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How Mental Health Care Workers Meet Client Needs for Care in Organizational Contexts

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by

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Abstract

Modern community-based mental health care is delivered by an assemblage of services that attempts to meet the diverse needs of the population. Frontline mental health staff deliver these services directly to clients in ways that reflect their personal and professional orientations to treatment. However, the delivery of mental health services by these workers cannot be understood without taking into account the organizational contexts in which they practice. Twelve participants who work in the mental health field for a variety of organizations were recruited for semi-structured interviews. Their responses were analyzed to uncover the experiences and attitudes that underpin the relationships that they develop with clients, the interactions between organizations and providers, and the processes that affect all of these stakeholders. These relationships influence client experiences as providers assist them in their journey to connect with services that aim to be useful to their mental health needs. As services are delivered, various performance measures are collected, analyzed, and utilized to improve those services at the client-facing level and for organization-wide reporting. Ultimately, resource constraints prompt organizations to make allocative decisions when implementing their programs, and providers work within those constraints to provide client care. This is not a straightforward process, as practitioners navigate the tensions between what they perceive to be ideal care and what is possible, while simultaneously using discretion on an individualized basis, working within organizational policies, and attempting to optimize the use of resources toward the goal of offering optimal care.

Preface

This thesis is original, unpublished, independent work by the author, D. D. Stefulic. The reported interview data were covered by Ethics Certificate number REB18-1723, issued by the University of Calgary Conjoint Faculties Research Ethics Board for the project “Aligning Patient Needs with Institutional Resources in Mental Health Care: A Qualitative Study” on December 5, 2018.

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Dedication

Dedicated to Suzanne Kanuka

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Chapter 1: Introduction

Mental health care in Calgary can be characterized as an assemblage of services that offers resources to diverse clientele in a variety of ways. Mental illness often accompanies other major challenges such as substance use, homelessness, and poor physical health. Some organizations serve specific clientele for a narrow range of issues, while others are more inclusive and offer a wide range of services for a more holistic approach. Potential clients can connect with mental health care services from different points, and sometimes the first organization can fully meet their needs. In other cases, the first organization may not be able to meet those needs fully or at all. In those cases, staff may refer these clients to other organizations within the assemblage of services. It is common for a client to move through a variety of settings at different times, depending on where they are at in their mental health journey.

The central argument of this paper is that the experience and quality of mental health services cannot be understood without examining how the work of service providers is shaped by the organizations in which these individuals practice, as well as how these providers in a geographical area work interdependently through their organizations, despite the heterogeneous nature of the mental health services landscape. The interactions between providers and their organizations as well as the interactions between organizations greatly influence the type of care that is offered to clients and the available treatment pathways. Ultimately, it is not sufficient to consider how practitioners interact with clients on the basis of their training and treatment orientations. These factors are still important, but their practice within the organizational context will influence how that work is actually performed.

The content and focus of this thesis are inspired in part by Lipsky's (1980) book, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. In this book, the work of

service providers such as teachers, police officers, and welfare workers is examined within the bureaucracies in which they work, and how that translates to interactions with clients. Although the book does not focus on mental health practitioners and their organizations in particular, there are many parallels in the themes that arise in the book and in this thesis. As a result, some of the sections in this research draw inspiration from Lipsky's work by focusing on issues such as discretion, client-provider relationships, rationing, and performance measures. Some of Lipsky's arguments are introduced in the literature review, and these ideas provide lenses through which the findings of this study can be viewed.

The present study is based on twelve interviews with mental health practitioners who work for a variety of organizations. Chapter five will examine the importance of organizations in providers' perspectives of their work and clients by drawing on these interviews. This will involve discussing the relationships between providers and clients. These relationships are crucial to the treatment process, and this analysis will explore influences of factors such as treatment philosophies, organizational policies, resource constraints, and the challenges that are faced by clients who use substances when they attempt to access services. In the course of treating clients, organizations tend to track various performance metrics, both at the client level and the organizational level. These measures are important to consider because they affect decisions about how services will be delivered. Finally, this chapter will examine how organizations shape the work of providers as good or acceptable through the constructed perspectives of those providers.

The various organizations for which people interviewed work aim to improve the lives of their clients through a multitude of approaches, and chapter six will further utilize the interview data to examine the work of providers as they provide frontline services by tracing the client

journey from assessment to the treatment and referral processes. It will begin by exploring some of the diverse ways in which services are delivered at the client-facing level. In the assemblage of services, referral is a practice used extensively by most organizations, and the relationships between those organizations help to shape how referrals are conducted. Since clients often use a variety of resources at different times in their treatment journey, it becomes important to consider formal and informal case management practices that occur both within and between organizations; this is a way of helping clients effectively navigate the assemblage of services depending on their abilities to manage their own connections to resources. The final section of the chapter will address the challenges that organizations and practitioners face due to limited operational resources. Essentially, the sixth chapter is somewhat more descriptive in nature than the fifth, and its purpose is to provide more applied examples of client care within the organizational environment.

Chapter 2: Background

Mental health services are delivered by a variety of providers and organizations. In many cases, providers work for organizations to serve clients, and the scope and structure of that service delivery will depend significantly on organizational directives. In some cases, practitioners will work independently in a private practice setting. Once an individual makes contact with an organization and/or provider, there is normally some sort of assessment process that occurs before the commencement of treatment. This chapter will provide a brief background discussion of organizations and providers (including their typical occupations), assessment tools, and information on substance use. The latter is included because this is a significant issue that many people struggle with when they make contact with mental health care services.

Mental Health Organizations and Practitioners

Within the city of Calgary, there is an assemblage of mental health resources comprised of numerous organizations and individual practitioners. For the purpose of this discussion, these resources will be organized into the general categories of Alberta Health Services (AHS), other organizations that provide services to those with mental health needs (e.g., non-profit organizations and outreach programs for the homeless population), and individual practitioners not funded by the health care system. Health care practitioners such as family doctors and psychiatrists are typically funded by the health care system (Government of Alberta, 2019). Other practitioners not funded by the system include psychologists or counsellors who receive payment from out-of-pocket fees or private insurance plans.

At a provincial level, AHS offers patients a variety of resources, including physicians, hospital emergency departments (EDs), urgent care centres, and telephone helplines (Alberta Health Services, 2018a). Some of these are direct access resources because they are available for

individuals to make contact and request assistance themselves. As a result, these resources are advertised in publicly available places (e.g., the AHS website). The services offered by AHS differ in terms of access and the types of needs that can be met. For instance, those who require urgent care (e.g., in cases of suicidal ideation) are advised to call 911 or to visit an ED/urgent care centre (Alberta Health Services, 2018b). For less urgent cases, AHS provides phone numbers and lists of services that can be contacted for treatment and referral (Alberta Health Services, 2020). Once an individual makes contact with AHS resources, there is the possibility of being referred to services that are not directly accessible, such as therapy programs, psychiatrist appointments, or inpatient hospital treatment.

There are a variety of private organizations and independent practitioners in Calgary that provide services to diverse clientele. Some of the organizations are multi-service in nature, such as homeless shelters. In other words, they are not solely oriented toward addressing clients with mental health issues, but they may offer programs and staff to support clients with those concerns. The independent practitioners, such as clinical psychologists, often maintain their own offices and advertise their services on their websites. Patients who seek care from these practitioners may encounter financial barriers since these services are usually not paid for by the provincial health care plan. For instance, as of January 1, 2018, the Psychologists' Association of Alberta (2018) recommends a fee of $200 for a 50-minute session with a psychologist. This is a significant expense, particularly if many sessions are required. Aside from out-of-pocket payments, some individuals may be able to use coverage provided by a private insurance plan, such as supplemental insurance provided by an employer (Canadian Mental Health Association, 2014).

Within organizations and in private practice, there are numerous types of individual mental health practitioners possessing different types of qualifications; each of these occupations are associated with varying levels of education and professional approaches. The following are some of the professions that tend to be involved in mental health care:

- Psychiatrists: medical doctors who provide diagnoses and treatment for mental illnesses (Canadian Psychiatric Association, 2020). Psychiatrists can prescribe medication, and their services are covered by the health care system (Davis, 2006).
- Psychologists: mental health care providers who usually provide assessment, diagnostic, and treatment services (Chodos, 2017). Psychologists receive training at the graduate level in psychology and usually specialize in particular areas, such as child psychology (Canadian Psychological Association, 2020).
- Social workers: these providers focus on the wellbeing of individuals and groups, with consideration for both personal and social problems (Canadian Association of Social Workers, 2020). They provide various services such as therapy, counselling, and connecting clients with other resources (Chodos, 2017). Training usually consists of a bachelor or master's degree in social work (Canadian Association of Social Workers, 2020).
- Nurses: these providers frequently work in clinical settings. Nurses utilize their knowledge of the medical field in their work and may be involved in monitoring the use of medications (Davis, 2006). There are different types of providers in the nursing profession, such as registered nurses, registered psychiatric nurses, and licensed practical nurses, with each type having its own educational requirements to attain either a diploma or bachelor's degree (Canadian Nurses Association, 2020a).

- Occupational Therapists: these providers work to rehabilitate individuals with mental and physical disabilities (Davis, 2006). Occupational therapists require a master's degree in occupational therapy (Canadian Association of Occupational Therapists, 2020).

Mental Health Assessment Tools

During the process of assessing, diagnosing, and treating individuals with mental health concerns, practitioners often make use of one or more assessment tools, which are generally categorized as diagnostic or dimensional in nature. One of the most comprehensive resources for the diagnosis of a wide variety of mental disorders is the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013). The DSM-5 is used by qualified practitioners (e.g., psychologists and psychiatrists) to assess and give diagnoses to individuals presenting with mental disorders. There are also other tools, such as screening questionnaires and rating scales that track the progress of treatment.

There are a variety of tools that allow clinicians to use a small set of standardized questions to ascertain the possible presence and severity of a disorder. One example is the Patient Health Questionnaire consisting of nine questions (PHQ-9) which focuses on depressive symptoms and was developed with DSM criteria in mind (Kroenke & Spitzer, 2002). Another tool is the General Anxiety Disorder scale with seven items (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006). In addition to the purpose of assessment, there are also tools that track the progress of treatment, such as the Outcome Rating Scale (ORS). This is a brief questionnaire that asks clients to indicate their level of well-being on four scales that measure well-being in an overall sense, in addition to the dimensions of individual well-being, interpersonal well-being, and social well-being (Miller, Duncan, Brown, Sparks, & Claud, 2003). These scales are a set of four lines, each ten centimeters long, which represent a continuum for each dimension. Clients

mark the place on each line that corresponds with how they perceive a particular item within the range of low to high. The practitioner then measures the position of the mark on each line and totals the score, with the highest possible being 40 (Low et al., 2012). This allows for the tracking of progress over time.

Psychological assessments can be broadly categorized into diagnostic (also referred to as categorical) and dimensional instruments (Swtizer, Dew, & Bromet, 2010). Diagnostic instruments, such as the DSM-5, guide practitioners in diagnosing mental illnesses (American Psychiatric Association, 2020). In other words, the criteria for a particular mental disorder are met or they are not (Switzer, Dew, & Bromet, 2010). By contrast, dimensional instruments represent positions on continuums that indicate the severity of symptoms. Practitioners who promote the diagnostic approach to assessment argue that mental disorders indicate a lack of normal functioning, and that diagnoses are necessary for the provision of services (Switzer et al., 2010). Kessler (2010) notes that decisions to treat clients are usually categorical in nature, but that the evidence for the basis of treatment decisions is usually based on dimensional factors (e.g., assessing severity). Compared to diagnostic instruments, dimensional instruments tend to focus on a narrow range of symptoms and often result in a score (e.g., adding up scores from individual items in the assessment). Switzer et al. (2010) argue that assessment instruments are not objective – societal beliefs surrounding the etiologies of mental disorders along with their solutions will be reflected in the assessment tools. Mirowsky and Ross (2010) contend that diagnoses are not required to offer assistance to those who need it, and that labels can be detrimental if other relevant traits of the client are ignored. Ultimately, Kessler (2010) argues that categorical and dimensional approaches should be used in tandem, as opposed to the exclusive use of one or the other.

Substance Use in the Mental Health Landscape

When considering the diagnosis, treatment, and case management of individuals with mental health issues, it is crucial to acknowledge the significant levels of comorbidity with substance use. Alberta is in the midst of an opioid crisis (Government of Alberta, 2017). In 2017, there were 733 deaths in the province that were attributed to accidental opioid overdose (Government of Alberta, 2018). This figure does not include the deaths linked to other substances, such as alcohol and non-opiate drugs. There are various services available for substance users, including supervised consumption sites, co-occurring disorders programs, and other treatment programs.

For individuals who are substance users, one of the services that AHS offers is supervised consumption sites. According to Alberta Health Services (2019a), these services "provide a place where people can use drugs in a monitored, hygienic environment to reduce harm from substance use while offering additional services such as counselling, social work, and opioid-dependency treatment." The Safeworks Supervised Consumption Services (SCS) in Calgary was first opened in the fall of 2017, and as of July 31, 2019, there were 93,732 visits (Alberta Health Services, 2019b). Although many clients of the facility use substances on site, they are also provided with supplies for use offsite (e.g., clean supplies for injections). Some clients are referred to other services such as social work, detox, and housing. There are also numerous inpatient and outpatient programs that provide treatment for individuals with mental health concerns (InformAlberta, 2020). These resources exist both within AHS and in the private sector.

Chapter 3: Literature Review

The organizations that provide mental health services are staffed by a diverse mix of practitioners. These practitioners are the frontline workers who directly interact with clients and deliver services on behalf of their organizations. It is important to conceptualize how their practice is shaped within the organizational context and in interactions with clients. Fundamentally, treatment ideologies along with ways of influencing client experiences as they interact with services are crucial factors for client-provider relationships. At the administrative level, organizations influence the services that can be offered, as well as the ways in which clients will be helped by both the individual practitioners and the organization as a whole. As services are delivered, performance is measured in various ways, and challenges arise when attempting to generate these measurements accurately and usefully. This section will provide an overview of these issues, in addition to addressing the coordination and delivery of mental health care in the context of contemporary deinstitutionalized community settings. Finally, co-occurring disorders are of concern to many individuals who use these services, and it is important to acknowledge the needs of this population.

The Practice of Mental Health Care Workers

Mental health care workers hold a variety of ideologies around their practice, such as how they view the treatment process, and these orientations are also reproduced and reinforced at the organizational level. These ways of conceptualizing practice manifest in the day-to-day work of practitioners, and this section examines some of the important elements of the client-practitioner relationship. These include how interactions are controlled by the practitioner, the role of discretion, and working together toward mutually agreeable goals.

Fundamentally, it is valuable to acknowledge the diversity and significance of the treatment ideologies that are held by individual mental health practitioners and the organizations in which they work. Scheid (2004) defines a treatment ideology as "the complex set of beliefs health care providers hold about mental health, illness, and treatment" (p. 42). She explains that beliefs encompass the causes of mental illness, client roles, and the legitimacy of specific treatments. Treatment ideologies are collective, rather than individual in this context (Scheid, 2004). Further, these ideologies shape the practice of providers and influence organizational structures. These practices and their supporting organizations can become somewhat insular; Linden (2015) argues that each profession in the health care field can be seen as a silo due to differences in training and licensing. At a broader level, the organizations themselves can modify or reinforce the beliefs of providers (Scheid, 2004). Organizational ideologies can also be shaped by societal expectations (e.g., the preference for community treatment as opposed to institutionalization) and professional norms. Regarding the latter point, mental health services employ workers from multiple fields, so there can be variable emphases on biomedical, rehabilitative, and psychotherapeutic interventions, for example (Scheid, 2004).

There are orientations to client care that emphasize the autonomy of individuals, with approaches that focus on support. Two of these orientations are recovery and harm reduction. According to the Mental Health Commission of Canada (2009), recovery is "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" (p. 122). When individuals who use substances connect with services, practitioners sometimes approach those clients through a harm

reduction lens. This involves helping clients to use substances in ways that reduce the risk of harm, without the expectation that they stop using substances (Centre for Addiction and Mental Health, 2018). Recovery and harm reduction have different objectives, but they are both approaches that aim to support clients while respecting their autonomy.

Although practitioners can interact with clients through recovery and harm-reduction approaches, which emphasize the value of autonomy, it is also important to acknowledge mechanisms of control that can occur during interactions. According to Lipsky (1980), workers can exert control over clients in four basic ways. First, they distribute benefits and impose sanctions. Second, they structure the context of interactions on the bases of time, place, frequency, circumstances, and available resources; this optimizes organizational resources and structures client behaviour. Third, clients are taught how to be clients. Certain behaviours are expected (such as being deferential in some circumstances), and these expectations are sometimes enforced coercively. Fourth, clients are often informed about the limits of what can be done, which is a reflection of the organization's priorities. Workers sometimes selectively tell their clients how to work within the system in a favourable manner, and this is a way of exercising discretion while maintaining the system as it is.

To build on Lipsky's (1980) explanation of the ways in which workers have control over clients, it is useful to elaborate on the flexibility that workers exercise when interacting with clients in mental health settings. For example, Davis (2006) explains that eclectic treatment approaches are common among practitioners. He argues that this may be attributed to time limitations and a lack of detailed knowledge of any specific approach. As for how to best approach clients, Davis (2006) asserts that there is a need for practitioners to truly listen to clients and to understand their needs. A component of this dialogue is the idea of practitioner-

client negotiation in the treatment process. Reis and Brown (1999) discuss how treating the client as a partner in the process and taking different perspectives into account are ways in which the provider can reduce the likelihood that clients will drop out of treatment prematurely (as defined by the practitioner). Lasalvia, Bonetto, Tansella, Stefani, and Ruggeri (2008) found that agreement between practitioners and clients on the care that is needed substantially contributes to more optimal treatment, based on outcomes rated by both parties.

The role of provider flexibility when working with clients raises the question of how this element of practice exists within bureaucratic organizations. Fundamentally, Lipsky (1980) situates workers within these organizations and demonstrates how they navigate the tensions between working conditions – issues such as policies, management practices, and resource constraints – and how they would ideally like to serve clients in an individualized manner. Weber (1922) emphasizes calculable rules as essential for modern bureaucracies. Further, he states that "Bureaucracy develops the more perfectly, the more it is "dehumanized," the more completely it succeeds in eliminating from official business…all purely personal, irrational, and emotional elements which escape calculation" (p. 334). This observation is a crucial component of Lipsky's (1980) analysis because the challenges that he portrays for workers (e.g., frustrations surrounding the difficulty in providing what workers feel is optimal individualized service) relate to the dehumanized nature of bureaucracies and the push toward calculable rules. Essentially, Lipsky (1980) demonstrates how the human elements of workers' practices conflict, coexist, and are negotiated within bureaucratically organized workplaces. These human elements are tied to the use of discretion when working with individual clients, along with the ways in which practices are reflected in performance measures.

The points raised above illustrate some of the complexities that exist in the relationships between clients, providers, and organizations as they interact with one another. There are a multitude of factors that influence how those interactions will work and how each stakeholder brings particular viewpoints and goals to the relationships. In addition, provider discretion is an important part of the client-provider relationship because it allows flexibility and individually tailored services that may otherwise not be possible if organizational rules are followed rigidly and without concern for the circumstances of each client. The concept of discretion itself is tied to the organizational context because providers are making case-by-case decisions within – and perhaps sometimes outside – the circumscribed limits of what an organization allows. As these interactions unfold, there are various ways in which the performance of practitioners and organizations are assessed and utilized for changes to services, but there are complexities around the process of generating useful metrics, measuring performance, and reporting results. This process is also subject to influences from the interests of various stakeholders. However, the voices of these stakeholders are not treated equally. Lipsky (1980) argues that client demands tend to have relatively little influence on the practice of workers; the expectations of the public, the workers' peers, and professional standards tend to have more influence.

Lipsky (1980) discusses the challenges that arise when attempting to measure the performance of street-level bureaucracies. Stated simply, it is difficult to measure performance because goals can be ambiguous (e.g., differing opinions about what the organizational objectives should be) and he states that the discretion of workers as they interact with clients presents complications when attempting to create these measures. When particular performance measures are tracked, it is an indication of what the management prioritizes, and this may motivate workers to focus on performing well in those areas at the expense of other areas.

Performance measurements become further complicated when much of the work is performed away from scrutiny, such as in private sessions between clients and providers. Outcome indicators are also problematic because it can be difficult to determine the degree to which outcomes are the result of provider performance or client capability (Lipsky, 1980). Ultimately, most workers see themselves as doing a good job (Lipsky, 1980).

Lipsky (1980) argues that quantitative outcomes become surrogate performance measures for the actual quality of performance – workers adapt their practice to favourably influence these measures, but otherwise maintain autonomy in their work. For example, a mental health organization might report how many clients are seen per month and the average number of sessions per client, but these metrics do not necessarily reflect the actual quality of treatment. Also, these measures can be limited in their ability to capture the human dimensions of individual clients, such as the experiences and meanings that are generated in the process of recovery (Watson, 2012). This discussion invites the question of effects on clients as organizations strive to meet certain goals. Managers are pressured to increase productivity and lower costs, while the greatest effects of the decline in service quality are experienced by clients who have limited power to influence such realities (Lipsky, 1980).

Mental Health Assessment

When individuals seek mental health care, assessment processes are used to determine if and how treatment will proceed. The emergency department (ED) environment will be used as a model to explain how a relatively thorough process of assessment can unfold. There are varying levels of formality and approaches depending on the organization and provider characteristics, but it is useful to examine EDs in particular because they involve elements of inpatient and outpatient treatment, coercive and non-coercive treatment, and referral, and they employ a

variety of mental health practitioners. In other words, there are elements of the ED environment that exist elsewhere, and there are some elements that are fairly unique to the ED due to the types of services that they provide. Also, EDs are often a first point of contact for individuals who seek mental health treatment, and this is especially the case considering the shift toward deinstitutionalization and fewer purpose-built mental health facilities (Marynowski-Traczyk and Broadbent, 2011). Often, the use of EDs by mental health patients is due to a perceived lack of alternatives (Clarke, Dusome, & Hughes, 2007). In the broader mental health care landscape, it is common for people to not know about available resources when they would like assistance with mental health concerns (Towns & Schwartz, 2012).

When individuals with mental health concerns enter the ED, they normally move through the following steps during their visit: triage, consulting with a psychiatric emergency nurse, ED physician consultation, a psychiatry consultation (if needed), and a disposition (admission or discharge) (Clarke, Brown, Hughes, & Motluk, 2006). According to Clarke et al. (2006), approximately 30% of patients who enter the ED with mental health issues are seen by a psychiatrist. During the triage process at the beginning of the visit, Brown and Clarke (2014) note that some EDs automatically triage potentially suicidal patients as high priority as a way to minimize liability that may be caused by patients who leave without being seen. Triage is a method of differentiating between clients (Lipsky, 1980). It allows for provider discretion when dealing with clients, and it allows some clients to be advantaged over others (e.g., in terms of wait times).

There have been some important findings about the environment of the ED and its operation that hinder optimal mental health treatment. A common concern among ED nurses is that they are not able to give mental health patients an adequate amount of time for their

concerns (Marynowski-Traczyk & Broadbent, 2011). In Marynowski-Traczyk and Broadbent's (2011) study, some ED staff expressed frustration because they were not able to provide help to the degree that they would ideally want. In other words, mental health issues are rarely resolved in the sense that many physical ailments are cured, and therefore, the ED can become a revolving door for some patients. Finally, the length of stay in the ED was perceived by some triage nurses as mostly due to the long assessment process rather than the triage system itself.

Patient perspectives provide useful insights on experiences in the ED that are less than optimal for those suffering from mental health issues. Clarke et al. (2007) studied these perspectives, and they described a number of important findings. From an environmental standpoint, patients often felt the ED provided inadequate privacy and an excessive amount of stimulation; these concerns were also echoed by ED personnel (Clarke et al., 2006; Marynowski-Traczyk & Broadbent, 2011). In terms of the experience in the ED, patients wanted to have information about community resources when leaving the ED, and their families also wanted relevant resources about mental health (Clarke et al., 2007).

Coordination and Delivery of Mental Health Care

When individuals seek mental health care, it is often the case that they will connect with more than one provider and/or service. This is especially the case for people with complex or multifaceted needs. Sometimes the individual will see multiple providers within the same service, or a referral to outside services may be needed. In these cases, issues such as collaborative care and case management become relevant to consider. However, the considerations around the coordination and delivery of mental health care are complicated by the allocation of resources through mechanisms such as rationing, and these mechanisms are

influenced by factors such as who makes decisions, ideas about supply and demand, and the use of evidence-based practices to justify certain interventions over others.

Mental health care delivery in the community is situated within a historical context that demonstrates how the motivation to address the shortcomings of institutionalization has generated new challenges for patients and providers. The shift toward deinstitutionalization, which started in the 1960s in Canada, was driven by three broad factors according to Davis (2006). First, there was the advent of new medications that could be administered on an outpatient basis. Second, there were changes in attitudes toward keeping the mentally ill out of the community; concerns were raised about patients' rights and the prospect that being in an institution could exacerbate mental disorders. Third, there were economic factors – namely, the operating costs of psychiatric facilities – although Davis (2006) notes that the economic argument is debatable, especially considering the costs that ended up being shouldered by other services in the community as a result of deinstitutionalization. Frederick, Tarasoff, Voronka, Costa, and Kidd (2017) argue that the promotion of community-based treatment in mental health treatment discourse is vague and problematic. They point out that the proponents of this idea often ignore the barriers to inclusion that individuals with mental illness face such as racism, poverty, and stigma. At this point, inpatient care tends to occur within general hospital psychiatric units (Davis, 2006). Over time, patient stays have become shorter both in general hospitals and in specialized psychiatric hospitals.

Given the diverse services and providers that exist in community settings, the concept of collaborative care has been promoted as a way of improving coordination of client care. Kates et al. (2011) define collaborative care as "care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual

support" (p. 2). They emphasize the importance of communication and coordination within collaborative relationships in order to provide effective and efficient services. The authors note that there are numerous challenges providers face when attempting to build these relationships, including funding constraints, lack of time, lack of training in collaborative practices, and insular professional cultures. From a broader perspective, Kates et al. (2011) envision an integrated system that involves collaboration across all levels of services – individual practitioners, organizations, and systems. Essentially, the collaborative care model promises to coordinate the specialized skills of various providers for the betterment of clients.

The efficiencies in services and cost that are promised by collaborative care raise the issue of how organizations allocate limited resources. Lipsky (1980) examines the question of resources from a supply and demand perspective. He argues that demand usually increases in response to greater levels of supply. Lipsky also notes that when supply is increased, there is a tendency for organizations to increase the quantity of resources as opposed to improving the quality of existing services. There is also the argument that encouraging client input and becoming more responsive to clients can be contrary to the interests of the organization because increased demands may necessitate more rationing of services (Lipsky, 1980).

In order to deal with limitations on resources, organizations make use of rationing to determine what services should be provided to particular people, in addition to the quantity of resources offered to each client (Lipsky, 1980). Specifically, organizations can ration services in different ways, including the specification of client characteristics and types of cases. An example of this rationing in the context of mental health services would be an organization that only accepts low-income clients who do not require in-patient treatment for their psychiatric

issues. Clients who do not fit those characteristics would need to find a different service that caters to their specific needs.

One might be inclined to argue that rationing is simply a product of supply and demand relationships within the sphere of economics, but Light and Hughes (2001) contest this viewpoint by exploring the interests and values that underpin the practice of rationing. They state that rationing "formulates a particular linkage between allocative decisions and resources which can work to support certain interests against others" (p. 552). For example, a policy that rations particular resources may be seen by management as efficient and effective, while frontline workers may perceive it as a cutback that threatens the quality of services. Some people have proposed that evidence-based medicine will clarify allocative decisions and reduce rationing because only the most effective treatments will be given to clients (Light & Hughes, 2001). However, Light and Hughes (2001) point out that effectiveness and benefits for clients cannot be easily determined through evidence-based medicine because individuals will have different conceptions of what outcomes they personally value.

Teghtsoonian (2009) analyzed a strategy document for the treatment of depression and argues that the preference for evidence-based treatments reinforces the neoliberal orientation toward individualism and fails to adequately integrate social and environmental factors. Further, she raises the concern that the discourse around treatment takes on a binary quality (i.e., either there is evidence to support effectiveness or there is not), and that this stifles the dialogue around the merits of various treatments. Mykhalovskiy and Weir (2004) caution against these types of perspectives because they point out that criticisms of evidence-based medicine from political economy or humanist perspectives are often made in the abstract, without adequate consideration of the actual uses of this approach from research and application perspectives. For instance, they

point out that evidence-based approaches can be used as decision aids that empower clients to make more informed choices about their treatment when presented with multiple options. An inclusive way of integrating evidence-based practice into clinical care is to broaden the types of evidence that are considered. Rycroft-Malone et al. (2004) suggest that in addition to experimental evidence (e.g. randomized controlled trials), other dimensions such as clinical, client, and provider experiences, as well as environmental factors, should be studied rigorously and incorporated into the evidence base.

Decisions surrounding the rationing of resources are usually determined by a relatively small group of powerful people, such as managers, and justification for this practice relies on the notion that they will act fairly and in the best interests of the individuals who are affected by those decisions (Light & Hughes, 2001). However, this is not a simple process because there are power struggles among decision makers when making choices about how rationing is to occur. Light and Hughes (2001) refer to a phenomenon that they call "soft rationing" which means that workers may exercise flexibility in their work and make commitments that are not strictly permitted by their budgets, but they still work within the pre-existing constraints that have been imposed (p. 565). This is one way in which frontline providers can exercise their discretion within the context of these power struggles surrounding allocative practices.

One way to manage resource constraints is to make referrals to other services. Lipsky (1980) argues that referrals allow organizations to appear helpful while processing clients in a way that is responsive to high demands for service. He explains that both clients and providers may benefit from this arrangement as long as the referred resources have the capacity to accept new clients. Essentially, referrals allow for more clients to be processed by a particular organization without actually receiving service. To take this further, an organization may argue

that referral is a service in and of itself, and that the decision to refer elsewhere is not necessarily a failure of that organization to offer useful treatment to the prospective client.

Another way in which the client journey is shaped and resources are managed is the practice of case management, and this works in conjunction with referrals. According to the Canadian Nurses Association (2020b), case managers "provide organized support for people struggling with their illnesses. They do so by helping patients cope with and understand their conditions, by connecting them with the services they need and by coordinating health care and social services, often with a variety of organizations" (p. 1). Pescosolido, Wright, and Sullivan (2010) argue that case management, regardless of type, possesses an essential feature of restructuring and managing social supports that may have been insufficient for the individual suffering from mental health concerns. They outline the social nets of various case management models in the following ways: the relationship between the client and case manager, the areas of the community that are targeted, and the comprehensiveness of the interactions. They assert that the success of case management programs is dependent on these factors because they influence the adoption of treatment methods by the relevant stakeholders.

Pescosolido et al. (2010) describe three major types of case management models. First, there is the broker model, and it usually involves case managers who connect clients with the services that they need to improve their lives in the community. Caseloads can be high, and this model is generally reactive in the sense that case managers respond to client issues as they arise. Second, there is the therapeutic model. This type emphasizes a therapeutic relationship between the client and case manager and requires more training than what is needed in the broker model. Finally, there is the therapeutic team approach, and Assertive Community Treatment (ACT) is an example of this approach. ACT uses teams of providers from multiple disciplines to provide a

variety of specialized services. There is a focus on reducing hospitalization and helping clients to live successfully in the community. It also allows for a variety of provider viewpoints on the client's situation and avoids the need for an individual practitioner to have a wide range of expertise. It can also improve the continuity of care for the client (e.g., withdrawn involvement of one provider on the team may not pose a significant disruption to the client). Essentially, the broker model follows a medical model approach, where clients with issues connect with case managers to treat their problems. The other models expand the scope of case management and attempt to address the limitations of the broker model (Pescosolido et al., 2010).

Although it may appear that intensive forms of case management are optimal, there are cases when this type of intervention has the potential to use a lot of resources while yielding less benefit than desired. Burns et al. (2007) examined whether intensive case management, such as ACT, leads to a reduction in the time spent in hospital by those who suffer from severe mental illness. For the purpose of this study, the authors defined severe mental illness as someone presenting with schizophrenia, bipolar disorder, or depression that is accompanied by psychosis. Burns et al. (2007) found that intensive case management was most effective in reducing hospital stays for patients who were already high users of hospital care. Conversely, patients who were relatively low users of hospital resources did not benefit as much from intensive case management.

Another example of facilitating clients who have specific needs is how services adapt to the homeless population. Campbell, O'Neill, Gibson, and Thurston (2015) conducted interviews and focus groups of homeless individuals and health care providers and found that mental health and substance dependency were the most frequently expressed concerns. When building relationships between providers and the homeless population, Oudens and McQuistion (2006)

note the possibility that clients may not feel comfortable with formal meetings, so they advise that it may be useful to meet informally and for short periods (e.g., going for a walk). An element of this is the discomfort that homeless individuals often feel when they enter health facilities and are confronted by security, for example (Campbell et al., 2015). Falk (2006) suggests that homeless individuals who feel a sense of estrangement from services may require a lengthy period of rapport with providers. Within this relationship, there is an emphasis on the importance of helping these clients to meet their basic needs. Further, providers often recognize the value of acting as advocates for their clients as they help them navigate the treatment process (Campbell et al., 2015).

The Role of Co-occurring Disorders

Individuals who experience mental illness are more likely than the general population to also experience substance use disorders (Davis, 2006). This association is also referred to as the presence of a co-occurring disorder or a dual diagnosis. According to Davis (2006), this population has not benefited from optimal treatment in the mental health services sector or the health care system in general. He identified some of these barriers:

- mental health staff may not be trained to assess and treat individuals who have substance use disorders;
- some providers hold negative attitudes toward substance users;
- there may be deficiencies in the recognition of co-occurring disorders;
- there is a traditional practice of focusing on the primary diagnosis to the exclusion of other issues; and
- services are not sufficiently integrated.

Davis' (2006) last point about service integration speaks to larger issues within the assemblage of mental health services. Davidson and White (2007) argue that there have been widespread calls for integration of mental health and addiction services, but that this separation continues to persist. They cite numerous reasons for this separation such as professional cultures, politics, and ideological orientations.

The prevalence data for comorbid mental illnesses and substance use are variable, depending on the diagnostic criteria and demographics of the studied population. For example, Shand (2010) stated that one third of individuals in Calgary and Edmonton who were diagnosed with a mental illness also presented with substance use problems. On a larger scale, Rush et al. (2008) conducted a study that examined national level survey data. Specifically, they analyzed responses from the *2002 Canadian Community Health Survey: Mental Health and Well-Being* (as cited in Rush et al., 2008). Responses were analyzed based on the 12-month prevalence of a set of psychological disorders, as well as 12-month substance use and dependence. According to their analysis, 1.7% of Canadians reported experiencing both substance use problems and mood or anxiety disorders. Rush et al. (2008) noted that this number is likely low due to the exclusion of some psychological disorders that are known to have high comorbidity with substance use (e.g., post-traumatic stress disorder and personality disorders). They also noted that these figures can vary if specific subgroups of the population are examined.

Considering the relationship between mental illness and substance use, the research by Rush et al. (2008) supports the finding that those who have mental illness are more likely to have problems with substance use than those who do not have mental illness. This relationship is also consistent in the reverse direction (those who have substance use problems are more likely to have a mental illness). When addressing this issue, Rush and Koegl (2008) argue that mental

health services for those with comorbid mental illness and substance use should be sensitive and responsive to the needs and demographic profile of clients in order to offer optimal care. For example, subpopulations that tend to be frequently involved with the criminal justice system may benefit from extra attention to the legal aspects of their situations.

Chapter 4: Methods

Twelve participants from a variety of organizations were recruited for semi-structured interviews to provide insight on how health care providers connect their patients or clients with services, and the challenges that are encountered in that process. Due to the constraints of this project, the goal was not to obtain a representative sample of participants; instead, this is a purposive sample that was intended to examine a cross-section of providers from a variety of services within the mental health care field in Calgary. Given the focus on the work of mental health care providers within the context of organizational environments, efforts were made to represent a variety of organizations, both in terms of size and type. As such, the participants included individuals from the fields of social work, psychology, medicine, occupational therapy, research, nursing, and management. Table 1 organizes the respondents based on their occupational role(s) and gender presentation. The numbers add up to greater than twelve because some participants have multiple roles. For example, one participant might be a social worker and a manager. The "other" category refers to participants who engage in significant work that does not fit into the other categories, such as those who conduct research. Table 2 shows the number of participants per workplace type (all participants are counted only once in this table). The respondents can be roughly categorized into three categories of employment: the non-profit sector (e.g., homeless shelters and outreach organizations), Alberta Health Services, and private practice (clinical psychology in particular). The "other" category refers to organizations such as outreach and multiservice facilities that do not fit fully into the other categories.

Table 1

Occupational Role and Gender of Participants

	Manager	Social Worker	Psychologist	Physician	Occupational Therapist	Nurse	Other
Women	4	4	1	1	1	1	3
Men	0	2	0	0	0	0	1

Table 2

Number of Participants per Workplace Type

Private Practice	Emergency Department	Homeless Shelter	Counselling Organization	AHS Staff (non-ED)	Other
1	1	2	4	2	2

The study was motivated by an interest in mental health services for vulnerable populations, and this formed the basis of the sampling approach. With this interest in mind, a broad range of participants was chosen because this approach allows for an analysis that considers the variety of trajectories that clients may take, as well as the approaches that are employed by various organizations and practitioners. For example, patients who seek mental health services in an ED or urgent care environment often encounter a trajectory that is similar to that of a patient who seeks medical attention for a physical ailment – there is a process of formal triage, assessment by an emergency physician, and then decisions surrounding the admissibility of the patient or suitability for other outpatient resources. By contrast, an organization using a counselling-based approach may have a more informal process where the client is connected directly with a counsellor. In other cases, individuals may seek community resources such as homeless shelters to meet basic needs, and the mental health component is offered or requested at the same time.

To recruit participants, emails were sent to publicly available contacts, usually located on the internet. Overall, the recruitment process involved many messages sent with a relatively low response rate. In some cases, more information was requested and then sent, but the organizations did not follow up. During this process, it was evident from the correspondence that many of the organizations and/or staff members were quite burdened by their caseloads and research requests, and this likely affected their ability or willingness to participate in this study. In the end, efforts to connect with a relatively comprehensive cross-section of organizations within the mental health sector in Calgary were successful, as participants were recruited from several of the most prominent organizations in the city. Given the very large number of services that offer either direct or indirect support for mental health concerns, this is not to suggest that every possible or relevant perspective was included in this research.

The interview questions were based on questions contained in an interview guide (see Appendix). The purpose of using this guide was to ensure that certain topics were covered in each interview. The discussions started by asking participants about their backgrounds. This helped to establish how they came to be in their profession, as well as their current role and the associated duties. The rest of the interviews focused on practice within the organizations, as well as the operations of the organizations that may not be directly related to individual practitioners' own work. Since the interviews were semi-structured, participants were able to steer the conversation in different directions. Although the goal was to address the major topics in the interview guide, the conversations often addressed issues that were particularly important to the interviewees. For instance, some participants work extensively with clients who use substances, so those conversations tended to have a greater focus on issues surrounding that type of work. Also, the occupation and role within the organization influenced the direction of the interviews.

Interviews with managers, for example, tended to have more emphasis on organization-wide issues, while interviews with practitioners focused somewhat more on their interactions with the clients that they see on a daily basis.

Prior to interviews being conducted, the websites of participants' organizations were examined to gain background information about the organizations, such as their missions, available resources, and approaches to service delivery. Although all interviews were conducted according to the structure of the interview guide, it was helpful to have this extra information to ask for clarification or elaboration on parts of the organization or service that may be useful to understanding the topics of discussion. The websites exhibited a great deal of variability in the amount of information that was available; some contained relatively basic information, while others were considerably more detailed. Finding information on the specifics of AHS services was particularly challenging because the website is very large and complex, and the ways that programs interconnect are not always clear. As a result, the interviews with AHS employees also involved an emphasis on clarifying how their programs fit into AHS service delivery in general, as well as asking for their knowledge about other relevant programs. Despite these efforts, it is clear that a complete understanding of services and relationships in AHS would be a significant and lengthy undertaking.

Interviews were audio recorded and then transcribed. To protect the identities of the participants, their names and employers were then anonymized with the exception of AHS. The latter employer is not anonymized because it is sufficiently large to avoid the identification of specific employees; also, it would be exceedingly difficult to discuss some of the services (e.g., emergency medicine) without implying the role of AHS. The names of the interviewees were replaced by pseudonyms to allow for differentiation when discussing their statements in this

thesis. Essentially, the individual employers and employees are not the units of analysis in this research. Rather, the purpose is to form a better understanding of the challenges that mental health care providers tend to encounter as they assist their clients in navigating various treatment options, and how that work is constrained and influenced by the organizational environment. For the purpose of this analysis, the terms "clients" and "patients" will be used interchangeably. The majority of respondents referred to the people they serve as "clients," with the notable exception being the hospital environment, where "patients" was more commonly used.

The anonymized transcripts were then imported into NVivo software in order to perform a qualitative analysis. This process started with the production of a codebook that contained codes based on the questions in the interview guide, with the goal of covering the most important themes. Major themes were represented as top-level codes, and then nested codes were created under those themes. For example, "case management" was a top-level code, with "formal" and "informal" as the nested codes to separate interview data that expressed different types of formality in case management practices. Based on this codebook, top-level codes (nodes in NVivo) were created, along with the nested codes. After the preliminary coding scheme was constructed, the categories were revised as potentially important themes emerged from the interview data; this process uncovered what would be useful and what was redundant or not useful for the analysis. For example, there was a top-level code for substance use, and two of the nested codes that distinguished between opiate and non-opiate substances were eliminated because there was not enough information in the interviews about types of substances in order for this distinction to be useful in the analysis.

One of the challenges that arose during analysis and exploration of interview data was to maintain a distinction between participant accounts and the interpretation of the interviewer.

However, the effects of interpretation are inevitable to some degree because some of the observed attitudes, for instance, were implicit and needed a greater degree of interpretation as opposed to some of the explicit statements contained in direct quotations. Also, the choices of what to include and what to compare in order to form accounts of various phenomena reflect the approach and interests of the interviewer. Many quotations have been included in the two substantive chapters in order to provide the reader with more direct accounts from the participants, while still providing interpretive discussions and analysis.

During the course of the interview process, it became evident that the provider-organization interaction is an important analytic theme that exerts a significant influence on the ways in which services are delivered to clients. Some providers were more candid than others regarding these interactions, and there were a few opportunities to gain higher-level perspectives of organizations through interviewees who hold management positions. In other words, those managers were able to provide insights into the management perspectives of their organizations in addition to their clinical insights. Many of the important discoveries about interactions between providers and organizations became evident indirectly when discussing the topics that were anchored by the interview guide – only some of the discoveries came from directly asking about these interactions. The following chapters will draw on the interview data to uncover insights about relationships between providers, clients, and organizations.

Chapter 5: The Importance of Organizations in Providers' Perspectives of their Work and Clients

When considering the clinical context of providers and their work with clients, it is valuable to examine the influences of organizations on those relationships and how this is conceptualized by providers. The organizational environment and the interactions that occur there provide allowances and constraints that affect the treatment process. This chapter explores the client-provider relationship and how this relationship interacts with decisions at the organizational level as well as the treatment approach of the practitioner. In particular, the concepts of readiness and client independence are important themes that tend to permeate these relationships, as described by respondents. When accessing services, there are certain challenges that can be encountered by individuals who use substances, and this is reflected in both organizational policies and the experiences of clients as told by providers. The treatment process is then measured by practitioners and organizations in various ways; these measures are used within client-provider sessions in addition to performance tracking at the organizational level. Although both quantitative and qualitative data tend to be collected by organizations, the usage of these types of data appear to differ, with an apparent emphasis on the former. Finally, there will be an analysis of ways in which respondents construct how organizations shape their work as good or acceptable. These attitudes are embedded throughout the examples in this research, but this section will deepen the analysis of attitudes that are especially important for understanding work within organizational environments.

Each organization in this study has a unique combination of type and number of staff members, organizational structure, and physical facilities. Organizations have purposes that determine the types of services that will be offered, as well as the clientele that they will serve.

When practitioners are employed by those organizations, their work is shaped and constrained by these organizational purposes. For instance, six of the practitioners in this study were social workers, but their actual job descriptions and day-to-day duties varied considerably. Some of them work exclusively as counsellors, while others have management positions that require them to utilize their knowledge about mental health care delivery, as well as the skills required to run an organization. These managers sometimes have a client caseload in addition to their management duties.

There is also variability in the types of services that providers are expected to perform in the clinical environment. In a crisis counselling organization, for example, practitioners are required to address an extremely diverse clientele who present with almost any conceivable issue. One of the counsellors talked about having to "work in multiple centres," meaning that he employs diverse skillsets when working with clients. Even though the purpose of crisis counselling is stabilization rather than therapy, as stated by the participants, they still need to develop a broad skillset that allows them to connect effectively with their clients. An important aspect of connecting with clients is knowing the limits of the care that they can provide. As a result, some types of clients are referred elsewhere if the providers are not equipped to handle the situation (e.g., risk of harm to self or others).

Client-Provider Relationships

The success of mental health services relies on the relationships that develop between clients and providers. One way to conceptualize a client-provider relationship is as a form of negotiation. At a basic level, the client is seeking services, and the provider is determining their ability to provide what is needed based on what is available as well as the constraints of what can be provided (i.e., organizational and discretionary constraints). Beyond the negotiations of

assessment and referral, clients and practitioners impose expectations on how their interactions will progress during treatment sessions. A common expectation is that the client needs to be "ready" to engage with various aspects of the treatment process, and they are often encouraged to develop independence and the willingness to mobilize certain resources themselves. Fundamentally, improving the situation of the client is the main goal of the relationship; how that is achieved can take many forms and many barriers can be encountered.

Several respondents discussed "readiness" in the interviews, and in particular, the idea that many clients are not ready to embrace treatment. The following excerpt was from an interview with a crisis counsellor, Will, who was talking about client readiness to be stabilized, consistent with the goals of the organization:

> But do they need to be ready? Absolutely, and that being the most crucial part…If you're not ready, you're not ready, and that's ok too. It's ok not to be ready and the point is for people to walk out of here without shame. You know? You don't want to change it right now, that's ok. They're not ready, you're not ready. It's ok, no judgment.

This attitude indicates that the provider is able to offer assistance to the extent that the client is willing to accept it. Will's attitude about readiness was echoed in various ways by most of the other practitioners. There is a clear orientation toward the idea that the client is ultimately steering their own journey and that the practitioner will facilitate that journey by utilizing the treatment and organizational resources at their disposal. Most of the services examined in this research are for clients who seek assistance on a voluntary basis.

Readiness can be seen as a process in the course of treatment rather than a yes or no position that determines whether or not services will be offered and accepted. For example, one of the counselling services requires that clients see a practitioner one-on-one before entering

group therapy. This was explained by Shirley, who works at a counselling organization at the management level in addition to having a client caseload, using a model that outlines stages of change as it relates to the experiences of her organization:

> The reason why we [require counselling before group therapy] is we've learned that a whole lot of people aren't ready, A, for counselling and for group. So while we think people who are referred to counselling actually want counselling, the majority of people who come are actually not ready. I don't know if you know Prochaska's Transtheoretical Model of Change or the Stages of Change. So most counselling programs around the globe expect that people are either in precontemplation or action meaning they thought about the problem, they're ready to do something, or they're coming in ready to do something. That's not the case in real life. Most people actually come in, they know they have a problem, they're not really ready to do something about it. So by putting them into group too quickly, we run the risk of them dropping out of group. And they can drop out of counselling too for the same reason.

This partially acts as a screening tool that allows the practitioner to gauge the readiness of the client for a group setting to increase the probability that they will benefit from this type of therapy. Instead of leaving the decisions about the direction of therapy entirely to the client, there is a predetermined structure for all clients in order to mitigate some of the challenges with follow-through. This structure is implemented on the basis of challenges that the providers foresee, which may differ from the clients' perceptions of how the treatment process should unfold. Another way of viewing this approach is that practitioners respect what they perceive to be the readiness level of clients, but "readiness" is also the imposition of rules and guidance that

practitioners feel is in the best interests of the clients' treatment processes based on past experiences of service delivery.

An implicit part of the attitudes surrounding client readiness is that the treatment process is often seen by those interviewed as a cooperative effort. In other words, the practitioner does not depict themselves as providing treatment in a one-way fashion, with the client simply absorbing the information and making changes accordingly. Also, the practitioner does not see themselves as directing treatment in a coercive fashion. Respondents often describe treatment as a process that requires active participation from the client, and this ties into the concept of readiness. The crisis counselling service in particular is useful for demonstrating this dynamic. Efficiency of sessions (in terms of maximum benefit within a limited time frame) is emphasized and client initiative is seen as instrumental. Assigning homework, such as reading books or watching YouTube videos, requires the clients to have the motivation to engage in these activities on their own time and to absorb information in a way that is useful to them within the context of the counselling process. This emphasis on homework is useful for the treatment process, as explained by Will, and it also prompts the clients to mobilize self-directed resources beyond what is available in the counselling sessions. If a client chooses not to participate in these activities or is unable, there is the implication that the therapeutic benefit and efficiency of the process would be diminished.

The concept of readiness is tied into the negotiation process as well. Will talked about how clients are encouraged to become curious about their healing process and the learning that goes with the homework. Importantly, he framed it as selling the process:

> But you need to sell that, you need to sell it to clients about why it's worth it, you know? You can't just…yeah, you can't just expect that people are going to do homework

> because it's homework. You have to sell why. Why are you going to bother learning [the particular skill that is being developed in this process], why do you want to learn it now? And the easiest way to sell it is just to tell people that hey, if you learn this skill now, you get to have a different future. Wouldn't that be amazing? And then you might be moving towards making a sale, towards selling that curiosity, selling that skill, learning.

This is an illustration of the negotiation process because clients are not always accepting the treatment process at face value and implementing suggestions at the instruction of the practitioner. Instead, there is a discussion of why the suggested approach is useful, as well as a discussion of incentives that would help motivate the client to participate – the incentive being the prospect of a better future by learning particular skills that may be introduced through homework assignments and then integrated with the counselling sessions.

Considering that the goal of the crisis counselling organization is to stabilize the clients' situation as opposed to offering comprehensive therapeutic services, one might wonder how becoming curious, learning new skills, and doing homework would be considered crisis counselling as opposed to components of therapy. During the interview, Will was asked if the crisis counselling helps clients in their healing journey (i.e., a more therapeutic goal), and he responded with the following:

> Absolutely, absolutely, and I tend to frame things towards healing anyway because why are you going to bother learning if it's not for healing, right? So even though that's not the technical goal, it doesn't mean we're going to say no if it happens in the room. I mean that's amazing, but it's technically not the goal even though we aim for it, but it's not the goal. If it doesn't, you know, if all we manage to do is to stabilize the situation, that's success for us in the crisis field.

This indicates that crisis stabilization is the baseline goal for the interaction, but it is understood there are also possible therapeutic benefits of the process. Additionally, Will explained that the counselling that is offered at his organization is sometimes sufficient for the clients' current needs. In other words, some clients do not need to be stabilized and then referred for longer-term and/or specialized services.

A common theme among the interviews was the goal of encouraging clients to develop and maintain a sense of independence, and this applies to both the mental health treatment process as well as the goal of meeting basic needs when applicable. The homework example mentioned above can be seen as a way of encouraging independence – self-directed use of resources requires some degree of independence. This orientation toward independence was usually implicit in most of the interviews, but there was one provider, Linda (a nurse and manager at a homeless shelter), who was more explicit:

> One thing we have to be careful of is that we're trying to make the clients more independent and compliant with their needs. So their medications being compliant with their medications, being compliant with their appointments and stuff. So you know, when we bring someone into the [facility], a lot of time the clients feel, I don't have to go anywhere, look I've got a psychiatrist here, I've got nurses here, I've got a doctor here, I've got whatever it is they feel that you don't need to house me, I'm comfortable staying here.

This was stated in reference to the organization's goal of providing housing and related supports for clients. In this case, the organization feels that it would be ideal for clients to become stable, housed, and able to access resources in the community as opposed to accessing the services at the homeless shelter for a long period of time. From an organizational standpoint, the goal of

independence is beneficial because transitioning clients successfully away from the organization's services allow staff and resources to be available for new clients – this is likely very important particularly for organizations that struggle to meet demand. The statement by Linda also suggests that clients should be "compliant" with certain aspects of the treatment process. This was not a commonly used term among respondents, but there tended to be a delicate balance between imposing the expectations of the organization and/or provider and "meeting them where they're at." The latter idea was expressed by multiple respondents, and it reflects the orientation of respecting client autonomy, which is an important component of some ways of approaching clients (e.g., harm reduction).

Based on the providers' accounts, it appears that a common perspective, stated implicitly and explicitly, is that the organizational goal of client independence also aligns with the goals of the treatment process. In other words, as clients become more independent, the organizations can reduce demand on their services through successful treatment approaches and the provision of supports in the community for their clients. Although this seems to be the ideal scenario, the reality can be more complicated. Some of the interviewees lamented the revolving door of treatment and discharge, especially in acute care environments such as the ED. In terms of follow-up, Hannah, an ED physician, explained that when patients in the ED are given recommendations to contact any number of outside resources (the patient is expected to initiate this process themselves), she has "no way of knowing if they do…and I generally don't follow up to make sure that they do." These statements suggest that some individuals are not being provided with the degree of follow-up that they might find useful, and it may also suggest that some people are unable to become independent in accordance with the expectations that are imposed by mental health services.

It is important to acknowledge that the challenges around follow-up are not exclusively confined to the ways in which mental health care is delivered. There can also be considerable difficulties with client motivation. For example, Elizabeth, a manager at a referral service, discussed how "historically, [her organization] spent a lot of time calling people two, three, four, times to follow up on referrals, so we had really ready motivated doctors, but the patients themselves weren't interested, weren't ready, weren't motivated." This led to a different approach involving letters sent to clients so that they could self-initiate the process (this is also discussed in the referrals section below). This underscores the attitudes that practitioners tend to have about client readiness – involvement in services can be encouraged, but if a client is not ready or willing, especially for voluntary services, practitioners are limited in what they can do.

Although active participation may be seen as optimal by many practitioners, some also recognize that clients vary in their ability and/or willingness to engage in this participation, and this is especially evident for those presenting with substance use issues. A harm reduction approach was explicitly supported by some participants, as reflected in Linda's statement: "We're not asking you to quit, we're not telling you you need to quit. What we're saying is let's look at you using more safely and let's decrease the drug use so it doesn't affect you the way it is now." Essentially, harm reduction – particularly in the supervised consumption context – is framed by participants as a way to prevent clients from dying or suffering acute harm. The provision of other services, such as treatment, is secondary and is not a condition of using the harm reduction resources.

Another issue surrounding substance use is the feeling of being stigmatized. A common way that practitioners attempt to mitigate stigma for clients is by meeting them where they are at. This attitude is a way of conveying acceptance for where a client is at in their condition (e.g.,

mental illness or substance use) without judgment. From that position, the practitioner offers services that may be useful for the client. Laura, a nurse who works at an outreach organization, characterized this process as follows:

> It's about what do you need right here and right now. You know, how can I help you wherever you are in that space medically, geographically, like maybe you need just a place to come in and stay warm for a minute. Maybe that is your immediate need. And so that's what we do. So we approach everybody with that sort of kindness, that trauma informed approach, and the harm reduction approach. So, you know, so you use drugs, so you have HIV, so have hepatitis C, nobody cares. What can I do for you today as a person? And yeah, that tends to go a long way. We really have a great ability to quickly build rapport with people because we treat people like people and it seems silly just to say that but, you know, the folks that we are working with don't always get that.

To reduce stigma for clients, providers often rely on the building of rapport. For example, one provider mentioned outreach teams that partner with her organization and how they often meet clients for coffee at a convenient place to create a more comfortable, casual atmosphere as opposed to requiring that clients come into an office where they may feel stigmatized for being homeless.

Substance Use and the Challenges of Utilizing Services

The role of substance use in treatment delivery can create particular types of challenges outside of the supervised consumption environment. In facilities that offer temporary housing and other basic needs, such as homeless shelters, there is sometimes conflict between what clients want to do and what staff will allow. For instance, Linda talked about the prohibition of substance use at the shelter and that clients are often searched if it is suspected that they may be

in possession of prohibited substances. Further, she stated that clients often use the washrooms in the facility as “unofficial consumption sites” because staff are trained to handle overdoses. Staff check the washrooms every fifteen minutes, and Linda stated that clients have given feedback indicating that this feels intrusive. This is an example of how organizational policies may not align with the actions of workers and clients within the facilities. The training of staff for overdoses (along with the stockpiling of naloxone to reverse overdoses) and the frequent washroom checks implicitly acknowledge that these activities will occur regardless of policy.

Substance users also face challenges with navigating services for both the substance use and other mental health concerns. Most of the participants provide services to substance users on a regular basis, but the ability to treat this aspect of their situation tends to be limited. For example, some providers focus on the underlying issues that may drive substance use, such as management of circumstances and emotional states, but they generally do not provide specialized and intensive treatment for substance use in particular. The options for detox appear to be limited to specialized organizations, according to respondents. Even in the hospital environment, Hannah stated that individuals often come to the ED requesting admission in order to be kept away from alcohol, but this request is usually denied unless they are suffering from potentially dangerous withdrawal symptoms, such as seizures. For services that do offer detox, admission is not always immediate, and this can be a concern for clients according to Andrea, the manager of mental health services at a multiservice organization: “Our folks are ready on the day that they’re ready just like everybody else, right? When you’re ready to change, you’re ready to change and you might not be ready tomorrow, so if there were more services or it was easier to access them on the days when you need them, that would be great.” Also, Linda noted that some treatment centres that focus on substance use do not want to deal with other mental health

concerns. These issues reflect the general wish of multiple participants to have increased and timely access to treatment that specializes in co-occurring disorders.

As clients and practitioners work toward treatment goals, clients who use substances often struggle with being stigmatized, as noted in the previous section, and this issue was raised frequently in the interviews. Aside from the stigma that clients may experience in the broader community, such as community backlash against supervised consumption sites, they can also encounter stigma in health care environments. According to Linda, some clients are reluctant to visit one of the city's urgent care centres because they are often "greeted by security." In other words, clients feel like the security guards are suspicious of the clients' motives when visiting the facility. She went on to say that clients "feel stigmatized, they feel marginalized, they feel nobody will take them seriously or that everybody just gives them attitude that you're here drug seeking, you're here because of this, you're here because it's cold outside and you want a warm place to sleep."

Performance Measures

Respondents were asked about performance measures employed at their workplace, and these refer to the following levels: client, provider, and organization (there is some crossover between these categories, but they are separated here as an explanatory aid). Performance measures are utilized for a variety of purposes, but they tend to be used for evaluating client progress, organizational performance, and applying for funding. Some of the participants and their organizations also engage in research activities that play a role in evaluating service delivery and the effectiveness of various initiatives. All of the organizations in this study utilized performance measures in some way, and participant attitudes revealed different sentiments about the use of quantitative and qualitative performance data. The collection and utilization of

performance measures are complex issues that vary among the organizations, and it is beyond the scope of this research to conduct a full exploration of this aspect of organizational management. However, the responses uncover some of the providers' attitudes regarding the services they provide and how those services operate at the organizational level.

There are a number of client measures that are used in the assessment and treatment processes in order to screen for particular issues and to measure progress during sessions. The diagnostic instruments described by interviewees for use with clients tended to be roughly categorized into two types. The first is an array of assessment instruments, such as the GAD-7, to assess the presence and severity of disorders. The other is session tracking, which is often used in every session, and allows the client and practitioner to conceptualize the progress of treatment according to how the client rates various dimensions, such as in the Outcome Rating Scale (ORS). For session tracking, practitioners emphasized the value of being able to see how clients are progressing from session to session – this allows for a visual and quantifiable representation of the progress that has been made over time (usually represented by points on a number of spectrums).

Interviewees were asked about their opinions on the usefulness of the outcome rating measures, and the feedback was positive, although this sentiment was not always consistent from the beginning. Some of the practitioners shared that they had experienced skepticism when they were first introduced to these measures because there was the prospect of more paperwork and they were not entirely convinced of the usefulness. However, all of the interviewees who used these measures expressed strong support at the time of the interviews. As stated by one of the practitioners, the value of the outcome rating tools is what one makes of it. He went on to say that if it is simply treated as paperwork, then the value will be fairly limited. Similarly, it was

stated that some clients were skeptical of outcome rating scales in the beginning, but that they tended to find them very useful once they became more familiarized with the process. At one of the more research intensive counselling organizations, Shirley (a participant in a management role) emphasized the importance of outcome-based measures to track client progress over the course of therapy, in addition to the fact that they are mandatory in the organization. She went on to discuss how practitioners at the organization have been asked to leave for not participating in these evaluations. It is not entirely clear if these individuals were asked to resign or if they were fired, or if both approaches were used depending on the circumstances. With regard to these practitioners, Shirley explained that "they really don't want the accountability. They find the accountability oppressive at the beginning. And I think where it changes, they really want to be practicing on their own and not have people bother them and I keep saying it's not about us, it's about the clients."

At the organizational level, there are different tools to gain feedback about the operation of services. At a more basic level, the organizations tended to collect quantitative data such as number of clients seen, call statistics (when applicable), and financial measures. Some of this data can be quite sophisticated; at a telephone-based referral service, there is a computerized system that tracks various metrics for each call. This type of information is utilized by organizations to track performance and provide reports for funding agencies in addition to internal review processes. One interviewee specifically stated that his organization has received a significant amount of funding as a result of the outcomes that were reported through performance scales used in service delivery. At most of the organizations, quantitative reports on the services rendered are utilized to attract funding and to create accountability for the effectiveness of

services. Formally collected in-depth qualitative feedback seemed to be conspicuously absent from most of the performance measures described.

Although formal qualitative feedback appears to be lacking compared to quantitative data, individual practitioners valued this type of feedback from their clients. At the beginning of the interviews, the participants were asked about their backgrounds and motivations for working in their field. A common theme was that they had a keen interest in assisting marginalized people to improve their situations. Alongside those types of comments were also the experiences of being exposed to profound suffering and the challenges of working with people in those situations (e.g., child welfare and adults who have experienced significant trauma). Essentially, it became clear that many of the participants were deeply passionate about the value of the work that they performed and the populations that they serve. As a result, qualitative client feedback is an important component of their work for personal satisfaction and professional development.

The inclusion of qualitative client feedback serves to humanize the interactions between clients and providers. Given the emphasis by some providers on reducing stigma, meeting clients where they are at, treating them with dignity, and acknowledging their value, it is reasonable to expect that quantitative measures alone will not be sufficient to capture the totality of the client experience. One practitioner, Laura, talked about measuring engagement and a sense of community through interpersonal connections between clients and staff:

> The things that we can't measure are you know, because somebody feels engaged in something or a part of a community. Sometimes they start to use less [substances] and we can't measure that necessarily, right? So they believe they have a bit of a purpose or some worth because they have people that are treating them like people and then they start to feel more value in themselves and, you know, that impacts their overall health and

> wellbeing and stuff like that and who's measuring that? I have no idea. I often suggested at [former employer] that we, you know, we should measure how many hugs staff get from clients over at [former employer] as a quantitative measurement of how people are feeling and how they are engaging with their care because you get hugs all the time over there. I've never hugged my family doctor. Like that's not a thing. Or my lab person, like that's not a thing.

This statement speaks to the ideal of having these clients exist within a more compassionate and understanding environment where their issues are taken seriously and addressed in the most effective way possible. It also speaks to the challenges with accurately capturing the complexities of client experiences (engagement, feeling valued, etc.) and how that would be measured and ultimately utilized in the process of conceptualizing performance and making adjustments to service delivery on the basis of this information.

Even when client feedback is acknowledged, there can be limitations around if and how that feedback is utilized by an organization. For instance, Linda stated that "we do listen to [the clients at the shelter] and then there's times where we have to tell them that at this point, this is a [employer] issue and that the [employer] needs to deal with this in the best way we know how." The regular washroom checks to prevent overdoses and the clients' objections about this being intrusive is an example that Linda used to discuss how her organization balances listening to clients with making decisions. Overall, qualitative data are collected through both formal and informal means, but it is difficult to clearly articulate the ways in which this type of information is utilized in formal organizational policies and the process of securing funding based on the responses of the participants. Some interviewees acknowledged that client feedback is listened to and considered, but the responses were fairly vague. With the quantitative reports, by contrast, it

was clear that the data are frequently formatted into reports that are directly related to the funding process. Sarah, who works as an occupational therapist at an organization that operates a homeless shelter in addition to offering other services for vulnerable populations, stated this quite bluntly: “There’s no, like, anecdotal performance measures. It’s very much hard numbers because we have to prove it to our board because we’re donation based. So it’s just services. It’s literally services per month.” Although there are metrics of client experiences in most organizations, such as trends in scores on outcome rating scales over the counselling process, it was not evident if funders consider (or are interested in) qualitative client experiences when deciding who they will fund. The funding agencies themselves were not studied here, and the funding process was not explored in depth, so this observation is not an evaluation of how these entities operate.

With regard to performance measures, it is useful to consider how they relate to the treatment methodologies that are employed. This is where some of the discussions with interviewees regarding research activities is relevant. Broadly, there is variation in the types and prominence of research activities among the organizations. The more basic approaches use different types of performance feedback that were accumulated to inform policy decisions and revise service delivery to (hopefully) improve effectiveness and be more responsive to client needs. Some organizations, however, make research central to their practice. One of the large counselling organizations takes this approach. There are specialized research personnel, and there are formal relationships with university researchers. According to Shirley, the participant from this particular organization, the service delivery is explicitly anchored in evidence-based practices, and outcomes are carefully tracked and compared with outcomes using similar approaches in the research literature. Further, some of the staff publish findings in books and

peer-reviewed journals. In essence, this organization makes extensive use of the research process to improve service delivery, introduce efficiencies, and contribute to literature in the field – Shirley explained that her organization has created a "culture of feedback."

Research is an important activity within AHS as well, but the way in which it is conducted differs somewhat from community-based organizations. In AHS, there are many research groups and programs that conduct pilot projects and perform other research activities within the various departments. The implementation of research findings in actual programs can be complex due to bureaucratic challenges. Some of the participants expressed frustration with the implementation of new initiatives, but for different reasons. A current employee stated that AHS can be somewhat obstructionist with new initiatives for reasons such as liability. An example that was given is an initiative in EDs to provide peer navigators who have lived experiences of mental health and substance use issues to support patients who could benefit from such a service. The same respondent explained that there have been concerns about the possibility of some navigators becoming drug dealers for the patients. This concern was characterized as "short sighted."

On the other hand, a former AHS employee lamented the implementation of new, trendy approaches to mental health treatment with the sentiment that good, effective services should be enhanced instead. Although this was a very limited sample, it indicates some of the challenges that exist in large organizations. There are countless stakeholders with diverse interests and treatment philosophies, added to what some interviewees perceive to be bureaucratic inertia that can hamper implementation of new initiatives. By contrast, Laura noted that her small organization is able to be nimble when implementing new ideas: "And because we're not the big guys, big AHS, we have almost a little bit more opportunity and leverage to be able to make it

our own without having to go through many layers of bureaucracy if we needed or wanted to change something, so we can kind of make those changes as we go pretty quickly as we find what's working and what's not working."

Regardless of the size and type of organization, they all appeared to be working on organization-wide improvements and innovations with varying degrees of research involvement. Based on conversations with the interviewees, it seems as if the ability to quickly integrate new ideas (e.g., generated from research or from more informal initiatives) is correlated with the size and complexity of the organizational management structure. As noted earlier, Laura talked about how her small outreach organization is able to be innovative and nimble. By contrast, former and current AHS employees have explained how it can be challenging to implement new initiatives in a large organization, such as the peer navigator program mentioned above. In all cases, it seems most accurate to characterize those changes as a progression toward ideals that may be impossible to fully realize. For example, it was common for interviewees to cite the lack of funding as a major constraint to their services. This implies that having unlimited access to funds would allow for ample staffing levels, state of the art facilities, and more comprehensive services with fewer gaps. Since the ideal of unlimited funding is unlikely to occur, the organizations tend to use various feedback processes to see what works and what does not, and then to make changes within existing constraints with the hope of offering more effective services. These feedback processes include formal research activities, client feedback, practitioner feedback, and organization-wide metrics.

Providers' Ways of Constructing How Organizations Shape their Work as Good or Acceptable

Earlier in this chapter, there were examples of provider attitudes, such as those toward clients and the use of performance measurement instruments. This section will further discuss provider attitudes with a focus on how the limitations of organizations and other external forces (e.g., the health care system) impede the ability of providers to offer the quality of services that they feel is optimal for their clients. Some of these limitations can include the challenges of offering effective services for high system users, in addition to a lack of resources. Across most of the interviews, it appeared as if the providers felt that they were doing good, effective work with the resources that are available. For example, Sarah felt that "in terms of the service that individual health care providers provide, I think it's spectacular – we just need more of them." In other cases, providers did not reflect on their personal performance in an explicit way. Instead, they tended to talk about how clients are benefiting from the services that they provide in the context of what they are able to offer within resource and organizational limitations.

The challenges of working effectively were usually attributed to limitations within the organizations, the community, and the health care system. This is not to suggest that the providers came across as arrogant or lacking in self-awareness. The interviews did not explicitly prompt providers to reflect on their personal performance; the semi-structured approach was designed to allow providers the freedom to express concerns that they felt were the most important. Essentially, they were asked to discuss improvements that they would like to see within their organizations as well as what they would like to see with respect to outside resources. For the limitations within organizations, most of the interviewees tended to attribute those limitations to a lack of resources as opposed to any sort of failing within the organizations

themselves. It is not clear if these respondents avoided this type of criticism of their organizations due to discomfort or if the sentiments were genuine.

Hannah, the ED physician, was a notable exception in the sense that she was quite candid about the limitations of the ED environment. When asked if the ED is able to adequately meet the needs of patients who present with mental health issues, she answered with the following thoughts:

> Oh no. No, no, no. We suck. We are horrendous at this. I think because for a number of reasons. I think it's sometimes hard to recognize when there's an overlying mental health concern to a presentation. If the patient doesn't disclose it or isn't aware of it themselves, I think that there's a lot of time needed to understand someone's mental health and wellbeing and the emergency department is certainly not set up for one physician or nurse to be able to spend 45 minutes to an hour with a patient when there are 60 other patients waiting to be seen with varying degrees of life threatening concerns. And then I think thirdly there's a big disconnect between emergency services in the hospital setting and in the community. I think that there's many services available but it's very hard for me as one emerg doc to stay on top of them, let alone know how they all interact with each other because there's so many different groups and organizations and agencies that offer different elements of it but it's very hard to understand how and if any of them are coordinated.

This statement speaks to two large issues that occur within the ED. First, there is the time constraint. All organizations that were studied have various constraints on the resources that can be expended on a particular client or patient (e.g., number of sessions and/or types of services offered). In the ED, these constraints seem to be particularly evident because the interactions

with physicians are relatively short. Consequently, complex and long-term mental health treatment is not conducted in that environment. The other prominent issue is the challenge of being familiar with the complex assemblage of resources and when and how to direct patients to those resources, especially when many of them exist outside of AHS.

Overall, there was a tendency for AHS personnel (former and current) to be more candid with criticisms of their organization. The reason for this is not entirely clear, but one could speculate that the large size of the organization along with the fact that any particular employee may not personally know or have close contact with upper management made them more comfortable to share their opinions. For non-AHS organizations, interviewees were generally open to discussing ways in which their organizations could improve, but significant criticisms were rarely articulated. One exception was a provider from a faith-based organization. This individual provided fairly pointed criticism toward the organization, particularly in relation to the integration of faith-based beliefs in service delivery and staff training. The discussion covered how these beliefs are potentially problematic for Indigenous and LGBTQ+ populations, and how funders for the organization donate because of the faith-based philosophy.

There was a general acknowledgement of the reality that some clients are not receiving optimal care, along with a sense of frustration. More than one provider discussed the issues with frequent system users and how they felt that many people are discharged from the hospital after a mental health crisis without receiving adequate support or discharge planning. Sarah talked about a case management initiative that involves a partnership between her organization and another multi-service organization. She explained how this would be valuable for frequent system users:

> I think we need [nurses who take on a case management role] based in the hospital because people are being discharged improperly and then they become frequent fliers. So

> our clients become really big – like they just suck money out of the system, like that's what they do, right? Because they're frequent fliers to the hospital, they're often hospitalized, then they get the complications and it's because we just don't have enough support for them when they get discharged.

This observation reflects the strain that frequent system users place on the health care system, and other providers also spoke of limitations that clients struggle with. Substance users were characterized as particularly likely to be more transient and less likely to consistently connect with resources and keep appointment times. Additionally, in her role as an occupational therapist, Sarah spoke about the cognitive impairments that are experienced by many of her clients and how those conditions can make it difficult to remember to attend appointments.

Another significant source of frustration was the lack of resources that providers felt were needed for adequate client care. One component of this issue is the coordination of outside resources in order to improve the effectiveness of in-house programs, and this was an issue that Linda felt the need to address:

> There was a psychiatrist that would come [to the shelter] once a month half a day to see clients. That didn't last very long. The psychiatrist wasn't comfortable coming in here, felt unsafe because the psychiatrist is with homeless and addicts and even though we always had one of our team with the psychiatrist, the psychiatrist just wasn't sure that this was the best place to be. And since then, we've had no psychiatry at [employer]. Just the outreach teams that come in. So that's the big frustration for me is right now I'm seeing very little improvement especially at [employer]. But when I hear about what's happening in the community, I'm still not seeing a great improvement in the community. I'm not sure why because there seem be…you know, if we have, you know, all these

> psychiatric medical students out there, it would be great to have them come out and do outreach in the community and then as they graduate, imagine what they could do. It would be wonderful, but I'm not seeing that.

This statement implies that one of the limitations faced by the organization is not simply a lack of resources due to financial constraints (although this may ultimately play a role here as well). Essentially, it demonstrates the potential challenges that organizations may face when attempting to arrange for collaborative care and to attract personnel who possess certain qualifications.

Conclusion

This chapter explored some of the issues that providers feel are important in their work with clients and how the organizational context shapes that work. The client-provider relationship is a key component in the process of delivering services, and the discussion above has underscored some of the issues that need to be navigated, such as negotiation around the specifics of the treatment process, practices that encourage client independence, and the balance between client autonomy and reinforcing practice guidelines. The issue of substance use presents another layer of complexity around considerations such as stigma and organizational policies on possession and use of those substances. As these services are delivered, performance data are collected that provide insights at both the session level and the organizational level. The collection and usage of this data vary between organizations, with differing emphases on quantitative and qualitative metrics. When providers reflect on the work that they do, they construct accounts that reveal how organizations shape their work as good or acceptable. The perceived limitations tend to focus on the external constraints of resources and systems, as opposed to deficiencies in the providers themselves.

The next chapter will build on these issues by tracing the client journey through mental health services, along with discussing the challenges that are faced in the process. Although there are different steps in this process, they are all subject to the decisions that organizations and providers make about resource allocation and how to best manage client care with those resources. Ultimately, the provider accounts uncover how their ways of interacting with clients and delivering services are shaped by what is permitted or possible within the organizational context.

Chapter 6: The Work of Providers and Organizations to Facilitate the Treatment Process

For organizations providing mental health care, the services that can be offered are constrained by available resources. By extension, the practice of individual providers is shaped and constrained by what their organizations offer and the pathways of care that have been established. This section will discuss some of the processes encountered and major trajectories available to clients when seeking mental health care services, the ways in which services are coordinated within and between organizations, and ways that organizations make use of limited resources in that process. The trajectories of those seeking mental health services will vary depending on a multitude of factors such as type of assistance required, the organization of first contact, the presence of complex needs (e.g., homelessness in addition to mental health concerns), financial situation, and willingness to participate in the treatment process. At a very basic level, a client will make initial contact with a mental health service, be assessed, and then connected with the appropriate resources within an organization or will be referred elsewhere. The treatment process can be complex and multifaceted, and some of these possibilities will be explored here, including the use of case management for some clients. This chapter will conclude with a brief overview of operational resources, which include the financial and political realities that affect the operation of mental health organizations.

Assessment

When clients make first contact with an organization, they are usually assessed to determine their needs and whether or not there are suitable services that can be offered. Depending on the organization, assessments normally take place in person, online, over the telephone, or some combination of the three. For in-person assessments in non-ED environments, clients will often speak to a staff member to determine the types of needs that they

have, and then there is a determination as to whether the organization will be able to meet their needs. A participant's account of the ED assessment process will also be discussed here. It is important to make a distinction between assessment for the suitability of an organization and/or practitioner to provide services for a client and the assessment that occurs when making a determination about the client's condition and needs (i.e., diagnosis and treatment plan). For the latter, it is useful to make a distinction between formal and informal types of assessments. For example, a client may be formally diagnosed with a mental health disorder using DSM-5 criteria. Within this framework, each disorder has specific indicators that must be met in order to receive a diagnosis, and qualified providers are trained to make these diagnoses. In other cases, the client may share their concerns with a practitioner, and treatment may proceed without a diagnosis – this would be an example of an informal assessment. In either case, assessment acts as a communication process with varying degrees of structure that allows the provider to conceptualize the presenting concerns of the client and to "fit" the client into a particular diagnosis or to at least label those issues.

Online and telephone consultations exist for some organizations, and this is especially the case for services that specialize in referrals or crisis counselling. If a prospective client fills out an online form consisting of personal contact information and a brief overview of their issues, there is normally subsequent telephone contact where a staff member gathers more information and arrangements are made to commence in-person appointments. The crisis counselling service is particularly interesting because it utilizes both modes of contact; this gives prospective clients more options when initiating their entrance to the service. Also, this organization offers a telephone helpline that serves as an anonymous way for callers to ask for advice when they are experiencing a crisis situation. For many, the helpline may be the only contact they have with

that organization. In other cases, the caller may ask for or be offered the option of initiating sessions with the in-person counselling service.

During the assessment process, there are often efforts made to provide a good match between the client and counsellor (this applies to multiple organizations). At a counselling service, Shirley emphasized the importance of matching clients and practitioners as a component of better outcomes:

> One of the reasons why we match where possible is because in the research literature this is called client preferences, and if a client believes that they really need a blonde-haired blue-eyed counsellor, they'll do better if they get that counsellor. I'm using that as one example. They may say I want somebody who does CBT [cognitive behavioural therapy] or I want somebody who does something else and we'll match those where we can.

Shirley works for a particularly large organization with many counsellors. Smaller services with fewer counsellors would no doubt be subject to greater limitations on the amount of diversity that they can offer with respect to practitioner characteristics. Interviewees often discussed how they give information to clients for the purpose of connecting with other resources if that course of action would be more suitable. In other words, there was no indication that clients were simply turned away without advice if the client-organization fit was not suitable. It is not clear how successful these clients usually are with connecting to those other resources.

In the assessment processes, clients are assessed for the purpose of determining if the organization can be helpful for their needs in addition to referring them internally to the most suitable program if applicable. For example, a homeless client presenting with mental health concerns may be connected to programs that address housing, employment, and mental health. In these cases, the concern is generally pursuing the betterment of the client's situation in addition

to the mental health component, and staff may determine that a formal diagnosis would not be useful for that client and their treatment journey. In some organizations, many of the workers are not qualified to make diagnoses, but may have access to providers who are able to diagnose if that is required for particular clients. The interviewees gave the impression that these diagnoses are only done when deemed necessary (e.g., for certain types of referrals). Also, some participants indicated that clients tend to contact their organizations for assistance with concerns not directly related to mental health, such as shelter, and that those clients are encouraged to utilize the mental health services during the initial intake process. This applies particularly to organizations that offer services other than mental health care, such as homeless shelters and multi-service organizations for vulnerable populations.

Most of the organizations in this research did not appear to utilize formal diagnoses for disorders extensively – they tended to use them on an as-needed basis. Instead, they normally use other types of assessments, such as dimensional scales and/or informal conversations about the issues the client is facing and how the provider could be helpful. In most cases, it became evident that the focus of the assessment process was on providing responsive and effective treatment based on the concerns reported by clients, rather than focusing on whether clients met required criteria for particular diagnoses (this is not to suggest that treatment based on a formal diagnosis is somehow less valuable). Shirley expressed the position that diagnoses have limited usefulness at her counselling organization: “We identify problems and the reason why we don’t do [diagnoses] is because there’s no research that shows relationship between diagnosis and type of treatment and the diagnosis and outcome.”

Due to the marginalized populations served by many organizations, assessments are often needed for government service eligibility. This includes programs such as AISH (Assured

Income for the Severely Handicapped) in Alberta, as mentioned by one provider. She noted that this assessment process was contrary to the way in which she normally relates to her clients. Specifically, these assessments require a deficits-based approach to identify impairments that would qualify for the program to which the client is applying. By contrast, this provider prefers to use a strengths-based approach when communicating with clients. This example demonstrates how the demands of the assessment process require the practitioner to conform to a specific viewpoint that may contradict a preferred way of practicing.

The assessment process in an ED environment tends to differ from that of other types of organizations. It involves acute physical health care when needed, the possibility of inpatient admission is considered in some cases, and staff have the legal authority to remove the ability of patients to make decisions for themselves in certain situations. According to Hannah, there are three general ways in which a patient moves through the ED. The first is if there has been serious physical harm; the patient is met briefly by a triage nurse and then they are sent to the resuscitation bay to stabilize the physical presentation. The second route occurs when a patient is admitted to the ED, monitored, and receives an assessment by a nurse or physician within one to two hours. The third way occurs for those with less acute concerns. They may wait for several hours in the waiting room before being met by a nurse or physician. If the patient's needs cannot be met by the ED staff, along with a subsequent discharge, they are connected with a crisis team comprised of psychiatric nurses who engage in a detailed discussion about the relevant concerns. Through this process, it is decided whether the patient will be discharged into the community with appropriate resources and follow-up or if a meeting with a psychiatrist would be more suitable. At that point, the patient may be offered admission or discharged. At any point along this journey, if the patient presents an acute risk of harm to self or others, they may be subject to

actions taken under the Mental Health Act, which gives medical personnel the authority to make treatment decisions on the patient's behalf, including the ability to use restraints and preventing them from leaving (Government of Alberta, 2020).

One way in which the assessment process for AHS services differs from other organizations is how it shares and utilizes patient records. When asked about complex judgment calls, such as whether or not someone presents a safety risk, Hannah explained how the ED uses medical records from prior interactions to gain a more complete picture of the patient's history and as a tool to better determine if the patient is being truthful. She went on to say that the assessment process can be more challenging for first-time patients, since this historical data would be absent. Another component of the assessment process is asking questions of family to assist in gaining more information. At a different AHS service, consultation with family and friends can occur as well; in this case, these individuals may call for information about resources on the patient's behalf. Although these outside parties may be involved peripherally, the confidentiality of the patient is still maintained. The use of historical data in the ED to determine truthfulness and risk stands out from the other organizations because the other interviewees did not discuss a similar approach, with the exception of taking appropriate action in cases of risk to oneself or others. This is likely due to the lack of access to medical records by organizations outside of AHS. Essentially, the ED is taking more authoritative action when personnel determine that the patient is not able to make decisions that they feel are not in their best interests (e.g., admitting patients against their will in certain situations), and this is an example of providers using their discretion when guiding the patient through the assessment process.

Delivering Services

The client journey through the treatment process is shaped by the ways in which organizations structure their services. The delivery of those services can be conceptualized at the levels of both organizations and practitioners. Organizational goals determine the services that are offered, as well as the general policies that govern the delivery of those services. Individual practitioners have particular ways of working with clients, and this is the component of service delivery that the client encounters most directly. It is important to note that the organization-provider distinction does not suggest that they operate independently; the work that the providers perform is influenced by organizational policies and philosophies. The accounts of participants reveal how services are shaped by various constraints, options, and goals, as well as issues around duplication.

When commencing treatment, clients are sometimes constrained by limits on the number of sessions that are offered, or there may be a fee for service. The crisis counselling organization has a limit of six sessions for one round of counselling. In other words, that limit applies to the current timeframe and current issue; clients are welcome to come back for another round of sessions, especially if several months have passed. Within that policy, there is flexibility; the providers stated that a limited number of extra sessions can be offered on a case-by-case basis, but that it is subject to supervisor approval and is not publicly advertised. Further, one of the providers discussed how the counsellors are permitted to take on a limited number of long-term clients. This is an example of how providers can use their discretion to make exceptions to standard organizational policies when they deem that it is worthwhile to offer more sessions. One of the counsellors explained that the session limits allow the organization to keep waitlists minimal and to offer rapid service to its clientele. It is important to note that for services with

caps on the number of sessions, the interviewees stated that the average client utilizes significantly fewer sessions than the maximum.

The practices of organizations, and by extension, practitioners, are constrained by the scope of their services. For instance, organizations that serve the homeless population offer a wide range of services, such as shelter, food, employment supports, physical health care, and mental health care. These offerings require considerable space and financial resources to operate. By contrast, Patricia, a private practice psychologist, works as a sole provider and offers a specific type of psychotherapy service (CBT). When a provider or service is not equipped to help a particular client, this is where referrals are crucial.

Another major limitation imposed by organizations is that the treatment goal may not consist of comprehensive therapy with the end goal of fully addressing the presenting issues. Crisis counselling and the ED environment are two notable examples. When discussing the ability to meet demands for counselling services in a timely manner, Will stated the following:

> We tend to be fairly fast because we try to turn people over with keeping in mind that the goal is stabilization, not healing. So meaning that the problem doesn't need to be finished. There just need to be enough resources, the person functioning well enough, and that's success for us. Your life doesn't need to be perfect to signal the end of crisis counselling. You just need to be resourced, feel like you know what, I think I got it. I might need to go to therapy now to do more physio type work, that recovery type stuff. So we basically meet people at the peak of the crisis. So you're constantly working at this part, seeing the peak and bringing it down and then as soon as it's starting to stabilize, then you start to transition out because that's the only way you can be available for the next one.

By limiting the scope of the treatment to stabilization, this organization is able to maintain rapid client intake with increasingly limited resources (there are fewer counselling staff members than before, but the demand has continued to increase). There are also limits on the number of sessions at this service as another method of managing resources. The earlier discussion about the ED demonstrates similar limitations; patients are triaged, assessed, stabilized, and referred elsewhere when needed. It is not designed for long-term treatment of mental health concerns. In this way, the ED and the crisis counselling organization are similar, but there are some key differences. The ED is tasked with treating a wide variety of concerns beyond the scope of mental health, and many of the staff members are not mental health specialists. The ED is also able to admit patients to inpatient programs within the hospital, while the crisis counselling service is limited to the scope of outpatient sessions with a social worker.

The examples of the crisis counselling service and the ED illustrate how different organizations fill various niches within the assemblage of mental health services. Also, aside from the scope of treatment, organizations show variation in the ways that they serve clients at particular points in the trajectory of their situations. For example, the crisis counselling service deals with various types and degrees of crises (ultimately determined by the client) and accepts a wide range of clientele, but there is a limit when the client is at risk of harm to themselves or others. In this case, the ED is equipped to handle these situations due to qualified personnel who have the legal authority to make decisions for patients in some cases. Some organizations such as homeless shelters serve clients who may be experiencing crises in multiple areas of their lives simultaneously, such as mental illness, substance use, and homelessness.

It appears that the specialization of some resources and the limitations of what is offered are products of resource and staffing constraints, and not purely based on conceptions of how

treatment would be ideally delivered. For example, as stated above, the crisis counselling organization focuses on stabilization rather than therapy and offers a limited number of sessions. These constraints help to ensure that waitlists are minimal and they allow the organization to meet the growing demand for its services. In other words, including a therapeutic approach and removing the session limit would almost certainly require a significant increase in financial resources and possibly further staff training in order to offer a therapeutic process. Ultimately, the organization relies on referrals to other organizations when clients require therapy that extends beyond the crisis counselling and stabilization focus. However, these constraints do not eliminate the challenges of high demand. A participant who performs client intake work stated that "a lot of that work is referring out though, which is something that I really don't like to say, but it's true." This indicates some degree of discomfort with having to use referral as a resource management tool.

While the crisis counselling organization is an example of a service that provides a narrow range of services due to a relatively narrow scope of what it offers, the ED offers a narrow scope of mental health services due to the wide variety of interventions that are available in that environment. Essentially, it is evident from Hannah's account that ED physicians in particular are tasked with meeting a high workload of patients who present with all manner of physical and mental health issues. Time is constrained and priority is given to stabilization and assessment. From that point, a patient can be admitted to another unit in the hospital or referred to other services for further treatment. Again, in order to offer greatly increased services for mental health concerns in the ED, there would likely need to be more resources and more training for staff to work with mental illness in particular.

In organizations that provide treatment, it is important to consider the treatment methodologies that are used to address client issues. Certain types of practitioners are employed by organizations depending on the services they choose to provide and how they will be provided (e.g., social workers in a crisis counselling organization). The nature of the training and qualifications partly determine the types of interventions that can be offered. For example, a practitioner may not be qualified to make formal DSM-5 diagnoses and to prescribe medications. As a result, their work may exclusively involve some type(s) of psychotherapy. The specific treatment approaches used will be dependent on the capacities and preferences of the organization and individual provider. This can mean that the treatment methodology a client will receive is to some degree contingent upon the skills and preferences of the provider, as opposed to the preferences of the client – some managers explained that they allow practitioners to utilize their preferred treatment methodology. For example, Richard, a counsellor with administrative duties at a crisis counselling organization, stated that "each counsellor has their own eclectic approach in working with their clients and that may be narrative therapy, that could be CBT." This would appear to allow for provider autonomy in choosing the approach that they feel is most compelling, as well as providing clients with more choices when pairing them with practitioners. This ability to choose could be constrained by provider availability as well as the degree of variety in approaches that are offered among the practitioners. Also, some practitioners may become versed in multiple approaches, especially if they encounter a diverse client population; the ability to use multiple approaches also necessitates the ability to "know when your duties require you to know how to change modalities based on the presentation," according to Will.

With respect to treatment approaches, there was variation in attitudes toward traditional versus more novel treatments. As discussed earlier, one provider lamented the use of "trendy" approaches as opposed to improving existing therapies. By contrast, Megan, who works as a counsellor at the crisis organization, provided an argument for offering novel treatments:

> I would argue…across the board, we're stagnating. We're slowing down in treatment modalities, right? You know, if I had been born thirty years ago and gone to graduate school then, it's quite likely that I would have learned roughly the same material when it comes to frontline clinical work. So I think we need more research as well as more money for counsellors. So, you know, as an example I'm reading Bessel van der Kolk's *The Body Keeps the Score* and you know, he's such a big name in this world right now and he talks in great length about how something like EMDR [eye movement desensitization and reprocessing] which is gaining traction with significant amount of research, is still not really taken seriously, and yet, the clients that I see here are looking for it. They're looking for it because they're hearing that, you know, this is something that's effective and efficient to a certain degree in that I can skip over the labour of talking in great depth about the abuse that I've experienced. So we need more, we need more modalities because I don't think there's going to be the one cure-all method of counselling everybody and rather than being limited by – that sounds judgmental – but limited by, you know, CBT which is kind of the cornerstone of so many people's practices, we need more options.

This argument raises the question of whether or not practitioners should be free within organizations to explore different and novel treatment modalities, or if they should be confined to more traditional approaches which may have more established bodies of research support. The

practitioners who advocated for new approaches did not give the impression that traditional modalities are obsolete or lacking in usefulness. Instead, they seemed to question what they perceived to be a loyalty to older treatments without considering both a diversity of approaches as well as promising new treatments. The willingness to consider new and/or diverse treatment approaches appears to be consistent with the counselling organization mentioned earlier that attempts to meet client preferences whenever possible.

An interesting and unexpected finding was the emphasis by multiple providers on the value of group therapy. As mentioned previously, one of the large counselling services offers a variety of groups that cater to different concerns. In order to be admitted to those groups, clients are required to connect with a counsellor one-on-one first in order to assess suitability and readiness to participate in that setting. An interviewee from that organization emphasized the positive outcomes that have been observed from the group therapy environment. Not only do clients tend to benefit therapeutically to a greater degree than with individual counselling alone, but they often develop supportive social groups that last long after the official facilitation has ended. Aside from the therapeutic benefits, the economy of scale was cited as an advantage – more clients can receive therapy using fewer resources. As a result of the success with groups, this organization is planning to conduct further trials to examine the feasibility and benefits of expanding these programs.

As noted earlier in the discussion about assessment, perceived effectiveness takes precedence in the process. This attitude was particularly evident in portions of the interviews that addressed the treatment process. There was often an implicit attitude that the goal of improving the client's situation to their satisfaction is primary and that the provider's role is to use the available resources to facilitate this improvement. For some practitioners, particularly in

counselling settings, it appeared as if there was a "whatever works" philosophy that underpinned their approach to treatment. This applied particularly to those like Megan who embraced a wide variety of treatment modalities, even if some of them are not well-established to the same extent as approaches like CBT. The more traditional providers (i.e., those who might use one well-established approach) did not explicitly state they were against the "whatever works" philosophy, but appeared to invest their focus on a narrow approach with the expectation that they would mainly work with clients who they feel would benefit from that treatment modality. The implication was that incompatible clients would be referred elsewhere.

The flexibility and diversity in treatment modalities are important from an organizational perspective. For a single psychologist working in private practice, for example, they may only work with clients who fit with the chosen treatment approach(es). Clients who do not fit may need to seek other resources on their own or have the referral process facilitated by someone who is willing to undertake this task. A large organization with many counsellors has the potential for more variety in treatment methodologies, especially if it officially encourages diversity among its staff – this is the case with the large counselling organization described earlier. Staff have the freedom to choose the approach(es) that they feel most competent with and clients can choose to work with practitioners that they feel would most effectively meet their needs. This idea reflects what was explained by Shirley:

> We don't have an overarching theoretical model for the centre…and what we require, though, of every counsellor to have a theoretical orientation because that grounds them, being theory-based. It allows them to provide good evidence-based practice for their client, gives us more breadth and depth amongst our counsellors, and we do the same thing in group. We're not necessarily looking for a specific theoretical orientation. If you

> watched our groups, you'd probably find that…our strategies can be identified aligned to particular theoretical models, more than one generally, sometimes two or three. But the clients really benefit from that and from the relationships that they develop with the counsellors and the groups. So that's quite deliberate, and again, it's based on the research literature.

This statement explicitly acknowledges the organization's commitment to allowing their counsellors a fair degree of autonomy in how they practice. This arrangement would appear to relieve some pressure on individual practitioners to be competent in a large variety of treatment modalities. By contrast, the practitioners from the crisis counselling organization expressed some of the challenges associated with having to possess a very wide repertoire of skills. Essentially, there is the sense that this flexibility is encouraged as long as the results provide evidence for the effectiveness of the theoretical orientation.

Examining service delivery from the perspective of multiple organizations existing as an assemblage of services, there were important comments from practitioners regarding the duplication of services, at both individual and organizational levels. At the individual level, some practitioners specifically talked about avoiding the duplication of services. For example, at the crisis counselling organization, Richard spoke about assessing clients for suitability to utilize the service and stated the following: "See, my role is very much to see, yeah, if it's a good fit or not. So if they already have counselling, we would say they'd be doubling up on counselling, therefore, you know, what are some other options?" Aside from any possible therapeutic concerns about duplication, it is evident that duplication is seen as an inefficient use of resources. Among all of the organizations examined, this service appeared to be one of the most constrained with regard to resources (i.e., significant funding cuts while managing an increasing workload).

The avoidance of counselling duplication implies that priority would be given to those who do not have pre-existing counselling resources. This, along with session limits, are ways in which the organization can maintain minimal waiting lists.

At the organizational level, decisions on the scope of services are often influenced by available funding. Sarah, the occupational therapist who works at an organization that serves the homeless and other vulnerable populations, discussed how referral is beneficial so that her organization does not need to duplicate what is already available elsewhere:

> We have two physicians who come in twice a week for half days who provide [medication] support in that way. Most of the time you'll find that most…we don't want to duplicate services, right? So if somebody's pregnant, we send them to [multiservice organization]. They have a great prenatal program and [organization] has a great primary care centre up near like [community] area and then they also have like an LGBTQ+ that serves youth clinics, so often times people are already served by primary care physicians. They already have that hub. If they don't, then they come and they see our two doctors, but our two doctors are from [multiservice organization], right, so there's no need to recreate the wheel. A lot of our clients will use like at least a little bit of each agency, which is smart, right?

By referring clients to other organizations for specific needs such as pregnancy and physician services, this organization can avoid the expenditures and complexities that are associated with offering additional services. Although organizations may attempt to avoid service duplication, there appear to be systemwide issues causing duplication that is more difficult to avoid without closer integration. An example of this is a statement by the manager of a counselling organization about clients being fully reassessed when they access AHS services. In other words,

that assessment process is being duplicated because the results from assessments performed by outside organizations are not available or utilized when different services are accessed. This observation speaks to the questions of if and how the operation of organizations should be integrated and/or accommodated. Within organizations, a minimization of duplication can be easier to implement. At one multiservice facility, if a client requires a consultation with a psychiatrist, their counsellor is present at the appointment to provide background information in order to streamline the efficiency of the appointment.

The service delivery characteristics such as session limits, fees for service, organizational goals, treatment modalities, and scope of services all work to create the boundaries of what can be offered and to whom those services can be offered. When the available mental health services in the city are viewed in their totality, there is generally a service or multiple services that will cater to many types of needs. Some organizations are better equipped than others to serve diverse clientele with multiple needs. In some cases, clients may connect with multiple organizations simultaneously to meet their needs. Practitioners try to avoid service duplication, however, in order to make efficient use of resources.

Referral

Referral is a crucial component of mental health service delivery, and all of the interviewees and their organizations utilized referral to varying degrees. Broadly speaking, referral serves important purposes for both the organization and their clients. For the former, it became clear in this research that referral helps to fill gaps in available services and it also mitigates resource expenditures. For clients, referral allows them to receive the types of services that they need, and this may involve simultaneous usage of services that are offered by multiple organizations, or they may be referred when the organization of first contact cannot adequately

offer what they need. Also, there are services that specialize in assessment and referral and do not offer treatment. However, the practice of referral is not without challenges. Stakeholders such as physicians and the public may not have a comprehensive understanding of the numerous services that are available, and client participation in the referral process can be unsuccessful and resource intensive in some cases.

When engaging in the referral process, waitlists become an important factor. Waitlists for services can range from no waits to waits that are measured in years. For basic counselling services, all of the organizations examined have either no waitlist, a short waitlist, and/or a triage process. The latter point is notable because the practitioners recognize that some clients have more immediate mental health needs, and there are provisions in place to offer faster service for those clients. The ED in particular is designed around this approach; all patients are triaged when they seek treatment, and this applies to both mental health and physical health concerns. Even for organizations with less formal assessment processes than the ED, there are often various ways of triaging clients. At a basic level, for example, a client with more urgent needs may receive priority when booking counselling appointments.

The referral service that was studied in this research keeps a list of services, along with updated wait times for each of those services. Similar to the approach that is taken with individual practitioners, the referral service often utilizes a combination of referrals to services that have short and long waitlists. For example, if a client has complex mental health needs that require immediate attention, they might be referred to a service that is available immediately (e.g., crisis counselling) in addition to being placed on a waitlist for a service that takes longer for admission. This referral service, among others, is a crucial coordination resource for both clients and practitioners.

To further underscore the importance of referral services in general, a common finding in the interviews was that practitioners often did not have detailed knowledge of all the resources that are available in the city. AHS alone is very large and complex, with each program having its own purpose, admission criteria, and waitlist. Indeed, Elizabeth, a manager at a referral service, said her organization has to do a considerable amount of work in the form of information campaigns about available services:

> So the vast majority of the work that we do is letting [people] know what's available in the Calgary community because there's a lot. You know, we have 1,500 resources in the database here that we maintain and so because our clinicians do this job all day, every day, they get really good at resourcing and they really have kind of what I would call a breadth and depth of knowledge of resources that sometimes other people don't have, right? So that kind of idea – I hear it a lot – is that you know, there's no services, and there's such gaps out there and I think there are some gaps for sure. I also think there's a lot of gaps in knowledge, right? A lot of gaps in you know, sort of, I'll hear people say, "Well this doesn't exist." And well, yeah, it kind of does over here, or if that doesn't exist for this population, oh, well, there's this program. Do you know about that? And lots of times people don't so because they don't know about it, they assume it doesn't exist, right, in the landscape of services and supports in the community.

The figure of 1,500 resources in the database underscores the daunting task of keeping track of the resources that are available, along with which resources are suitable for each prospective client. At this organization, staff specialize in knowing these resources and coordinating the referral process. Practitioners at other organizations, however, are usually tasked with performing clinical and administrative duties on top of the referral role. In the interviews, it

seemed that most practitioners have a relatively good idea of what is available among the more prominent services that relate to their clientele, and they maintain a formal or informal database of those resources to make referrals as needed.

When clients are referred to services, there are often issues around follow-up by the originating organization. As far as the level of follow-up that occurs, there was a range of responses, from no follow-up to a more intensive case management approach. Aside from staffing and resource constraints that may occur when an organization decides if and how to follow up with clients, there are challenges around client participation. At the referral service, Elizabeth talked about how they used to attempt to follow up with clients, but that a lot of time and effort was expended on clients who would not follow through with the resources due to a lack of readiness or motivation. Also, she described how her organization used to call potential clients when they received physician referrals, with a 30-40% rate of failed contact or declined services. To make this process more efficient, letters are sent instead, and potential clients must call the service to move the process forward. Elizabeth explained that the organization is already inundated with the work that they currently perform, which is to give information, provide assessments, and coordinate referrals. These are examples of how an organization may need to make a decision to limit the scope of services and introduce certain efficiencies in their practices in order to devote sufficient resources to accomplishing their primary goals.

Case Management

Case management practices are essential to the operation of organizations, as well as to the treatment approaches that are offered to clients. It is important to note, however, that "case management" is being used here for the purpose of this discussion, rather than being a term that was explicitly used by all interviewees. Participants do not always use the same language to

represent this concept; another term such as navigation system may be used. Here, case management refers to the practice of facilitating the movement of clients through different resources and practitioners. In large organizations, this could mean coordinating the provision of services in different departments. For example, a client may be experiencing homelessness and mental health concerns. An employee of the organization may coordinate the client's journey so that they would meet with specialized staff to treat the mental health concern, another department for employment guidance, and so on. Often, case management practices extend to external organizations. For instance, a staff member of a small organization with a limited scope of practice may assist a client with connecting to a needed service in another organization. As discussed below, respondents tended to express that case management is used on an as-needed basis, such as with frequent system users, and that challenges arise with communication among organizations.

A type of informal case management that was offered by some providers consisted of connecting their clients with other resources and taking an active role in assisting the client with that process (e.g., helping to arrange appointments). However, a common limitation is that it is normally outside of the providers' scope to physically accompany clients to appointments at services offered by other organizations. A notable exception to this is that some organizations offer outreach services, so those staff members actively go to other organizations to work with clients who need assistance beyond what the original organization is able to provide. The value of cross-organization case management was acknowledged by Laura in the context of her small outreach organization:

> I think from a systems perspective, having sort of just a team, you know, one team that kind of fills that gap across the board for everybody because what happens is you have

> folks that maybe access some resources here but access some other resources there, access some other resources there and nobody really knows how to connect all those dots because we don't have all the information. So if there was one team that could kind of intercept all of those organizations and realize all the touchpoints that one particular person is having, be able to intervene and plan accordingly.

This statement not only speaks to the potential benefits of case management across organizations, but it also uncovers some of the gaps in knowledge that occur when a client is accessing multiple services. In other words, if each organization is meeting a client's needs within a narrow scope, opportunities may be missed to coordinate services more effectively from a collaborative care perspective to provide optimal treatment and avoid duplication of services.

Some organizations utilize formal case management approaches. These initiatives have different names, but the common goal is to provide an official process of coordinating services for particular clients. Formal case management is sometimes implemented through dedicated staff and there may be programs in an organization that are specifically dedicated to case management, such as the community case management program discussed below. Not all client care is coordinated this way even when these approaches are in place. For instance, some clients may have relatively simple needs, or they may be able to coordinate service contacts on their own. It became evident that case management tends to be implemented on an as-needed basis. In other words, practitioners determine whether or not a specific client would benefit from case management. In theory, this selectivity is both sensitive to the needs of the clients and serves as a way of managing resource use.

The ED environment is an excellent example of the degrees of case management that can be implemented. When a patient presents to the department, they may be given contact

information for external services if it is deemed that a more intensive management approach is not needed. In this case, it is completely the responsibility of the patient to take the initiative to contact those services, make appointments, and follow through. For more severe cases, including high system users, there is the option of connecting with programs within AHS that provide case management. The issue of frequent system users is particularly relevant here and was mentioned by multiple providers. Generally, respondents implied that many of these individuals with complex needs tend to be discharged from the hospital with insufficient resources to continue their treatment journey. As a result, there are formal efforts within AHS to coordinate discharge planning for this population in particular:

> There's a community case management program that involves Calgary Police, EMS, Calgary Transit, some of the shelters in town that meets once a month to discuss very like high burden systems users, whether they're people with mental health who always set fires in the Calgary Transit's garbage bins or that the police are often involved with. There's a group that tries to help mitigate their presentations to hospital and shelters and stuff like that and keep them housed.

It would be valuable to analyze the success of this initiative because it attempts to address a common frustration among interviewees, which is the "revolving door" phenomenon of some people going to the hospital frequently because they are not properly supported in the community, and may not have been discharged with adequate resources to address their mental health and basic needs.

When analyzing the case management approaches of a variety of organizations, it became apparent that there are particular benefits to implementing this approach within large, multi-service facilities. Specifically, two providers who were affiliated with one of the largest facilities

of this type were interviewed (one was a current employee and the other had recently started employment at a different organization). Both providers acknowledged the value of case management within the organization, particularly because it was feasible to accompany clients to different programs within the facility and to introduce them to the practitioners in those programs. This allows for clients to meet most or all of their needs in one place and may help them to feel more comfortable because of the "warm handoff" that occurs when one practitioner directly introduces the client to another practitioner. The current employee (manager of mental health services) of this organization, Andrea, stated that "we just started with our care coordination team idea about two years ago and now we've got a bit of a more robust team and now we're looking at moving all of our care to team-based care. So we haven't started yet creating those teams, but we're getting there. We're closer than we were two years ago." It appears that large organizations such as this one, which employs a variety of providers in numerous programs, are more equipped to offer this type of case management, as opposed to smaller and/or singularly focused organizations that need to provide external referrals for a lot of clients in order to meet complex needs.

Another way of conceptualizing the role of case management is in the limitations that clients face in managing their own treatment journey. As Laura stated,

> We're asking people in the middle of their mental health crises to try to organize themselves enough to get to all these appointments and schedule them. Like it's bananas that we would even ask people to do that…we feel like there's loads of resources out there and people can access them, but when you think about the logistics of actually accessing them, like, you don't have a home, you don't have a cell phone, you don't have a job. So you don't really even know that it's Friday. You know, every day is kind of the

> same thing – survival mode, survival mode, and so to think like, oh, ok, well we can refer you to a mental health support, they're booking eight weeks out but we can book you this appointment Wednesday at 9:30. You don't have an alarm clock, you sleep outside, you don't have a phone so we can remind you. Then that clinic because they don't have a phone to get a hold of that person, they can't confirm the appointment, so then they cancel it and so these are all things that happen on the regular for folks and so yeah, it is a massive, massive challenge.

This raises the question of the acceptable level of burden that should be placed on clients to manage their treatment options. Presumably, some clients will be more able and/or willing than others to play an active role in this management, and the interviews reflected this reality. It also reflects the ways in which programs may assume that clients can meet certain expectations, such as keeping track of scheduled appointments.

As discussed earlier, case management tends to be applied on an as-needed basis. In organizations that have limited staff (no specialized case managers in particular), counsellors who offer case management for their clients do so with acknowledgement of the fact that taking on this role draws attention away from more directly therapeutic aspects of the session. This was particularly evident with the crisis counselling organization. There are a limited number of sessions that a client can have, and some of that time may be used consulting with the client on appropriate resources and helping them with the process of connecting to those resources. Will expressed that he fills this role when needed but emphasized the idea that "nothing's free." This statement could be interpreted as an attitude that it is ultimately the client's choice to determine how the time in the sessions will be spent. This approach also contains an implicit assumption that the client will know what the best use of that time would be. Even so, there appears to be

attempts by practitioners to use their experience and guidance to encourage clients to make what they believe would be a more efficient decision, such as completing homework outside of the sessions and consulting with other resources to arrange for further supports.

In addition to time constraints for providers when deciding to offer case management, there are also issues surrounding communication between organizations, and in some cases, within organizations. Elizabeth described how communication can break down between different services:

> The communication shuts down a fair bit even with family physicians, we hear that a lot from family doctors is, you know, I sent my referral, [employer] sent them to program A, B, or C and that's the last thing I ever heard, right? So we really do need to do a better job as a system in terms of communicating with referral sources, letting them know, ok, your patient or your client is now in our program. Here's who you call if you have a question or concern. Oh, they're being discharged from our program. Here's the discharge summary. Here's some recommendations that you can now follow them in the community successfully and safely and effectively. So again, another big piece of things that we're working on right now is trying to really increase and improve our communication.

In order for services to be coordinated between different organizations, multiple staff members need to coordinate their efforts, and this is a task that appears to exhibit wide variability. Some organizations have formal relationships at an administrative level, while others communicate when individual practitioners decide to make those contacts on their own as they see fit. In AHS, the Connect Care initiative promises to improve communication and the sharing of patient records, which will enable AHS staff and patients to access this information from a central

source (Alberta Health Services, 2019c). Connect Care aims to reduce the number of times that patients need to explain their medical histories, and to enable staff to better coordinate patient care. Sharon, an AHS researcher, stated that there will be "growing pains" with this system, but she expressed excitement about the potential of this system not only for patient records, but also for physicians to see information about research trials in which the patient is participating.

Some participants mentioned that client privacy can hinder the process of sharing information. This is particularly relevant to sharing between organizations. Sharing within organizations, by contrast, appears to be easier. For instance, Elizabeth explained that AHS allows for information sharing internally as long as the requests are reasonable and relevant to the service being provided. However, despite the benefit of existing as a large multi-service entity, AHS encounters challenges with case management. According to Elizabeth, AHS programs usually implement their own case management practices and that "historically, we've had a lot of what I might call silos. So a lot of different programs that pop up for a variety of – again, well intended reasons – but the ability to connect all the dots and to have them all work as one system of care has really been a challenge and is something that is actively morphing and shaping as we speak."

Case management practices are implemented in some form by most or all of the organizations studied here. The name of that practice and the form that it takes can vary considerably on the basis of funding, organizational structure, policies, and initiative of individual practitioners. It is clear that most of the interviewed practitioners acknowledged the benefits of case management for at least some of the population that they serve. Due to resource constraints and information privacy policies, it would appear that this variability of approaches is inevitable. Perhaps the initiatives taken by individual organizations to improve their case

management practices will create a more robust body of knowledge pertaining to the most effective ways of coordinating care in the contemporary mental health care environment.

Operational Resources

Throughout this thesis, there have been several references to resource limitations and some of the ways in which organizations and individual practitioners shape their service delivery to work within these limitations in order to offer clients what they feel is the best care that they can provide within those constraints. This section will expand the discussion, with more of an explicit focus on funding and how it is tied to organizational performance and the political landscape.

Although operational funding was not studied in-depth for this research, it is beneficial to briefly discuss this area due to its impact on service delivery. For the non-profit organizations, there tended to be a combination of public and private funding. More specifically, public funding is usually provided by the provincial government through mechanisms such as grants, and the private funding usually comes from charitable organizations. The attainment of both types of funding is often based on competition between organizations. It appears as if this competition-based funding model is a way that funders have decided to ration limited financial resources, rather than being a way to determine whether one organization is more deserving of funding than another.

The competitive aspect of funding is also at odds with the goal of better cooperation between organizations, and this idea was discussed by Elizabeth: “We need to see things from an abundance perspective that, you know, it’s not about our agency and we want to protect our money and our clients and you have your agency. But it’s really about this is a group of people, a group of Calgarians that need help and how do we work together to make sure that we get them

the help that they need, right?" Although interviewees talked about competitive funding, none of them conveyed a protectionist attitude when considering the various resources that are available outside of their organizations. While it is possible that upper-level managers have different attitudes than client-facing practitioners, it seems as if the competition for funding is seen by participants as a requirement for operation within the service delivery landscape based on factors out of their control, rather than being a guiding principle of their organizations.

Most of the services operate free of cost to the client or on a sliding scale depending on income. The notable exception is private practice psychologists. When discussing funding with Patricia, there was an acknowledgement of the financial barriers that clients can encounter. This has the effect of attracting clients who can afford these services (most clients of this practitioner are middle to upper-middle class) or who have insurance coverage, presumably through an employer benefits package. Patricia went as far as to say that "I think that there's no doubt we have a two-tiered medical system and I think we've had it for years. I think to pretend otherwise is not being honest." In other words, many of the clients using free services, and particularly marginalized populations with limited resources, likely would not access the services that are offered by private practice psychologists.

An important component of service delivery that shapes what organizations can provide is the ability to hire staff members, and this is dependent on funding. The crisis counselling organization, for example, has experienced a decrease in the number of counselling staff due to budget constraints, but the demand for service has increased. Despite this, they are able to avoid lengthy waitlists. Examining organizational practices among different services as a whole, it appears that several strategies are utilized as a response to what participants would characterize as inadequate funding. These include employing managers who also maintain a client caseload,

limiting the number of sessions, fees for service, and hiring certain types of staff on a limited basis. Regarding the latter point, one of the organizations hires a relief intake coordinator for short periods of time to alleviate the workload for the full-time intake coordinator. Also, another service hires psychiatrists to meet with clients on a limited schedule, as opposed to having them work in house full time.

When this research study began, the province of Alberta was under the leadership of the Alberta New Democratic Party (NDP). There was a provincial election in April of 2019 that resulted in a leadership change to the United Conservative Party (UCP). Although the interview guide did not address politics in particular, some interviewees expressed political attitudes that were related to their programs since provincial support is often essential for their funding and operation, and this can be seen most clearly with regard to supervised consumption sites. Richard had concerns about funding for counselling services and stated that "If we look more in terms of the platforms of different parties, I mean NDP seem to be one of the closest to try to do that, but of course it's very difficult for them. My main concern is if it's UCP, what are they going to do to accommodate this type of service?" This demonstrates a level of concern for service funding, particularly if there is the possibility of economic austerity measures in the future.

Conclusion

This chapter explored some of the possible trajectories that clients can experience as they connect with mental health care services, as well as the issues that can be encountered along the way. A client's movement through these services depends on a number of interrelated factors, including client characteristics and what an organization can offer in terms of resources and client-provider fit; the determination of if and how a client will connect with a particular resource usually occurs during the assessment process. Individual practitioners differ in their

treatment approaches, and this influences how they work with their clients. Some gravitate toward more traditional and well-established approaches, while others are more open to newer approaches that may not have as much of an evidence base. It appears as if the effectiveness for an individual client – the "whatever works" concept – is of primary importance to some of the participants. When an organization or provider is unable to meet the needs of a client due to factors such as a lack of fit between client needs and what can be offered, referral becomes useful in many cases. Referral serves as a resource management tool and it is also a method to connect individuals with suitable resources. In some instances, case management is used to assist clients in navigating services within and between organizations. However, this tends to be used on an as-needed basis due to limited resources. Ultimately, the services that are provided depend on funding from public and private sources. The provision of this funding is often competitive, and organizations use data from performance measures in the application process. The political landscape can be a cause for concern with regard to funding, especially since most of the services studied here do not rely on out of pocket payments from clients.

Chapter 7: Conclusion

All of the services examined in this study aim to be beneficial to clients in specific and varied ways, such as stabilizing people in crisis, providing psychotherapy, or helping clients to meet their basic survival needs. There seems to be a recognition that treatment can be a complex journey, often without a discrete endpoint. The nature of treatment itself is variable in the sense that some approaches involve crisis stabilization, while others are more therapeutic in nature, for example. As expressed in the interviews, sometimes the different types of treatment approaches can occur simultaneously, such as when clients gain therapeutic benefit from crisis counselling sessions. In situations where harm reduction is the emphasis of the client-provider interaction, the prospect of treatment may be something that is optional, but not a condition of utilizing the service. The realities of treatment for both mental health concerns and substance use are complex, difficult, and often hampered by environmental factors that are not in the clients' control (e.g., availability of resources and the imposition of a stigmatized identity).

Although there is often an emphasis on respecting the autonomy of clients and allowing them to dictate the goals of treatment among these respondents, there are many ways in which providers impose particular treatment pathways, and these approaches tend to be formalized at the organizational level. For instance, a client might want to enter group therapy immediately, but the organization may require a certain amount of one-on-one counselling first in order to mitigate the possibility that the client would drop out of group therapy before realizing the full benefit of that treatment approach. The specific approaches toward work with clients reflect Scheid's (2004) assertion that treatment ideologies influence the practice of mental health workers. These ideologies can come from professional orientations that become embedded in organizational structures, which can then influence official policies at the administrative level.

These treatment ideologies are then translated into the control over clients that Lipsky (1980) outlined, such as structuring the nature of interactions, and this can include dictating the maximum number of sessions, the setting, session length, and what can be done. However, it would be inaccurate to state that these elements of control are inflexible. For example, practitioners are often granted discretion with regard to their preferred treatment orientations.

Provider discretion is a key element of flexibility in the treatment process. The interviews demonstrated that providers tend to have relatively wide latitude when deciding on the treatment approach(es) that they will offer. However, this does not mean that there is no accountability, and this can be seen in the organization that requires all counsellors to use session tracking measures. An example of discretion from the interviews is the ability of counsellors in the crisis counselling organization to grant additional sessions above the set limit, subject to management approval. Unsurprisingly, none of the participants gave an example of discretion that they exercised outside the bounds of what is officially permitted by their organizations. Although the interviews were confidential and anonymized, participants were likely reticent to reveal these types of practices, in addition to explicit criticisms of their employers (with some notable exceptions). Perhaps this type of data would be easier to collect through participant observation, similar to what Diamond (1995) undertook when he became a nursing home worker and made first-hand observations of the interactions between staff and residents.

Treatment orientations that encourage individual motivation and self-direction, such as the recovery model, are framed by participants as positive and empowering, but they also appear to be products of the limitations around community-based care. By utilizing numerous resources on a voluntary basis, clients are usually not required to undergo treatment, and this is a contrast with more coercive means such as institutionalization. Also, due to resource constraints,

managers of organizations may feel that their resources are best utilized by people who actively want to be helped, and this idea is consistent with the emphasis on readiness. In other words, there is the implication that it is of little value to attempt treatment with an individual who is not "ready" for the treatment process. The exact definition of readiness is unclear, however, and the degree of readiness is likely determined by both the client and practitioner. For example, a client may feel that they are ready, but the practitioner may not feel that the client is in fact ready, based on their own judgement, such as when they insist that clients complete a certain amount of one-on-one counselling before entering group therapy.

The concept of readiness appears to coexist in various ways with the idea of meeting people where they are at. For organizations that serve clients who seek service on a voluntary basis (this comprises the majority of services), clients are usually depicted as having their own goals and the freedom to make decisions, which are then "respected" in accordance with the treatment approaches that most practitioners seem to embrace. However, it is also possible that practitioners need to be flexible and responsive to client demands because clients could withdraw their request for service if they are treated in a coercive manner. This is where the provider-client negotiation process is important in order to reduce the probability of treatment drop out (Reis & Brown, 1999). Some organizations, such as EDs, have the ability to use coercive means in particular circumstances, but this represents only a small portion of the services that are delivered overall. Even though this flexibility is exercised, there are still limits imposed by practitioners and organizational policy, and these limits can be framed within the idea of readiness. In essence, practitioners have the authority to limit services in various ways and direct the treatment process in ways that they feel are optimal on the basis of resource constraints,

treatment ideology, ethics, and a determination of whether or not a client would benefit from a particular service.

Once a client is in a position to engage with mental health care services, case management practices have become a way to address some of the issues that arise with the fragmentation of these resources, particularly for individuals who struggle with self-directed coordination of their own treatment. Despite the efforts of practitioners and organizations to utilize case management with clients on an as-needed basis, it is clear that this approach does not fully or adequately address the challenges that are faced when seeking services. This is not necessarily a failure of case management itself; some practitioners acknowledged that a lot of clients would benefit from some degree of case management, but that the reality of resource constraints makes this difficult to implement optimally. Also, some practitioners expressed the reality of not being able to navigate the enormous array of services that are available, in addition to the difficulties of setting aside enough time to take on the role of a case manager. This is especially the case for organizations that do not hire dedicated case managers – practitioners who take on a case management role are also expected to work primarily as therapists.

With regard to the case management models outlined by Pescosolido et al. (2010), it appears as if most participants who are involved in case management would fit into either the broker or therapeutic model. None of the practitioners specifically stated that they were involved with the therapeutic team approach. This is likely the case because such an undertaking would be time and resource consuming, and all of the participants worked primarily as treatment providers or in management. The community case management program mentioned by Hannah, the ED physician, might take on a more intensive approach, but there were not enough details provided to make this determination. For those who are willing and able to undertake any form of case

management, there is the challenge of navigating a service landscape with varying types of treatment approaches, procedures, and insularity of professional cultures.

Organizations often rely on other organizations to fill gaps in services, and this is a component of case management and a consequence of resource constraints. However, this raises potential issues around referring clients to multiple outside services in order to manage resources at the organizational level and what the consequences may be on a systemwide level. Given that each organization has various limits, it follows that there would be limits systemwide. Therefore, referring someone elsewhere does not remove the resource burden from the entire system – it mostly shifts the burden from one location to another. It would seem that some organizations use referral as a way to offload potential clients, particularly if wait times grow to a level that is not acceptable to clients who may have more urgent needs. As Lipsky (1980) suggests, referral can be a way for organizations to respond to high demands while appearing to be helpful in the processing of clients. Essentially, it is common for organizations that offer a limited portfolio of services to use the resources of other organizations to fill the gaps in their services. When organizations offer treatment to prospective clients, those services are subject to various forms of rationing, which are used as ways of determining what to offer to particular clients (Lipsky, 1980); this will inevitably privilege some interests over others (Light & Hughes, 2001).

Complicating the issues around case management, the diversity of services and practitioners in the assemblage of mental health services creates a degree of insularity – organizations or professions can be said to exist as silos (Linden, 2015). The existence of silos not only has implications for case management issues, but it also affects how the assemblage of mental health services operates more broadly. Silos present a somewhat conflicting position – services rely on each other, but there are often significant gaps in communication and

protectionist attitudes toward information sharing. In AHS, the Connect Care program (Alberta Health Services, 2019c) is a positive step toward better and more efficient communication within one large organization encompassing a multitude of services. For information sharing between organizations, perhaps some issues can be mitigated through requesting permission from clients to share information in order to maintain the integrity of patient confidentiality practices. Other issues such as redundant assessments, differing treatment approaches, and professional cultures can also create a disconnect between organizations, and this could have an impact on collaborative care efforts. Respondents tended to recognize the value of better communication and more streamlined coordination between services, but specific and actionable solutions seem to be elusive.

Another type of disconnect that is particularly important to consider exists between mental health services and treatment for substance use disorders, and this manifests in the options that are sometimes limited for those who suffer from co-occurring disorders. When embarking on this research project, there was not a specific focus on substance use issues (there are no questions pertaining to this topic in the interview guide). However, it became evident very quickly that substance use is a major concern in the mental health services field, and that practitioners commonly encounter these issues to some degree in their practice. For the larger organizations in particular, such as homeless shelters and multi-service mental health organizations, substance use is of great enough concern that they implement special procedures such as naloxone training and regular washroom checks to prevent fatal overdoses. The disconnect between services for mental health and substance use was mentioned by some of the participants, and this issue is echoed by Davidson and White (2007) who call for better

integration. Among the organizations studied here, there did not appear to be specialized services for co-occurring disorders with the exception of some programs within AHS.

Considering that clients were not interviewed for this research, it is imperative to be cautious about drawing conclusions from client experiences based on practitioner narratives. The interviewees are providing explanations from their own perspectives, and this includes what they believe to be the experiences of their clients. Nevertheless, these perspectives can be valuable not only to gain insight into client attitudes, but also to examine how practitioners perceive what clients tell them. With respect to positive client feedback, it is important to think about how much of that is based on the self-perceived efficacy of the practitioners, and how much is an actual reflection of the clients' experiences; in terms of measuring performance, this parallels Lipsky's (1980) assertion that it can be difficult to distinguish between provider performance and client capability when examining outcomes. Many clients have complex and changing needs, and successes in one area and at one time may not fully reflect experiences in other areas of their lives. Also, interviewees tended to give accounts of positive client interactions rather than negative ones, so it is difficult to determine the true diversity of client experiences at a particular organization and with a particular practitioner. Lipsky's (1980) statement that most workers see themselves as doing a good job is generally consistent with what was conveyed in the present research. A thicker description of personal performance would likely require feedback from management and clients.

The example of Indigenous and LGBTQ+ populations feeling uncomfortable interacting with a faith-based organization underscores the need to take client perspectives into account when thinking about the effectiveness and quality of service delivery. When asked about the gap between the reality of service delivery and what would be ideal, Laura explained that "I feel like

from our patients' perspective, the gap would be about the size of the Grand Canyon. Like it's massive. On paper, it probably doesn't seem that big, right? We feel like there's loads of resources out there and people can access them, but when you think about the logistics of actually accessing them…" This is an example of how the assemblage of services may offer resources that attempt to fill a wide variety of needs, but the implementation does not fully take into account the challenges that clients may face in accessing what they need.

Over the course of this research, it appeared as if the interviewees tended to take the position that effectiveness has precedence over following predefined ways of assessing and treating client needs. In other words, if an approach is deemed to be effective for the client (based on perceptions of the practitioner and client), then the goals of those interactions have been met. When evaluating a treatment, the self-reported progress of a client may be more valued by some clinicians than a strict adherence to evidence-based practices – this can be classified as the "whatever works" approach. Another possibility is that the assessment and subsequent treatment processes are designed to make clients fit into the resources that are available. It may be easier and less costly to conduct informal assessments and to proceed with treatment as opposed to hiring personnel who are qualified to formally diagnose clients. This possibility does not negate earlier statements about the limitations around the usefulness of formal diagnoses and the emphasis on effectiveness. Rather, it is possible that this may be a factor in the decisions that underpin an organization's approach to assessment and treatment.

Questions about performance measures were included in the interview guide because it is important to understand the metrics that are used to assess how well practitioners and their organizations are serving clients. These data indicate what types of information are valued, how it is used, and to whom it is reported. There was an apparent bias toward quantitative data based

on these interviews, and some practitioners felt that qualitative measures were not being used to the degree that they would find ideal, and that this type of feedback tended to be more informal in nature (i.e., reflected in comments that clients convey to providers). These attitudes could reflect Lipsky's (1980) assertion that quantitative metrics are often used as surrogate measures for actual quality in service delivery, but this issue was not explored thoroughly enough to make such a determination. It could be argued that effective use of client feedback by organizations at a formal level would ultimately translate to better outcomes, in both qualitative and quantitative dimensions. Given the common goal of providing optimal services for clients and involving them as much as possible in their treatment processes, this feedback would seem to be valuable if the interactions are to proceed as a cooperative relationship. Lipsky (1980) argued that client demands have relatively little impact on the practice of workers, and it is difficult to determine if this is the case among the participants in the present study – it is an issue that would benefit from further research.

In an organization, there are many stakeholders with potentially differing interests and visions, and it is important to take this into account when analyzing the ways in which services are delivered as well as the future directions of the organization. It also underscores the importance of the work that providers perform within the organizational context; there are complex relationships that ultimately determine if and how various types of care will be delivered. In other words, training and treatment orientations interact with organizational factors to produce the ways in which clients receive care. The push toward more effective services for clients is a common thread among stakeholders, but the path is often challenging and frustrating. Andrea expressed her thoughts on the process of improvement by stating that "our focus is not so much on achievement as it is just sort of progressing in the right direction, right?" This implies

that the achievement of ideal services may never be realized, but the organization nevertheless continues to strive toward this goal.

Limitations

In the discussions of client experiences and how they relate to practitioners and the organizations, the perspectives are fairly one-sided due to the fact that clients were not interviewed for this research. The inclusion of this data would have allowed for an analysis that could compare perspectives and bring greater insight into how these services are perceived by clients and how they conceptualize their own treatment journeys. Even so, it is still interesting and valuable to examine providers' perceptions of client perspectives, and this was done here to some extent.

The different dimensions of mental health service delivery that were explored in this thesis underscore the large array of complex practices that make up the assemblage of mental health services. Any one of the major themes (e.g., case management, rationing, treatment approaches) could have provided ample material for an in-depth research project. This is not to suggest that this project was too broad; the intention was to study the work of mental health care providers in a more holistic sense. When exploring the various components of practice during the interviews, it was sometimes challenging to explore each topic in depth due to time constraints. Although the interviews were guided by a set of questions, participants were given the freedom to focus on issues that they found particularly compelling or important. As a result, a particular theme may have been addressed briefly by one participant, and in much greater depth by another.

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Appendix

Interview Guide

Much of the interview will be handled as a conversation, which moves back and forth between topics and reveals naturally occurring concerns, meanings and actions. Generic prompts will be used to elicit examples and stories (such as: "can you give an example?" "How did that happen?")

Background Information

Please tell me about your formal job description and the associated duties.
[Prompt for following specific information if not spontaneously included in narrative]

- How narrow or broad the job responsibilities are
- When and how their formal role involves assessing and/or treating and/or referring patients who present with mental health concerns

Please tell me about how you came to be in this profession.
[Prompt for following specific information if not spontaneously included in narrative]

- Reasons for interest in this field
- Educational background
- Work history in this field

Practice

When and how does your work involve aligning patients' needs with resources in mental health care?

- Location of, and gaps in, resources in the health care system and community
- Ability to connect patients with additional resources in health care or community

How are patients assessed for mental health issues?

- Is there a formal assessment process at the facility?

What types of treatment options are provided by your organization?

- E.g., psychotherapy, medication
- Are there any staff who prescribe medications for patients?
- How do clients fill their prescriptions?
- Do staff provide assistance with administering medications?

Do you feel like you are able to provide optimal care to patients who present with mental health concerns?

- Why or why not? (Cases where patients are not provided with needed help)
- Feeling of support in work
- Resources in your organization
- Ability to meet demand for services

Please tell me about some of the improvements that you would like to see in your organization that would be beneficial to your work.

- Improvements that enhance the practice of the provider
- Improvements to patient-facing services

How are performance and outcomes measured in your organization?

- Specifically, job performance of the provider and outcomes for the patients after receiving services