate** – Services and programs are responsive and appropriate to individual and community needs
- **Accountability** – Our community is accountable for providing effective and safe services and support

(Mental Wellness Steering Committee, 2011, p. 8)

Prior to the work of the strategy, the Mental Health and Addiction Services portfolio did not have an agreed upon set of guiding principles from which to base decisions. Rather,
decisions regarding service delivery were made in isolation and resulted in a fragmented service.

7.3 Change Management Strategies

Change management strategies are also recognized as necessary processes to the implementation of any large system change. Change management is the theory and application of organizational and leadership practices that foster and minimize barriers to change. Bichel, et al. (2009) identified the Conference Model® as a change vehicle for improving access to services. This approach includes: clearly defining a purpose; utilizing workshop events to identify issues and solutions; and creating an implementation plan (Bichel, et al., 2009, p. 62). Smith (2008) presented a workshop to British Columbia Mental Health & Addiction Services on a Change Management Model that moves through the following processes:

1. **Consent to change** (the point of entry into the change process always begins with a notion to bridge a gap between a current and a desired state practice);

2. **Understanding of the current context** (introducing and maintaining change requires an understanding of the current context including attitudes, culture, policies and procedures, infrastructure, resources, constraints, opportunities);

3. **Specifying outcomes** (leaders are encouraged to develop outcomes that are specific, measurable, attainable, relevant and time bound);

4. **Assess readiness for change** (this step is often overlooked and proper consideration must be given to the personal and emotional aspects of the
change process. Even when evidence for change is substantial, factors such as culture, resources, and resiliency can have far greater impact on readiness);

5. **Prepare for change** (Requires multiple strategies to address attitudes, behaviours, knowledge, infrastructure, leadership and resources. Moving forward with implementation without the necessary preparation will usually result in superficial or even failed outcomes);

6. **Implement change** (can be one of the easiest phases of the model if all steps have been accomplished – with strong leadership, readiness and preparation, change can be an invigorating and positive process);

7. **Support and maintain change** (a plan to support and maintain change is required).

(Smith, 2008)

The leadership team has acknowledged the need to pay close attention to the process involved in change. When looking at the above change management process it is evident that the Mental Health and Addictions Service portfolio are still in the early stages of the change process. It was my observation that the leadership team has begun to define a desired stated and has spent a considerable amount of time understanding the current context. They have not adopted a specific model of change management; however, many of the managers involved are highly skilled in project management. Reviewing change models and being involved in change activities has taught me the need to be patient when it comes to change, and pay close attention to process, rather than just outcomes. This
patience can be difficult when the need for change is so obvious and the evidence for improved outcomes is strong.

7.4 Re-organization/ Integration of Services

The literature reviewed supports the integration and coordination of services (e.g. centralized intake) as an effective way to improve access and service delivery. There are numerous identified benefits to organizing services in a centralized way (Gardner, 2010). Stiffman, et al. (2001) found that providers’ organizational factors are the major determinant of access and Laditka and Jenkins (2000) found that, when asked for recommendations, centralized delivery systems were identified as an effective strategy to enhance service delivery. They went on to say that there is a lack of formal coordination of service delivery, and viewed this lack as a weakness in the mental health system, which limited the system’s ability to adequately address the needs of individual clients (Laditka & Jenkins, 2000, p. 85). Feldman, Sadtler, Lipman and Schiff (1979) found that integrated service structures such as a centralized intake and referral systems facilitate client progress in both a community and hospital setting (Feldman et al. 1979, p. 337).

Other authors looked at organizational complexity related to accessibility. Shanley, Reid and Evans (2007) examined help-seeking pathways and how clients navigate the mental health service system as a way to inform improvements to accessibility and effectiveness of mental health. They found that clients did not seek services in regards to one problem, rather they sought services for multiple, co-morbid problems. They suggested that help-seeking models need to address the “iterative referral process” that clients experience. This experience includes a multiplicity of entry points and a complex array of services.
The literature also identified recommendations around integration of mental health and addiction services at the point of assessment. Anthony, Taylor and Raffo (2010) examined current practices for screening/ assessing substance use among youth and young adults in community mental health systems. They found that, despite high rates of co-occurring disorders in youth/ young people with mental health disorders, services continue to be provided in silos with minimal communication between systems providing services to the same people. They also found that fragmented service structure contributes to poor transition services and may hinder assessment and treatment of substance abuse. They suggested effective collaboration and information sharing with related service providers, capitalizing on relationships, and early assessment approach such as brief screens for mental health and addictions at multiple time points (Anthony, et al., 2010).

Bichel, et al. (2009) suggested that organizing the care continuum through a patient focused lens is a positive change strategy that supports integration and access. They highlighted that “small limitations in the referral process can be a major impediment to care, resulting in frustration, increased wait times, missed appointments and inefficiencies (Bichel et al., 2009, p. 62). They concluded that the creation of a central access and triage system and the development of reliable and valid prioritization tools resulted in improved access, integration and coordination of care. A system improvement of “one referral form, one-point-of –access, and a standardized process to ensure equal access for all, regardless of the locale within the province” was presented as the ultimate goal for improved service integration and patient access (Bichel, et al., 2009, p. 61).
Leon and Braisted (1985) suggested that the single-point entry process requires a team of specially trained personnel. Masland, Snowden, & Wallace (2007) also concluded that services provided by a specialized assessment team resulted in more in-depth and accurate assessments; increased standardization and administrative control over who accesses care and the number of persons served; and resulted in a better match between clients and treating clinicians (Masland, et al., 2007, p. 559).

Although there is general agreement that better coordination and integration of services can enhance service delivery, evidence that these practices improve client outcomes if fairly limited (Laditka & Jenkins, 2000). This is an important point to consider as the leadership teams makes decisions about what changes within the system will be a priority.

Integration and coordination of services is seen an effective way to improve access and service delivery. In Saskatchewan, integration of mental health and addiction services has occurred at the Provincial Director level in all Health Regions since 2004. The goal of integration is to improve access and care for persons affected by mental health and addiction issues. Despite ongoing integration efforts, barriers still remain between mental health and addiction programs. As part of my practicum experience, I was assigned to a Provincial Task Group that developed an Integrated Service Delivery Framework (Draft – 2010); prioritizing activities which will improve and support an integrated continuum across mental health and addiction services. The priorities include: advancements in screening and assessment, clearly defined entry and transition points and principles of client centeredness and accessibility. The system needs to ensure that clients can access the right service through a simple, coordinated, continuum of care.
The movement is based on the development of clear pathways within the system, transitions and collaboration. Movement through the system should appear seamless to the client.

Based on the literature review for centralized intake that I completed, a working committee is being struck to consider the implementation of a centralized intake system that would integrate both mental health and addictions services. There are mixed reactions to this idea and discussions are ongoing. I have continued to be included in this process since my practicum placement finished, and have enjoyed the process immensely.

7.5 Organizational Leadership and Commitment

Organizational leadership and commitment are critical for change management and quality improvement efforts to be successful. Barnette and Clendenen (1996) suggest that, in a quality improvement environment, leadership requires a presence: a hands on approach that includes communication and availability. They go on to say that trust is critical and leaders must be comfortable enough with their employees to feel that they can trust them (Barnette & Clendenen, 1996). Leaders need to promote the new vision and mission amongst their staff to help them take ownership of the process.

The National Health Service Institute for Innovation and Improvement (NHIS) (2010) suggest that large change projects require dedicated project management to provide a structured, yet flexible approach to implementing change. Senior leadership engagement and attitudes to sustaining change are factors that increase the chances of success (NHIS, 2010).
There are numerous challenges associated with leading quality improvement activities. Quality improvement requires time, patience, and a commitment to ongoing dialogue with the leaders, and within the teams themselves. Chovil (2010) suggests that one of the most difficult challenges is convincing staff that quality improvement is valuable enough to take time away from client care. She advises that staff must be able to draw meaningful conclusions from the change in order to get behind it. Bichel et al. (2009) reported that navigating change across multiple service providers, in diverse settings, across the continuum of care can be challenging work. Barnett and Clendenen (1996) suggest that, in all environments, old habits return unexpectedly and there is a natural resistance to change. I observed that there is often an environment of distrust and caution about the intentions of management with respect to new initiatives.

The changes being considered and discussed are not only supported by the Mental Health and Addiction Leadership team, but have also received the support and attention of the CEO of the Regina Qu'Appelle Health Region. Leadership has committed to the process by hiring a private consultant to ensure that enough attention is paid to process and ensuring that they continue to move forward towards their goals. I had the opportunity to be a part of promoting the new vision amongst the staff and witnessing difficult conversations regarding trust. These difficult conversations are being held at all levels of the organization.

7.6 Knowledge exchange

Knowledge exchange as a tool for change was also identified in the literature reviewed. Coleridge (2008) defines knowledge exchange as the translation and dissemination of evidence based information (or promising practice) and skills in a
manner that facilitates successful adoption and application by individuals, organizations and systems. Mental Health and Addiction Services promotes a culture that supports ongoing learning. There are numerous training opportunities for staff and there is a commitment to evidence based learning. In a process of system transformation, it is imperative that all stakeholders work together to accelerate the translation of new knowledge into policy and practice (Mental Health Commission of Canada, 2009).

Mental Health and Addictions Services are committed to providing quality, evidence based services to their clients. They demonstrate this through their commitment to ongoing research, training and supervision for those working in the system. I participated in this process during my practicum placement, spending much of my time reviewing evidence based literature, and sharing this information with frontline staff, managers and senior leadership.

8. SKILLS

As a result of the current literature on mental health and addiction systems, there is an expectation and need for change. The theory, practice models, values and strategies guiding these changes support a transformation of the current system. Just as there are specific skills required of clinicians to invoke change in clients, there are skills required of individuals to lead transformation in a large organization such as Mental Health and Addiction Services. It appears that the leadership team are prepared to take on the looming challenges associated with this type of change.

An independent consultant who was hired to assist in the process, suggests that “transformational leadership is about a clearly defined vision that inspires individuals by
appealing to their values and desire to serve more than their own personal needs” (V. Sluth, personal communication, December 2010). She went on to say that transformational leaders:

- Are intellectually stimulating; they engage the mind and encourage creativity;
- Are inspirational/ motivational and have a clear vision, passionate language, and share stories that inspire others;
- Demonstrate individualize consideration by engaging the hearts of others, offering recognition, and good communication; and
- Posses idealized influence by role modeling desired behaviours.

(V. Sluth, personal communication, December 2010)

LEADS in a Caring Environment (2011) suggests that in order “to increase the likelihood of success, there is a pressing need to actively identify and engage all pertinent key players in a system in the conceptualization and framing of the issues related to Systems Transformation, as well as in collaborative planning and implementation” (Leaders for Life, 2011). The leaders within the RQHR have organized a number of planning days and retreats with this goal in mind. LEADS in a Caring Environment (2011) suggest that there are four capabilities required of leaders in order to achieve systems transformation.

- Demonstrate systems critical thinking – leaders think analytically and conceptually, questioning and challenging the status quo, to identify issues, solve problems and design and implement effective processes across systems and stakeholders.
• Encourage and support innovation – leaders create a climate of continuous improvement and creativity aimed at systemic change

• Orient themselves strategically to the future – leaders scan the environment for ideas, best practices, and emerging trends that will shape the system

• Champion and Orchestrate change – leaders actively contribute to the change processes that improve health service delivery

(Leaders for Life, 2011)

The leadership team are paying considerable attention to the dynamics of their complex system by applying critical thinking skills to determine what changes will assist in the creation of improved services for those with mental health and addiction problems. The leadership team have a vision for the future and they have worked hard to share that vision with the staff they employ and the community around them. They are realistic that there are significant challenges to achieving this vision and are spending time anticipating what issues may pose challenges. They have spent time discussing readiness for change, capacity for change and tools that will assist in the change process. The RQHR are aware that system transformation cannot take place without stakeholder involvement and engagement in the process. The Mental Well-Being Strategy (2011) is one of the strategies used to ensure that those most affected by the change will have a say.

There are some general qualities of leadership that must also be addressed to ensure success of this change process. Leadership requires consistency (and consistent messaging) and a lot of energy and dedication. I have witnessed how miscommunication
or lack of information has set the process back considerably. A leader requires a vision that is shared by those around her/him. They require credibility with their staff, the community and client base that they serve. The same skills that are required for change in the therapeutic model are required in changing large organizations.

Leaders in the RQHR are also thinking about how they can work together with the community to create change. These skills require significant time, commitment and passion from each of the leaders within the system. During my practicum experience, I had the opportunity to attend numerous meetings, working groups, steering committees, community consultations, LEAN activities, and planning days with the overall goal of developing strategies to lead change in the Mental Health and Addiction system. One of the observations I made throughout these experiences was the lack of client involvement in any of the decision making or consultative processes. I think that it is important to include those who use the system, those who have recovered as a result of the system, and those who are still early in their recovery.

9. VISIONS

This section will explore my visions for future work as a social worker, for the social work profession and for social change as a result of my practicum experiences. My vision for myself as a social worker is to grow as a leader. After this experience I realize that there are people who, regardless of position, have the ability to mobilize and lead people into change. I admire the qualities of those people and aspire to be more like them. A visionary has the ability to influence, excite and empower others.
Through my experiences, I observed that having a vision and developing vision statements are really important for leadership. They are usually bold statements the guide a process, movement or action. Through my practicum experience, I had the opportunity to participate in the development of a vision statement for the Mental Health and Addiction Services portfolio. This part of my experience was very exciting as the leadership team set their sights high; sort of like goal setting for clients. For me, my vision for my future work in social work is to continue to develop my leadership skills and use these skills to make change in the mental health and addictions system. Through my experience, I had the opportunity to observe leadership. I witnessed how one person can influence a room by inspiring them believe in a vision. I have also witnessed how one person can deflate a room. I have observed leadership come from those who hold no positions of power and from those who hold significant power.

My vision for my future in social work is that I develop the virtues that make a good leader: listening to others, making decisions based on values, working to change minds, striving towards excellence in the field of mental health, ensuring clients remain the focus and leading staff to be a part of something bigger for the Regina Qu'Appelle Health Region.

For the social work profession, my vision includes social workers feeling empowered to take leadership roles in the field of mental health and addictions. Social workers are learned in the concepts necessary to work within a Recovery model. As social workers, we empower clients to make decisions that will help them reach their goals, we see the individual within the larger environment, and we believe in self-determination. As the mental health and addictions field moves away from the medical
model of diagnosis; symptom management and care to a recovery model, social workers have increased potential to be leaders in this area.

My vision for social change is that every person in our community has the opportunity for optimal well-being. It includes hope that discrimination towards those suffering from mental illness and addiction is eradicated and is replaced with understanding and compassion. My vision includes a society where mental health and addiction issues are placed high on the agenda for government, policy makers, business leaders, researchers, schools and communities. I envision people having access to a mental health and addiction system that is comprehensive, coordinated, acceptable to clients and families, and that offers choice of treatment. I envision a system that responds to the unique needs of clients, and offers the most up to date evidence-based care. It is a vision of a system that acknowledges that each of our clients comes with knowledge, culture, families and ideas that have the ability to positively impact their well-being. Finally, my vision includes a mental health and addiction workforce that listens, that supports, that includes, and that motivates those suffering to work towards their personal recovery and well-being.

The Mental Health and Addiction Services vision is set and I believe that, as a result of the Mental Health Commission of Canada and leaders in the field of mental health and addictions, we have an opportunity to make a real difference in the lives of many.
10. CONCLUSION

I thoroughly enjoyed my practicum experience and appreciated the opportunities provided to me. The opportunity to participate in the leadership of a large organization such as this was a new and exciting experience for me. Mental Health and Addiction Services have engaged in a change process that is ambitious and honourable. I had the opportunity to observe first hand how change is managed in a large organization, and the attention to process that is required. The research and writing involved in the literature review and the strategic planning process further developed my writing skills and understanding of how the literature informs change. Lorri Carlson and her leadership team invited me into their strategic planning process, and allowed me to provide input as a valued member of the team. I have learned to be patient, involve others in the change process, and to listen to staff and communicate so that all stakeholders feel informed and included. Through observation, participation and research I believe I have gained a beginning foundation for my career in administration and my skills as a leader.

Through my involvement in the Mental Well-Being Strategy for Regina and Area, I have been encouraged to create new partnerships and engage in community dialogue. This experience provided a starting point for my involvement in system change in the Mental Health and Addiction Services system. It is my hope that I will be given the opportunity to further contribute to the development of an accessible, client-centered service guided by commonly agreed upon principles of exemplary service delivery.
11. REFERENCES


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