ASSERTIVE COMMUNITY TREATMENT (ACT) SERVICES:
CULTURAL COMPETENCE, CLIENT-CENTRICITY, AND THE ROLE OF
THE SOCIAL WORKER

by

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Abstract

This practicum report details my experiences in respect of the Assertive Community Treatment (ACT) program under Mental Health and Addictions Services, Northern Health Authority, Prince George, British Columbia, supplemented by a description of the outcome of my visit to the ACT program of the Community Support Network at Northcoast Behavioral Healthcare System, Ohio, USA.

My practicum learning goals pertained to the following aspects of ACT, especially in the context of Northern Aboriginal communities: procedures, services and clinical social work skills; client-centric and culturally competent treatment/services/support; and community settings. The report, therefore, gives an account of my activities and tasks, and details the outcomes. It includes statements of ACT team members as well as their experiences that contributed to my understanding of ACT application in the real world scenario. Anti-oppressive Social Work Practice and Aboriginal Healing Models form the theoretical frameworks of my practicum. The report also discusses the issues and challenges associated with ACT, apart from carrying my personal reflections.
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Glossary

Aboriginal Healing: The beliefs, values and practices associated with traditional healing practiced by Aboriginals.

Assertive Community Treatment (ACT): Client-centered, recovery-oriented treatment provided by a multidisciplinary mental health staff for community reintegration of clients.

Bipolar Disorder: Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.

CAN-C: A tool for the comprehensive assessment of the needs of the people with severe mental health problems. Its full form is Camberwell Assessment of Need-Clinical Version.

Client Empowerment: The choice of clients in choosing interventions, which involves cultural needs and preferences.

Community Support Network (CSN): Community mental health services provided by state mental health workers to people with severe mental health illnesses who are living in the community.

Critical Incident: Any situation faced by employees that causes them to experience unusually strong emotional reactions and that has the potential to interfere with their ability to function.

Cultural Competence: The capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours, and needs.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The standard classification of mental disorders used by mental health professionals in the United States and elsewhere.

Mania: Frenzied, abnormally excited mood.
PharmaNet: A British Columbia (B.C.)-wide network that links all B.C. pharmacies to a central set of data systems.

Schizophrenia: A complex biochemical brain disorder that affects a person’s ability to determine what is reality and what is not, resulting in delusions, hallucinations, social withdrawal, and disturbed thinking.

SYNAPSE: An electronic database for recording the daily activities and assessment of clients.

Sources: American Psychiatric Association, Canadian Mental Health Association, National Institute of Mental Health (Maryland, USA), Northcoast Behavioral Healthcare System documents, Northern Health Authority documents, Papadopoulos (2003).
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Further, I wish to thank the clients whom I worked and interacted with. Also, my sincere thanks go out to all those organizations that I visited during my practicum to achieve my learning goals.

I must not forget to thank Ms. Heather Lamb who was generous enough to share her MSW practicum report with me that gave me a fairly good idea about the structure and contents of the report.

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I have no adequate words to express my simple thanks to my parents and sister for their constant moral support, care, and guidance.
Introduction

This practicum enriched my professional understanding of ACT, especially in respect of client-centricity and culturally competent services. These components are integral to ACT, especially since individualized services are a predominant characteristic of ACT. Interaction with ACT team members who have hands-on experience in delivering ACT services and who had been extremely forthcoming in responding to my queries, greatly benefited me in terms of learning about the challenges and issues involved in providing ACT, for example, ethical dilemmas and implementation issues. Undoubtedly, professional codes of conduct and organizational policies can direct and instruct a social worker how to fulfill the professional role, but learning from experienced and on-field practitioners is a big advantage. In addition, my MSW courses enabled me to understand the ethical dilemmas in social work practice and the importance of client empowerment, which in turn helped me in my practicum.

In order to achieve my practicum learning goals, I felt an urge to gain cross-national insights into client-centric and culturally competent services. As such, I am glad I was able to visit Northcoast Behavioral Healthcare System (NBHS) in Northfield, Ohio, and interact with its ACT staff.

I supplemented my practicum tasks through research into ACT, cultural competence, and the traditional healing method used by Aboriginals. I think this exercise was essential in gaining a greater understanding of cultural aspects of treatment that takes applied, theoretical, and conceptual parameters into account. This will be beneficial for me as a practitioner since the circumstances in which I might find myself might vary regionally. In other words, there are no ready-made solutions—keeping oneself updated on literature helps. I have incorporated the research findings in chapter one as well as the literature review section.
This report consists of five chapters. Chapter One introduces ACT, Cultural Competence, and the Aboriginal Healing Method, given the paramount significance of these terms for my practicum. Subsequently, information about Northern Health, where I did my practicum, has been provided, followed by my practicum learning goals. The chapter ends with a description of the significance of my practicum. Chapter Two provides a brief critical review of the relevant literature. Chapter Three describes the activities and tasks that I undertook to achieve my learning goals. It then describes my practical gains. Chapter Four spells out the issues and challenges involved in providing ACT. It also contains my personal reflections and observations. Chapter Five provides the conclusion.

It may be added that the identity of interviewees (ACT team members) has been kept anonymous for the sake of confidentiality.
Chapter 1

Northern Health ACT Office and Practicum Learning Goals

This chapter introduces the reader to my practicum site as well as my learning goals. Prior to this, it provides an introduction to Assertive Community Treatment, Cultural Competence, and Aboriginal Healing Approach, which are associated with the practicum topic.

Assertive Community Treatment

Assertive Community Treatment (ACT) is a client-centred, recovery-oriented service delivery model for clients with the most serious mental illnesses and substance use disorders. Its origin is traced to the ‘training in community living’ programme that was launched during the 1970s at the Mendota Mental Health Institute in Madison, Wisconsin (Marx, Test, & Stein, 1973) by its medical professionals who realized the need for an effective community treatment programme to prevent clients’ readmission. The ACT model, unlike the traditional system of care, involves a multidisciplinary staff that works as a team in delivering the majority of treatment, rehabilitation, and support services required by each client in community locations (British Columbia Ministry of Health Services, 2008). The team typically comprises: a team coordinator, a psychiatrist, registered nurses, a social worker, an occupational therapist, a substance abuse specialist, a life skills worker, a vocational specialist, a peer support specialist, and a program assistant. Research shows that ACT, evidence-based practice, has yielded positive outcomes in terms of reducing hospitalization, enhancing housing stability, and bettering the lives of the recipients (Calsyn, 1998; Philips, 2001; Santos, 1993).

ACT, as a recovery-oriented treatment, is based on the Psychosocial Rehabilitation Model, which:
promotes personal recovery, successful community integration, and satisfactory quality of life for persons who have a mental illness or mental health concern. Psychosocial rehabilitation (PSR) services and supports are collaborative, person directed, and individualized, and an essential element of the human services spectrum. (About PSR Canada, n.d.)

Its main principles are as follows:

1. Psychosocial rehabilitation practitioners believe that all individuals have the capacity for learning and growth.
2. Psychosocial rehabilitation practitioners recognize that culture and diversity are central to recovery.
3. Psychosocial rehabilitation practitioners engage in the processes of informed and shared decision-making.
4. Psychosocial rehabilitation practices build on strengths and capacities of individuals receiving services and supports.
5. Psychosocial rehabilitation practices are person-centered; they are designed to address the distinct needs of individuals, consistent with their values, hopes and aspirations.
6. Psychosocial rehabilitation practices support full integration of people in recovery into their communities.
7. Psychosocial rehabilitation practices promote self-determination and empowerment.
8. Psychosocial rehabilitation practices facilitate the development of personal support networks by utilizing natural supports within communities or family members.
9. Psychosocial rehabilitation practices strive to help individuals improve the quality of all aspects of their lives, including social, occupational, educational, residential, intellectual, spiritual and financial.

10. Psychosocial rehabilitation practices promote health and wellness, encouraging individuals to develop and use individualized wellness plans (About PSR Canada).

Philips et.al (2001) spell out the following major principles of ACT:

- Specific Target Group—Services are targeted to a specified group of individuals with severe mental illness.
- Staff as a Team—Rather than brokering services, treatment, support, and rehabilitation services are provided directly by the assertive community treatment team that shares the responsibility.
- Small Staff-Client Ratio—The staff-to-client ratio is usually 1 to 10.
- Comprehensive Services—The range of treatment and services is comprehensive and flexible.
- Community Locations—Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings.
- Client-centered—Treatment and support services are individualized.
- Regular Services—Services are available on a 24-hour basis.
- Team Assertion—The team is assertive in engaging individuals in treatment and monitoring their progress (p.773).

It may be mentioned that the first ACT team in Canada was formed at Brockville Psychiatric Hospital in 1989/90. As far as Standards for ACT programs are concerned, they originated in the United States. They were improved, refined, and articulated in the form of the
British Columbia Program Standards for ACT Teams under the auspices of the British Columbia Ministry of Health Services (2008), according to which: “Client empowerment, involvement, and choice are fundamental to individualized, collaborative and effective ACT service delivery” (p.iii). According to Saleebey (2001), empowerment “indicates the intent to, and the process of, assisting individuals, groups, families and communities to discover and expend the resources and tools within and around them” (p.9). This report touches on the empowerment aspect by dealing with client-centric care.

**Cultural Competence and Aboriginal Healing**

Culture-based intervention has been considered important in northern social work practice as part of holistic healing. It involves provision of culturally sensitive treatment, use of clients’ cultural practices, and understanding of their cultural traditions, values and beliefs concerning health in order to provide quality care and service. In the words of Papadopoulos (2003), cultural competence is “…capacity to provide effective healthcare taking into consideration people’s cultural beliefs, behaviours and needs…cultural competence is synthesis of a lot of knowledge and skills which we acquire during our personal and professional lives and to which we are constantly adding…” (p.3). The table below is based on Sue’s tripartite framework (Centre for Addiction and Mental Health, 2004).

**Table 1**  
_Sue’s tripartite framework_

<table>
<thead>
<tr>
<th>Awareness of Own Cultural Values and Biases</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aware of and sensitive to own cultural heritage and self-identity with relation to ethnic and cultural definitions.</td>
</tr>
<tr>
<td>• Aware of own background/experiences, values and biases and how they influence psychological processes and affect clients.</td>
</tr>
<tr>
<td>• Able to recognize the limits of own multicultural competency and expertise.</td>
</tr>
<tr>
<td>• Acknowledges and is aware of own racist, sexist, heterosexist, or other detrimental attitudes, beliefs, and feelings.</td>
</tr>
</tbody>
</table>
- Aware of differences between self and clients in terms of race, gender, sexual orientation and other socio-demographic variables.
- Aware of cultural transference and counter-transference and defensive reactions.
- Engage in critical self-reflection regarding personal identity and attitudes to other groups, self-monitoring, and self-correction.
- Understanding of how oppression and discrimination personally affect oneself and one’s work.
- Values and respects wellness, self-care and self-awareness.
- Valuing and respecting humility and willingness to learn from others; open-mindedness.

### Awareness of Client’s Worldview

- Values/respects differences, diversity among and within a cultural group.
- Respects religious and/or spiritual beliefs of others.
- Respects indigenous helping practices and community networks.
- Values bilingualism.
- Can be non-judgemental.

### Knowledge

**Culture-Specific (Emic)**

- Possesses specific knowledge of normative values/beliefs about illness, normality/abnormality, help-seeking behaviour, culturally unique symptoms and interventions, interactional styles, and worldview of main cultural groups with which one is working.
- Possesses enough knowledge about cultures one serves to avoid breaching client’s taboos, health care beliefs, or rules of interaction.
- Knowledge of service resources for culturally-appropriate care.

**Culture-Generic (Etic)**

- Aware of institutional barriers that prevent some diverse clients from using mental health services.
- Knowledge of history, experience and consequences of oppression, prejudice, discrimination, racism, and structural inequalities
- Understands culture-bound, class-bound, and linguistic features of psychological help/interventions.

### Skills

**Engagement**

- Establishing rapport and therapeutic alliance in culturally congruent way considering culture-bound interpretations of verbal and nonverbal cues, personal space, and eye contact.
- Cultural empathy.

**Assessment/Feedback**

- Ability to assess issues as client’s level of acculturation, acculturative stress, and stage of gay or lesbian identity development.
• Ability to modify standardized tests/assessment tools and qualify conclusions appropriately (including empirical support where available) for use with identified groups, with consideration of their inherent cultural biases.
• Conduct assessments through open-ended questions to elicit client’s perceptions and beliefs, concepts/definitions of health.

**Treatment/Intervention**
• Ability to use cross-cultural communication skills.
• Ability to solve problem based on client perspective.
• Can seek consultation with traditional healers or religious/spiritual leaders and practitioners in treatment of culturally diverse clients.
• Ability to work with interpreters.
• Ability to exercise institutional skills on behalf of client; this involves out-of-office strategies (outreach, consultant, change agent, facilitator of indigenous support systems) that discard the intra-psychic counseling model and view problems/barriers as residing outside the minority client.

Let us briefly understand what the Aboriginal approach to healing is. Aboriginal communities such as Inuit, Metis, and First Nations believe in the inter-connection among people, the earth, and everything on it, and consequently their therapeutic interventions include setting up healing camps close to nature (Chansonneuve, 2007; McCormick, 2000). Besides, spiritual ceremonies of Aboriginal peoples such as sweat lodges, cedar baths, smudging, and Qulliq lighting aim at reducing anxiety and building interpersonal trust. In addition, “seasonal ceremonies, communal meals, potlatches, medicine walks, pow wows, feasts and giveaways…and Inuit community celebrations are all activities that promote healing through positive relationships” (Chansonneuve , 2007, p.37).

Chansonneuve (2007) spells out the following ten characteristics of an Aboriginal approach to addictions:

1. An Aboriginal approach identifies and addresses the underlying causes of addictive behaviours unique to the historical experiences of Aboriginal people in Canada.
2. The wisdom of Aboriginal cultures and spirituality is at the very heart of healing and recovery.
3. The relationship among suffering, resilience, experiential knowledge, and spiritual growth is acknowledged and honoured.

4. The interconnectedness among individuals, families, and communities is strengthened.

5. The differing pace at which individuals, families, and communities move through the stages of healing is understood and respected.

6. Healing encompasses a range of traditional and contemporary activities with an equally valued role for everyone in the circle of care.

7. Community health and community development are inseparable.

8. Culture is healing.

9. Legacy education is healing.

10. Healing is a lifelong journey of growth and change (p.60).

**Practicum Site: Organizational Information**

I did my practicum at the ACT office, which falls under the Mental Health and Addictions Services of Northern Health (NH) in Prince George, British Columbia. The NH multidisciplinary ACT team, with a client to staff ratio of 10:1, delivers outreach services in community locations and operates 7 days a week, 12 hours per day. It serves a total of 67 clients, of whom more than fifty percent are First Nations.

NH provides ACT to complex clients who are admitted on the basis of the following criteria (Northern Health, para 2):

- Clients with severe and persistent mental illnesses that seriously impair their functioning in community living (with priority given to people with schizophrenia or other psychotic disorders).
• Clients that suffer from other issues who may benefit from a coordinated treatment approach that includes coordination with the criminal justice system, homeless clients, and clients with acquired brain injuries and developmental disabilities.

• Clients with severe and persistent mental illness with significant functional impairments as demonstrated by inability to consistently perform the range of activities of daily living for basic adult functioning in the community, inability to maintain consistent employment at a self-sustaining level or inability to consistently maintain a safe living situation.

• Clients with severe and persistent mental illness who make high use of general hospital psychiatric services, specialty hospital services, tertiary level services, or psychiatric emergency services.

• Clients with severe and persistent mental illness with indicators of continuous high-service needs (i.e. greater than eight hours per month).

The NH ACT team consists of:

• Team Leader
• Psychiatrist
• Mental Health Social Worker
• Nurses
• Substance Abuse Specialist
• Peer Support Worker
• Life Skills Support Worker
• Vocational Specialist
• Community Occupational Therapist
The Team Leader's function is to collaborate on all the services that are delivered to the clients and is responsible for overseeing the care of the clients, co-ordinating the roles and functions on the team, and providing the "very best" services to clients. He also performs administrative duties such as budget monitoring. Responsible to the Team Leader, all members work together to provide flexible, community based services that are designed to promote the stability, recovery, and community reintegration of individuals who are suffering from mental illnesses and substance addition. This apart, mental health social workers, nurses, and substance abuse specialists maintain caseloads and collaborate with the interdisciplinary team to provide crisis intervention and follow-up services to clients. While the peer support worker's typical task lies in coordinating all services, the life skills support worker is responsible for assisting mental health and addiction clients with services "as outlined in an individual's care plan, with the goal of maximizing independent living" (Northern Health job description, 2010), and the Community Occupational Therapist provides "psychiatric community based occupational therapy to referred clients" (Northern Health job description, 2009).

Upon inquiry into the Continuous Quality Program, I learned that the ACT-PACT (Provincial Advisory Committee) undertakes provincial ACT evaluations in terms of hospital admissions for ACT clients, housing, and police contact. In other words, there is no separate evaluation of individual ACT programs.

When asked to share overall observation on the NH ACT program, staff stated that the program was unique since it reached out to a huge range of people including many of those who had not accessed traditional mental health services in the past, who found themselves incapable because of severe mental illnesses, and who were homeless and involved in criminal justice system.
**Practicum Learning Goals**

My learning goals fall under the following four categories:

1) **ACT and Clinical Social Work Practice in a Particular Context of Northern Health**
   - Acquiring professional clinical social work skills related to the activities of ACT social workers.
   - Gaining a deeper understanding of ACT as a recovery-oriented service delivery model.
   - Gaining an understanding of the range of services provided to clients.
   - Gaining a comprehensive understanding of the social work values and ethics as applicable to ACT.
   - Acquiring knowledge of most common clinical syndromes and common psychotropic medicines.
   - Learning how social workers engage family members of clients and/or provide family support and whether and what issues they face.
   - Learning crisis-intervention skills that are required for dealing with potential crisis situations related to clients such as risk of suicide.
   - Gaining knowledge about the parameters social workers use in conducting assessments and what issues or challenges they face.
   - Learning how social workers coordinate their activities with the ACT team, which involves understanding multidisciplinary teamwork.

2) **ACT and Culturally Competent Services**
   - Gaining a deeper knowledge of cultural competence in theory and practice.
   - Learning what makes ACT services at NH culturally competent.
• Learning how cultural considerations are factored into intake, assessment, treatment, and discharge.

• Gaining an understanding how social workers on the ACT team provide culturally competent services.

3) ACT and Client-centred Treatment/Services/Support

• Knowing how client’s participation is ensured in the development of the treatment/service plan and what this participation entails.

• Gaining knowledge about the integration of theoretical aspects of anti-oppressive practice through conducting assessments.

• Gaining conceptual knowledge about client-empowerment in respect of ACT.

4) ACT and the Community Setting

• Gaining an understanding of the provision of ACT services in community locations.

• Gaining an understanding of community resources specific to clients receiving ACT.

• Developing skills pertinent to the community aspect of services provided by social workers.

• Exploring the gaps, if any, in the provision of community living or support.

Significance of the Practicum

The significance of my practicum derives from its alignment with social work values as laid out in social work professional codes, from the theoretical framework of anti-oppressive social work practice, and from the limitations of the mainstream treatment.

Alignment with BC program standards. BC Program Standards provide:

ACT should ensure that clients receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with clients’ cultural beliefs
and practices, preferred language and disability (British Columbia Ministry of Health Services, 2008, p.45).

The primary obligation of a social worker is to maintain the best interests of the client (BCCSW, 2009, Code of Ethics section). As such, it is incumbent on him or her to adopt a holistic approach to intervention, based on the client’s preference or cultural background, rather than imposing any mainstream treatment. As the Code of Ethics provided by the Canadian Association of Social Workers (CASW, 2005) states, the social worker’s obligation is to respect socio-cultural diversity and individuals’ right to their “unique beliefs consistent with the rights of others” (p.4). Moreover, social workers are expected to demonstrate cultural awareness and sensitivity by striving to “understand culture and its function in human behaviour and society, recognizing the strengths that exist in all cultures” (CASW, 2005, p.4). Thus, the professional code of ethics itself provides that social workers do not neglect cultural aspects while dealing with clients. Moreover, cultural competence is required of social workers as they work in multicultural settings and come across clients who have a culture different from their own.

**Theoretical framework.** My practicum can be understood from the theoretical perspective of anti-oppressive social work practice (Heinonen & Spearman, 2010). Though this perspective addresses oppression suffered by the client at the individual, structural, and cultural levels, it may be underlined that oppression operates in various domains including healthcare. For example, imposition of treatment on a client, without considering his or her cultural needs, constitutes oppression. In the words of Carniol (1992): “[social workers] place their professional power at the disposal of clients in an explicit and conscious manner. They seek to share their limited power and to promote a client-worker relationship based on mutual dialogue rather than a
top-down interaction” (p.9). Thus, cultural competence is one of the applications of anti-oppressive social work practice. Philips et al. (2001) point out:

...some consumer groups believe that it [ACT] is a mechanism for exerting social control over individuals who have a mental illness, particularly through the use of medications; that it can be coercive; that it is paternalistic; and that it may foster dependency. (p.777)

From the perspective of anti-oppressive practice that emphasizes client empowerment, collaboration between therapist and client in determining goals and choosing intervention is considered critical to cultural competence (Hays, 2001; Lo & Fung, 2003; Sue & Sue, 2003; Tsang, 2003). Moreover, cultural competence is associated with client empowerment which is a stated component of ACT as per the BC Program Standards. Further, as per the holistic definition of mental health, provided by the Canadian Mental Health Association:

Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality. (Definition of mental health section)

The above definition suggests that well-being of the people with mental illnesses should be considered in the context of inter-personal relationships, community, and society. Thus, ACT which involves community living falls inevitably within the framework of a critical anti-oppressive practice approach which seeks empowerment of clients in contrast to coercing them and imposing interventions on them.

As for my future practice, it will be important for me to check any subconscious or unconscious, unintended, and inadvertent coercive practices in dealing with clients. Thus, the
words “client-centred” and “individualized” in the context of the ACT model and anti-oppressive practice hold special significance for me.

**Aboriginal clients and limitations of mainstream treatment.** Facts indicate that there is a high incidence of substance abuse among Aboriginals. “Alcohol-related deaths are 43.7 per 100,000 for Aboriginal people, compared with 23.6 per 100,000 for the general population” (Menzies, 2004, p.456). According to the National Aboriginal Health Organization (2011), “the use of illicit drugs is a serious problem among First Nations, Inuit and Métis. In 2002-2003 26.7% of First Nation adults used marijuana, compared to 14.1% in the Canadian population” (para.1). Tracing colonial roots to the alcohol addiction among Aboriginal people, Chansonneuve (2007) states: “The origins of alcohol abuse can be found in early Canadian history with the introduction of liquor by European fur traders in the early seventeenth century” (p.7). In the report to the Aboriginal Healing Foundation he points to the following gaps in intervention involving northern communities or Aboriginal addicts:

- A full range of services for the North from detoxification and treatment to continuing care programs staffed by qualified Inuktitut-speaking Inuit.
- Education and prevention resource materials available in Inuktitut.
- Pre-care services for Aboriginal youth that provide a safe place to withdraw from alcohol and/or detoxification and treatment services for Aboriginal women and their children.
- Cross-training for staff in an Aboriginal approach to addiction and mental illness (Chansonneuve, 2007, 73-74).

McCormick (2000) shares another perspective regarding cultural specificity of Aboriginals which poses a challenge to mainstream service providers: “One obstacle is that for
traditional Aboriginal people it can be very shameful and embarrassing to admit having problems of drug and alcohol abuse. This can prevent them from seeking help” (p.26).

Thus, there can be a missing component of a culture-specific approach which includes provision of culturally sensitive programs for Aboriginals, including their language and approaches to addiction treatment. In contrast, ACT is known for individualized service plans that call for culturally competent services. In my placement with the NH ACT Team, I was able to practice and reflect on these ideas.

In the next chapter I will provide a summary of the literature that relates to my practicum objectives.
Chapter 2

Literature Review

This review of literature revolves around the following key terms that are associated with my practicum: cultural competence, ACT, Aboriginal clients suffering from substance abuse and mental illness, and healthcare providers.

Research in the area of cultural competence has largely been conducted in the following contexts: exploration and examination of cultural barriers faced by Aboriginal clients in accessing healthcare services; perceptions and experiences of Aboriginal clients in respect of culturally competent interventions; and evaluation of effectiveness of culturally competent interventions, including ACT. Before I review these studies, it is important to underline that in contrast to service users, research on cultural competence has not been found to be conducted in the exclusive domain of cultural competence of ACT providers and the barriers they face.

The existing literature can be reviewed under the following sections:

1. Cultural Competence and Healthcare for Ethnic Minorities

Cultural competence in healthcare is being increasingly recognized as a vital strategy to address racial and ethnic disparities. Betancourt, Green and Carrillo (2002) conclude cultural competence in healthcare systems demonstrates the ability of the latter to provide care to clients with diverse cultural values and beliefs. Anderson et al (2003) reviewed five interventions to improve the cultural competence of health care systems:

i) Programs to recruit and retain staff reflecting cultural diversity of the community served.

ii) Use of interpreter services for clients with limited English proficiency.

iii) Cultural competence training for healthcare worker.

iv) Use of linguistically and culturally appropriate health education material.
v) Culturally specific health care settings.

“For each intervention reviewed, the outcome measures evaluated to determine their success were client satisfaction with care, racial or ethnic differentials in utilization of health services or in received or recommended treatment, and improvements in health status measures” (Anderson et al., 2003, p.72). The researchers point out that they could not determine effectiveness of these interventions because of few comparative studies. Other scholars have produced studies demonstrating how an awareness of a medical professional’s own cultural values and beliefs is critical to cultural competence (Gompertz, 1997; Williams, 2001). Gompertz (1997) also spells out the socio-cultural elements associated with racial and ethnic minority clients, which healthcare providers should take into consideration: culture-related syndromes, idioms of distress, socio-political functioning, and acculturation processes. Dell, Dell and Hopkins (2005) provide evaluation of holistic inhalant abuse treatment to First Nations youth and suggest social, psychological, and spiritual environments for recovery as part of resiliency.

From the perspective of anti-oppressive practice that emphasizes client empowerment, collaboration between therapist and client in determining goals and choosing intervention is considered critical to cultural competence (Hays, 2001; Lo & Fung, 2003; Sue & Sue, 2003; Tsang, 2003). In contrast, aiming to understand cultural competency comprehensively, Lo and Fung (2003) examined its generic and specific aspects in psychotherapy and spelled out the following phases: pre-engagement, engagement, assessment/feedback, treatment/intervention, and closure/discharge. In other words, cultural competence in healthcare is a complete process that begins prior to the phase in which the healthcare provider engages with the client. This is a major strength of their work.
The above studies, however, neglect research into cultural competence of service providers.

2. Barriers Faced by Service Users and Their Perceptions and Experiences

Under this segment, studies have focused on the barriers faced by culturally diverse clients in accessing healthcare services or utilizing them adequately, which underscores the need for cultural competence. Studies that bring out ethnically diverse clients' perceptions about mainstream treatment have also been analyzed in this section.

Cook, Omofolasade, and O'Brien (2005) document experiences of minority service users and their perceptions about cultural competence of healthcare providers. This study is particularly useful as the majority of minority service users were reported to be satisfied with healthcare in Omaha. This study can be a base for further research into factors of minority users' satisfaction vis-à-vis the mainstream health system. McCormick (1996) records experiences of the First Nations people of British Columbia in the context of culturally appropriate counselling, underscoring the importance of cultural competence. Similarly, Johnstone and Kanitsaki (2006) underline that on account of failure of health care providers to understand socio-cultural differences between themselves and their clients, communication and trust between them may be adversely affected, which in turn may affect quality of care received by clients. Other such studies have been conducted by Bischoff (2003) and Kelly and Bancroft (2007). In particular, Bischoff (2003) highlights the following problems emanating from consultations that are not culturally competent:

- Addressing clients' needs completely.

- Providing proper explanations.

- Showing respect during the consultation process.
Giving follow-up information.

Though the limitation of the above studies is the sole focus on miscommunication as a barrier in receiving effective healthcare, they can add or contribute to healthcare providers’ understanding of the importance of culture as a component of communication in healthcare. Besides, their findings can be applicable in the context of diverse ethnic minority clients.

Highlighting a different barrier, Kurtz, Nyber, Tillart, and Mills (2008) find that many First Nations and Inuit people feel it is not safe to access health care as they feel marginalized and have experienced oppression and racism within the health care domain. Women who participated in this study “talked about feeling judged and discriminated against simply because they are Aboriginal” (Kurtz et al., 2008, p. 57). This study was significant from the point of view of illuminating racism experienced by Aboriginals, revealing Aboriginal people’s perceptions about the mainstream health care system, and highlighting the stories of Aboriginal women in particular. As such, the combined issue of gender and racism was illuminated in this study.

Clearly, the necessity of cultural competence emerges from these findings. As regards perceptions of culturally diverse service users, Attagutsiaq, Joamie, Pitseolak, Ootoova, and Ijjangiaq (2001) highlight perceptions of Intuit elders about traditional health in contrast to mainstream treatment.

The above studies, however, do not take into account perceptions of healthcare providers in respect of delivering culturally competent services. But my practicum takes into account opinions and experiences of the ACT team in the context of cultural competence, which have been documented in this report in the next chapter.

3. Examination of Effectiveness of Cultural Competence of Healthcare Systems and Integration of Traditional Healing and Mainstream Treatment:
Incorporation of traditional healing and other theoretical approaches can result in good outcomes in terms of recovery and client satisfaction (Duran, 2006; Hill & Coady, 2003; McCormick, 2000; McCormick, 2005; Menzies, Bodnar & Harper, 2010). Studies have been conducted establishing linkages between the lack of cultural competence and such problems as incomplete assessments, incorrect diagnoses, and inappropriate treatment (Kirmayer, Groleau, Jaswant, Blake, & Jarvis, 2003, p. 153), because of which Aboriginal people tend not to use mainstream health services. The strength of these studies lies in highlighting the importance of traditional healing which should be integrated with mainstream treatment, given clients’ preference.

Illuminating power relations as a factor in cultural safety, Clark et al. (2010) discuss the power relations within the health care worker and client relationships. They state that health care workers should show respect for cultural taboos and form a multidisciplinary team. In this regard, it is apt to mention that the ACT team—the focus of this practicum—is multidisciplinary and, thus, contributes to serving clients by avoiding any rigid or particular perspective. For example, social workers, groomed in social work philosophy of person-centred treatment, add diversity to the team. Similarly, Anderson and Smylie (2009) evaluate health systems in Canada in terms of their performance in the context of First Nations, Métis, and Inuit clients and offer recommendations for further upgrading the system to better meet the needs of indigenous people. In a slightly different arena, Arn’arnaaq (2010) explores the place of health of Aboriginal Peoples within the health sciences.

In fact, a key theme running in the literature on cultural competence vis-à-vis Aboriginals in the context of integration of both traditional and mainstream models is the recognition of intergenerational trauma suffered by Aboriginals because of colonization. Menzies (2004) points
to the growing evidence that substance use among Aboriginals could be attributed to broader systemic issues, that is, their colonization in the past. Carvajal and Young (2009) write:

“Research shows an association between the effects of cultural dislocation, unresolved grief, depression, and low self-esteem with drug and alcohol misuse among Aboriginal groups in North America” (p. 211). Similarly, Chansonneuve (2005) documents cases in support of reclamation of connection with nature and other aspects of indigenous healing in assisting Aboriginal people with overcoming residential school trauma. Fletcher and Denham (2008) on their part provide a Nunawat case study based on their research into historical trauma, which suggest a move toward Aboriginal healing.

Chansonneuve (2007) explains that traditional Aboriginal teachings are especially important to addictions and trauma recovery because they have the potency to offset what was imparted to Aboriginal children at residential schools (they were taught that they were “savage and incapable of responsibility”) by nurturing “self-respect, self-care, and self-responsibility; and respect and responsibility for the family, the community, the nation, and the environment” (p.42). Hylton (2002) puts it in these words:

Healing, in Aboriginal terms, refers to personal and societal recovery from the lasting effects of oppression and systemic racism experienced over generations. Many Aboriginal people are suffering not simply from specific diseases and social problems, but also from a depression of spirit resulting from 200 or more years of damage to their cultures, languages, identities and self-respect. (Appendix C 5)

Similarly, Robbins and Dewar (2011) provide an account of application of Indigenous healing to Aboriginal communities toward their recovery from intergenerational pain. They advocate that future policy development and implementation support Indigenous peoples and communities in
maintaining and building upon the knowledge amassed by their ancestors. As such, the cultural component is required to boost Aboriginals’ self-esteem, whereas mainstream treatment does not take cultural needs into account (Blue & Darou, 2005; McCabe, 2007; Mohatt et al., 2008; Spicer, 2001).

Works have also appeared that explain the decline of Aboriginal healing in Canada because of colonization. In this regard, Deiter and Ottway (2001) point out that Aboriginal people perished after colonization as their population in North America went down to a fraction of 90 to 112 million. Mainstream health policies and services came to exclude traditional healing, exhibiting cultural insensitivity (Browne, & Smye, 2002).

The strength of the above studies in relation to substance abuse among Aboriginals is that they sought to locate the causes of addiction in societal structure and its institutions, tracing them to the colonial period. Hence, recovery has been linked to bolstering of self-esteem by connecting the Aboriginal clients with their culture and with their traditional healing practices. It may, however, be mentioned that not all Aboriginal clients might be addicts because of trauma resulting from colonial policies. Hence, client preference for the treatment should be ascertained rather than inclining toward a treatment model merely on the basis of research.

Finally, there exists literature that features research findings that support culture as a key determinant of health for Aboriginal people, for example recovery of First Nations, Inuit, and Métis women from illicit drug use (Niccols, Dell, & Clarke, 2010).

More culturally-sensitive research needs to be undertaken in this field in order to enable social workers to replicate success stories where possible. As Martin-Hill (2009) points out, there is an existing research gap between the community practice of traditional healing and the number of related cases available for review.
4. ACT and the Cultural Factor

Yang et al. (2005) through their research findings conclude that the ACT specifically designed for culturally diverse clients is effective in preventing relapse. On the other hand, Chow et al. (2010) highlight innovations and adaptations required for a culturally competent assertive community treatment team for severe and persistently mentally ill clients. In this regard, they suggest incorporation of the Multi-Family Psycho-education Group (MFPG) to an ACT Team. These studies indicate that ACT does not operate in a vacuum; program Standards are at best the guide, but the ground reality of diversity of clients and the nature of the clients' circumstances in life determine how ACT needs to be designed.

5. ACT and Related Issues

In a slightly different vein, Philips et al. (2001) highlight important issues that arise in the implementation of the ACT model, viz., a clear concept of the model's goals and treatment principles, safety of team members in the community, cultural competency, and professional boundaries in community locations. Cooley (2012) in the exploratory qualitative study on the perceptions of the social worker's role in ACT teams spells out the following four themes: interpretation of the social worker role; role clarification of the different ACT team members; overlapping roles of the ACT team members; and actions to help role clarification. Thus, proper implementation of ACT also needs a clear delineation of the role of the social worker in conjunction with coordination of his or her activities with the overall ACT functions.

This apart, there is literature on various aspects of ACT in connection with mental illness and substance abuse, for example, studies by McGrew and Wilson (2002), McFarlane (1997), Santos et al. (1993), Drake et al. (1998), Bond et al. (1991). But they do not have a cultural component as part of effective health care services.
This review has enlightened me considerably in terms of the importance of client-centricty and cultural competence, especially for Northern social work practice.

In the next chapter I will describe the specific activities and tasks I performed as well as the practical learning that occurred.
Chapter 3

Activities, Tasks, and Learning

In this section, I have provided a summary of what I did and learned in terms of activities and specific tasks toward achieving my learning goals as stated in chapter one. This is followed by the description of the outcomes or my learning gains. At the end, I have detailed my experiences in respect of the ACT program of Northcoast Behavioral Healthcare System (NBHS), Ohio, U.S.A.

Activities

Assessment and charting. I spent the first three weeks of my practicum orientating myself with the ACT policy and procedures, receiving training using SYNAPSE which is an electronic database for documenting client’s assessment and daily activities, and going out with the ACT team to deliver, administer, and monitor medication to clients and engage the clients socially.

It may be mentioned that the day at the ACT office begins with the Daily Task Meeting at which the team leader assigns the morning tasks to the team such as administering injections and medications, and social engagement with clients. Once I learned how to administer and monitor medications, my supervisor gave me the opportunity to undertake this task independently. Subsequently, my supervisor assigned me a client whose primary care coordinator was on leave. It was a great experience to learn about initial intake procedure and develop treatment care and weekly service plans for clients.

This apart, I learned how to conduct risk assessment and suicide assessment. I prepared a no-suicide contract for a client who was suicidal. In conducting assessments, social workers involve families as well. So, I contacted a client’s parents to learn about the level of financial
support they provide to their son and if they were handing him cash, since the client had a history of substance abuse. Importantly, I learned how to conduct mental health assessments. For this, I reviewed a mental status checklist, and entered information about clients’ behaviour, speech pattern, mood, and symptoms into SYNAPSE. Also, I learned how to diagnose mental disorders using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). For getting further insights into the diagnosis process, I interacted with the ACT team, watched videos, and read clients’ files. For instance, I had a meeting with a psychiatrist to discuss the case of a couple who were suffering from schizophrenia, and the woman had been reported to be physically assaulting her partner. We came up with solutions such as group counselling and therapy.

I became acquainted with commonly used abbreviations and symbols for charting such as AC (before meals), ADL (activities of daily living), bid (twice daily), C& S (culture and sensitivity), drsg (dressing), and FBS (fasting blood sugar). I also became familiar with the terminology for charting. For example, to describe the client mood, there are such terms as agitated, elated, euthymic (“mood is normal appropriately reflective of situation(s) of days events”), stable, and hypomanic (“a distinct period during which there is an abnormally and persistently elevated, expansive or irritable mood lasting at least four days but somewhat less intense than in mania”), whereas affect can be described as animated, blunted, fatigued, flat, or grimacing.

This apart, I learned how assessments could require intangible skills such as patience and flexibility of responses on the part of social workers. In this regard, I liked how the staff told me that it could be challenging if the client is not assisting with completing the comprehensive assessment. In that case, they exhibit patience in getting it completed and also refrains from using the word “assessment” since it could sound clinical to that client.
**Reaching out to clients.** I accompanied the ACT team in engaging clients in gardening, taking them to the Activity Center for Empowerment (ACE), taking them to coffee socials, going to their home, and checking their blister packs. Further, I accompanied clients to places such as the YMCA gym, Bear Lake outing, and restaurants for celebrating their birthdays. Such engagements also provide social workers with an opportunity to informally observe client behaviour for his or her mental health assessment. This apart, I attended the Homelessness Intervention Project (HIP) meetings. HIP is a gathering of multiple agencies that provide services typically to those who are not housed. It is an occasion for such agencies to connect with their clients as well as providing front line services to needy individuals by avoiding waitlists and red tape.

In order to make clients learn life skills and become independent in their activities of daily living, there are such practices as provision of ACE meal tickets that are given to clients who clean up their houses and come for injections. It is a sort of encouragement and reward for them to perform the work assigned to them.

I also worked with a client on anger management by knowing her problem and concerns. I gave her some homework to be followed up by her meeting with me. I also learned how money management for a client could be an important task for the team. In this regard, client’s spending of money on drugs can be an issue. Therefore, in one case, we divided the client’s use of money into four weeks, since he had used up his monthly allowance on drugs within a few days. Such issues present cases of conflict between client interest and what the client desires and require an appropriate response from the team. Thus, the practicum revealed cases when clients’ right to self-determination and the service team’s response may be mutually conflicting, but there are
exceptions when the client’s life is in danger and his or her choices cannot go completely unchallenged by treatment providers.

**Active participation in interdisciplinary team meetings.**

1. **Community Rounds:** Community rounds take place every two weeks. They basically involve provision of mental health and addictions services, forensic psychiatric services, and correctional services. It is ensured that clients are connected with at least one of these agencies.

2. **Staff Meeting:** Staff meetings take place every second week, enabling the ACT team members to discuss operational issues.

3. **Kardex Meeting:** Every second week, the entire staff goes through all the cases to discuss and resolve clients’ specific concerns. It is an opportunity for the whole team to collaborate on providing effective treatment. It is also a chance for the primary care coordinator and its mini team to have discussions on clarification of treatment goals and the tasks associated with achieving those goals. And on every alternative week the team undertakes a reflective practice—each primary worker identifies one client and has a more intensive reflective meeting with the mini team and the rest of team for a better coordination.

**Gaining knowledge about most common clinical syndromes and most common psychotropic medicines.** It is apt to mention the BC Program Standards guideline here: “All ACT team members shall assess and document the client’s mental illness symptoms and behaviour in response to medication and shall monitor for medication side effects” (British Columbia Ministry of Health Services, 2008, p.34).

I went through clients’ files to find out what they were diagnosed with, almost all of whom were found to be suffering from schizophrenia. Then, I read about schizophrenia and
other clinical syndromes such as bi-polar disorder and personality disorder. For example, schizophrenia’s symptoms are both negative and positive. Positive symptoms include hallucinations, delusions, grandiosity, thought disorder, and disorganized speech and behaviour. Negative symptoms include blunted affect, emotional and social withdrawal, weak concentration, lack of motivation, and passivity.

Also, I reviewed clients’ medical binders to learn what psycho-tropic medications they were on. I also read a book titled Psychotropic Agents (2010) edited by Burgmann, Magee, Remck, and Thompson, as suggested by my academic supervisor, which is an excellent source on medications and their side effects. Besides, I attended workshops to acquire knowledge about medications such as Latuda and Gen-Clozapine that are used to treat schizophrenia, as well as attending an extremely useful course titled “Social Work in Mental Health” at the university. Further, I interacted with the nurses on the ACT team to acquire first-hand knowledge of medications and their side effects.

The following tables serve as an example of my familiarity with medications and the syndromes they address.

<table>
<thead>
<tr>
<th>Medication Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic Agents</td>
<td>Alleviate psychosis found in psychiatric disorders such as Schizophrenia, Substance-induced Psychotic Disorders and Delusional Disorders</td>
</tr>
<tr>
<td>Antiparkinsonian Agents</td>
<td>Treat the extrapyramidal side effects of antipsychotic medications including akinesia (weakness) and akathisia (restlessness)</td>
</tr>
<tr>
<td>Antidepressant Agents</td>
<td>Treat disorders including Depressive Disorders,</td>
</tr>
</tbody>
</table>
Bipolar Disorder and Obsessive Compulsive Disorder

<table>
<thead>
<tr>
<th>Medications</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Disorder and Obsessive Compulsive Disorder</td>
<td>Treat Bipolar Disorder and Schizoaffective Disorder in order to prevent acute depressive episodes</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>Treat anxiety and insomnia</td>
</tr>
<tr>
<td>Antianxiety and Sedative-Hypnotic Agents</td>
<td></td>
</tr>
</tbody>
</table>

**Medications**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clozapine, and Quetiapine</td>
<td>Symptoms of schizophrenia in patients who have not benefited from other medications</td>
</tr>
<tr>
<td>Lithium Carbonate</td>
<td>A mood stabilizer, it treats Mania in people with Bipolar Disorder</td>
</tr>
<tr>
<td>Zopiclone</td>
<td>Sleeping problems</td>
</tr>
<tr>
<td>Lorazepam (Ativan), and Buspiron</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Lamotrigine, and Carbamazepine</td>
<td>Seizures in patients who have epilepsy. Lamotrigine is also a mood stabilizer</td>
</tr>
<tr>
<td>Benztropine</td>
<td>Parkinson’s disease</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Depression</td>
</tr>
</tbody>
</table>

**Critical incident stress debriefing.** I also became familiar with Critical Incident Stress Debriefing (CISD) when I attended a session addressed by a psychologist at the ACT office. It took place in the aftermath of a violent incident by a client at the ACT office where I did my practicum.
CISD is a process designed to mitigate the impact of a critical incident which is defined as "any situation faced by employees that causes them to experience unusually strong emotional reactions and that has the potential to interfere with their ability to function" (Northern Health-Workplace Health & Safety, p.1). In the interest of patient care as well as their own psychological health, social workers should be able to respond expeditiously in the wake of a critical incident such as suicide or attempted suicide of a patient or an act of violence toward a staff member. The responses include providing emotional support to traumatized employees, and contacting the appropriate organization such as Northern Health’s Employee and Family Assistance Program.

I think a social worker or any other professional must be conversant with appropriate responses to such critical situations that may occur at a workplace.

Visiting different program/sites of NH. I visited Nechako Centre and its Adult Day Treatment Program, Adult Detox, Youth Detox, Methadone Program, Eating Disorder Clinic, Early Psychosis Intervention, and Elderly Services Program. Further, I visited Community Acute Stabilization Team (CAST) that provides integrated Mental Health and Addictions services to adults who are over 19 years of age and present with a variety of mental health and addictions disorders as per DSM IV (Axis I and II) criteria. The varying diagnoses may include Personality Disorders, Mood Disorders, Bi-Polar Disorders, Obsessive Compulsive Disorder, Post Traumatic Stress Disorder, and Post-Partum Depression. In addition, I visited the Community Outreach and Assertive Service Team (COAST), which is a multidisciplinary team including a Social Worker, Nurses, Life-skill worker, and provides ongoing support for clients with persistent mental illness. Moreover, I visited the Community Response Unit (CRU) that is an entry point for any
individual seeking access to mental health and addictions programs. This multi-disciplinary team basically does the client intake and assessment, and facilitates referrals to appropriate services.

These visits were important for me to understand the functioning of these programs, their objectives, and services provided by them as well as their referral processes to facilitate clients’ referral to these organizations.

**Specific Tasks**

- Interactions with individual members of the ACT team: These interactions were aimed at learning about members’ specific roles, delivery of client-centric and culturally competent services, and about the issues and challenges involved.

- Understanding NH and NBHS policies, programs and procedures in relation to ACT and culturally competent services: I collected and reviewed material that could aid my comprehensive understanding of ACT as a recovery-oriented model in its manifold aspects. In this regard, I reviewed the pertinent material such as decision support tools, as listed on the Prince George ACT Peer Review Document under the following sections: Target Population and Admission Process, Structural and Functional Processes, External and Community Relations, and Administrative Organization.

- Discussion with the social workers: Client-centric and culturally competent services were among the key aspects of my discussion with ACT social workers. The related questions have been provided in the Appendix section.

- Research: I supplemented my practicum by conducting research into ACT’s association with clinical social work practice, cultural competence of ACT services, and client-centric services, including psychosocial rehabilitation principles.
Visit to the Department of Aboriginal Health: I visited the Department of Aboriginal Health at Northern Health to gain knowledge about Aboriginal Health and the related client-centered services.

Practical Learning

ACT procedures, client-centric services, and social worker role. At the outset, I will describe the role and values associated with social workers on the ACT team.

Social Worker on the ACT Team. The role of social workers on the ACT team consists in providing community based services for the stability, recovery, and community reintegration of clients who are suffering from mental illnesses and substance addictions. In this regard, their activities include conducting psycho-social and mental health assessments, entering into liaison with community partners, and identifying community resources. The NH document on job description spells out the following typical duties and responsibilities of a social worker:

- Provides immediate face-to-face intervention as required in response to client needs.
- Lead the team in engagement with the family members of clients and/or their natural supports in the treatment/service planning process.
- Leads the team in individual and/or multiple family support and therapy.
- Provides leadership to the team with respect to the entitlements, (e.g., financial, housing), advocacy.
- Provides crisis intervention and brief therapy services as needed.
- Consults with other professionals as needed.
- Provides information and educational materials to assist the individual and their identified supports to make informed decisions, and to access available resources.
- Provides leadership in building Mental Health and Addiction Services connections across the continuum of services.
- Collaborate with client in the formulation of a comprehensive service plan that is reviewed and modified with client on a regular basis.
- Provides outreach, case management, counseling, advocacy, and other needed services to clients in any environment including: the streets, shelters, prisons, hospitals, apartments, office, etc.
- Provides individually tailored services to each client based on psychosocial rehabilitation principles.
- Maintain written and computerized records, compile reports and complete other program documentation (including case notes, statistics, letters, psychological evaluations, etc.).
- Organize and participate in social activities with clients in the community.
- Coordinate and monitor referrals to community services, and advocate client participation in them.
- Leads groups, workshops, and in-services on topics such as substance abuse, safe sex, domestic violence, harm reduction and relapse prevention.
- Participate in on call rotation.
- Perform comprehensive mental health assessments of all clients.
- Cross train team members.
- Provide individual counseling/support to clients.
- In collaboration with other team members, develops policies and procedures.
- Attends and participates in team meetings.
- Maintains personal professional development.
• Performs related work as assigned.

Values and skills. Registered with the BC College of Social Workers (BCCSW), the ACT social workers at Northern Health are required to adhere to BCCSW guidelines in terms of social work ethics and values. When asked for a comment in this regard, the staff pointed out that since social workers work at a micro level, they are constrained in advocating change for overall social welfare, but micro changes impact the "big picture." For example, one of the team members liaises within the community where change trickles down to the front line. Other values the ACT social workers employ are beneficence and nonmaleficence. Furthermore, they are expected to act according to the organizational values and requirements.

It is pertinent to list the skills/aptitudes necessary for success as a social worker for ACT. In this regard, the staff highlighted the following ones: independence, excellent judgement, troubleshooting capabilities, readiness to work with the unknown, aligning one’s actions with treatment plans in the best interest of the client, crisis intervention, mental health assessment skills, and an appropriate response to a client’s suicidal attempts.

I gained some of these skills during the practicum, as explained in my activities above. But I understand that it takes time and experience for a worker to become adept in the required skills, whereas soft skills such as sound judgment demand continuous learning. I also learned about the challenges involved. For example, the staff shared that the biggest challenge one encountered upon first joining an ACT team lay in not knowing the baseline, especially when one has 60 baselines to learn.

It is important to elaborate on the crisis intervention skills that I learned. The advantage of an ACT team in terms of crisis intervention is that the team has people from different disciplines who can come up with required responses, depending on the situation. The examples
include provision of medical help, admission to hospital, and provision of emotional support.

Further, the staff explained that though the first step in crisis intervention is to determine what is going on and then make the appropriate referral, it is important to respond according to the level of crisis, which can demand utilizing resources such as Davis Drive or hospital or contacting nursing staff for medications.

This apart, I learned that if clients are functioning below their baselines, this constitutes the crisis situation. In this regard, staff stated that understanding their baseline is the first part, which demands dealing with the potential crisis situation involving recording, recognizing, observing and monitoring. For example, if a person is kicked out of the house, it constitutes a housing crisis. In that case, the team member will work with the client to formulate a short-term plan and a medium plan as well as finding a long-term solution. Thus, problems are broken up into smaller pieces in order to meet the basic needs first.

Discussion with the staff further clarified that crisis intervention skills involve assessing the client, knowing the baseline, and identifying the risk factors from clients’ past history.

*Engaging families.* Social workers encourage family members/supports of clients to work with the team around the client’s care. In this regard, staff suggested that after meeting the clients, one should always get their permission to contact natural supports such as families since the latter know the clients best. The staff, however, added an important caveat that one should strike a balance between sharing too much information with families and involving them in treatment planning. One of the ways the ACT staff engage families is to take them out for lunch, which also fosters connection between clients and their families.

When asked about the issues faced in involving families, the staff informed that there were largely no issues and that families were usually positive on inclusion in treatment plans. If I
allude to my experiences in India, families exhibit much interest in being involved at every stage of treatment, beginning with the client’s admission. This nature of involvement is sometimes challenging for healthcare providers since they are faced with consistent queries and also need to assuage anxieties of families. Thus, depending on the case and the region, the social worker should be able to work with different sorts of families, for example, anxious parents, agitated siblings, or even passive guardians who just wait and watch.

**Working with other ACT members.** In documenting a mental health assessment, the social worker may want to seek assistance of a nurse and attend psychiatric appointments with the client. For example, the staff informed that nurses are contacted in order to know as to what symptoms specific medications are meant to address and in case they are not addressed, the issue is brought to the nurses’ attention and documented in SYNAPSE. Similarly, since social workers do not prescribe medications, they have the option to attend psychiatric appointments with clients so that they can voice their own concerns and get some more support and education from doctors.

In regards to coordination among team members, I learned that the team leader makes sure that they meet every day for planning and coordination of tasks. This apart, there is an informal peer review process for members’ adherence to the BC Standards.

**ACT procedures, and client-centric services.** This section explains my learning gains in terms of my understanding of ACT in conjunction with its client-centricity. Apart from the associated procedural aspects, statements of team members have been included.

**Referral.** Agencies such as Community Response Unit (CRU) refer clients by completing a referral form and submitting it to the ACT Program Team Leader for review. The form contains the client’s personal information as well as information pertaining to his or her medical
information/previous treatment, legal history, housing history, addictions/substance use, and risk assessment and service requirements. The admission criteria are based on the Program Standards for ACT Teams in British Columbia (as spelled out in chapter one).

*Camberwell Assessment of Need- Clinical version (CAN-C).* The Team Leader presents the client to the team at the team meeting and assigns him or her to a Primary Care Coordinator (PCC). The PCC enters the following information in SYNAPSE: a) enrollment; b) HoNOs; c) Diagnosis; and d) MRR, as well as Intake Package of Consents which consists of such elements as limits of confidentiality; consent to “obtain and release information”; and patient consent to access PharmaNet. The PCC then records the information pertaining to the client Face/Cover Sheet which has such components as Name, Date of Birth and Casebook #, Date of Current plan, Recovery Plan Number, and DSM IV Diagnoses. It is pertinent to mention the NH Policy Statement on Client-centric Initial Intake:

The ACT team will conduct an initial client-centered assessment with each new client that is admitted and has consented to receive program services. The initial assessment is the first step in the individualized treatment/service planning process and will begin to formulate and prioritize the current issues as identified by the client.

The PCC then completes the Camberwell Assessment of Need- Clinical version (CAN-C) by working with the client. “The Camberwell Assessment of Need (CAN) is a tool for assessing the needs of people with severe and enduring mental illness” (Slade, Thornicroft, Loftus, Phelan, & Wykes, 1999, p.1). It consists of 22 domains of life such as accommodation, food, physical health, psychotic symptoms, and money. Its purpose is to ascertain client strengths and self-stated goals, build therapeutic relationships with the client and the family, and make diagnoses of psychiatric and physical health issues. It may be added that client strengths are identified by
using the ROPES (Resources, Options, Possibilities, Exceptions, and Solutions) Document. Moreover, such comprehensive client-centric assessment reflects cultural considerations since client-specific strengths as well as the domains of life, as stated above, issue from their cultural specificities as well. In other words, NH’s culturally competent services reflect even in the initial stage of a client’s interaction with the team.

Recovery plan. Afterwards, the PCC schedules a recovery planning meeting to develop the Recovery Plan which involves using the “client’s self-stated unmet needs (from CAN-C) and discussing with the client to prioritize focus areas”: functioning in daily life; housing; work and/or school; interpersonal and family; mental health problems/symptom management; physical health/wellness; legal; and other. The team also conducts a risk assessment. At the staff meeting, the entire team gives inputs on this recovery plan, and revisions are shared with the client. The final recovery plan is placed in the recovery plan binder with the Face Sheet. To work on the plan, the client and PCC prepare a Client Weekly Schedule. Clearly, the NH ACT recovery planning process is client-centric, which is in contrast to the treatment plans that are imposed by healthcare providers and clients have either no voice or are neglected, as discussed in the literature review section. Such situations are worsened when there are cultural differences between the client and the practitioner, and thus, the latter fails to understand the needs of the client that may emanate from the client’s cultural upbringing, such as preference for traditional healing. Hence, the NH ACT model comes across as an antidote to client-disempowering practices.
The weekly schedule is used to make the daily task sheet. Task are assigned at the Daily Task Meeting. Revise and share with the client. Strengths are reassessed in 6 months. The final version of the recovery plan is placed in the recovery plan binder with the face sheet. Client and PCC make Client Weekly Schedule according to the Final recovery plan.

Figure 2: Recovery Planning Process (Summary of the above steps has been provided in the Appendix section)

Description of Comprehensive Assessments. Comprehensive Assessments have been categorized as follows:

- Psychiatric History, mental Status, and Diagnosis (Psychiatrist)
- Physical Health (Nursing Assessment)
- Use of Drugs or Alcohol (A&D Assessment)
- Education and Employment (Vocational Rehabilitation Assessment)
- Social Development and Functioning (Social Work or Mental Health)
- Activities of Daily Living (Occupational Therapist Assessment)
- Family and Relationships (Social Work or Mental Health Clinician)

It may be added here that not all assessments are done on paper; there is also a visual assessment that includes clients’ mental and physical health and their everyday living skills.
Procedure:

a) The comprehensive assessments will be completed within one month after the client’s admission.

b) The service coordinator will present the results of the comprehensive assessments at the treatment plan meeting where all the team members who have been assigned direct care with the client will be present.

c) The service coordinator is directly responsible to ensure that the client is directly involved with the treatment plan.

d) The service coordinator will ensure the client consents to any involvement of other agencies and social supports in the treatment plan. (Shoemaker, 2010)

Furthermore, according to the NH policy statement:

The ACT team will develop a collaborative, client-centred treatment plan with his/her appropriate supports. The comprehensive assessments will guide the development of the individualized treatment plan. As per the ACT standards, the treatment plan shall:

a) Identify individual strengths/issues

b) Set specific short-term and long-term goals for each strength/issue

c) Establish the specific approaches and interventions necessary for the client to meet his or her goals, improve his or her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible.

It may be added that the treatment plan is based on the client’s consent to the services the client wants—the services provided by the ACT team are:

- Comprehensive and multi-disciplinary mental health services.
- Transportation to various activities, appointments and services.
• Medication monitoring and administration by ACT.

• Photos for identification purposes, during outings, and activities offered by the ACT team.

• Open all incoming mail addressed to the client that arrives at the ACT office.

• Inter-Agency collaboration with community supports and services.

• Frequent visits and ongoing contact to support the client with treatment plan goals.

(Northern Health, n.d.)

_Discharge planning._ A client is discharged upon mutual agreement between the client and the ACT staff for termination of services. Discharge Criteria is defined by:

a) Client has successfully reached individually established goals for discharge, and/or;

b) Client has successfully demonstrated an ability to function in most major role areas (i.e., work, social, self-care) without ongoing assistance from the program, and/or;

c) Client moves outside the geographic area of the ACT programs responsibility, and/or;

d) Client declines or refuses services and requests discharge. (Shoemaker, 2010)

Importantly, client determination is at the heart of evaluation of treatment goals as well. The staff stated that the yardstick of the success of a treatment plan is the client’s self-reporting that the treatment goal has been met, and that client-centric care also takes cognizance of what the client feels about medication. In other words, client satisfaction or judgment determines the status of goals.

_Team members’ statements._ Let us also know about opinions of the team members regarding client-centric care, which have been paraphrased as follows:
1. Client-centricity of the ACT model aligns with the values of social work. Contrasted with a prescriptive approach, this model uses a partnership approach and its philosophy consists in psychosocial-rehabilitation according to which everyone has the right to self-determination.

2. The client-centered approach can be strengthened if the staff assess their own social work practice and guide themselves to providing client-centric care by enabling or empowering the clients to have control over their own lives which they often lack.

3. Clients may not meet staff’s personal standards of daily tasks nor does the staff impose their own standards on clients. The minimum standard that is expected of clients upon their assessment is safety, for example in cooking.

4. In order to provide client-centric care, one needs to know as much as one can about the client. This involves taking the client history, making assessment, and then figuring out what is most beneficial for the client by involving the client.

5. Client-centric care involves asking the client what he or she wants in a number of areas: medicine, culture, community, and money. This step is followed by appropriate action by bringing together and working with the PCC/mini-team and the client.

6. Treatment plans are not developed at the team’s desk. The staff takes the CAN-C, followed by formulation of a treatment plan which is read by the client. In fact, clients review or read all the plans related to them such as community plans and weekly service plans. For example, if the client does not like the draft of the weekly service plan, it is modified accordingly. Also, medications are discussed with clients in terms of their satisfaction and feedback.

7. The client-centric approach extends to conveying the information from the client to the team. In other words, a patient understanding of clients’ needs and statements are important, so that any important information might not be missed.
In this regard, I remember a personal case in respect of a close relative whose queries to an assistant were not conveyed to the physician, which kept the patient in dark.

I have discussed the challenges and dilemmas related to client-centric care in the next chapter.

**Culturally Competent Services**

Northern Health (NH)’s view of Aboriginal Health is captured in the following statement:

Aboriginal health is holistic. It encompasses health determinates, is supported and fostered by Indigenous knowledge and know-how, and is community-based and driven. It includes health/mental health and addiction needs that call for accessible programs and services for all ages and stages of life. (Northern Health, para 2).

Moreover, one of the objectives of NH’s Aboriginal Health Services Plan 2007-10 was to improve cultural competency within NH through cultural training for its workforce and through culturally appropriate service policies.

The NH ACT team has Aboriginal partners such as Prince George Native Friendship Center (PGNFC), Carrier Sekani Family Services (CKFS), and Center Interior Native Health (CINH) that are important resources for knowledge about culturally sensitive practices as well for social engagement of Aboriginal clients. Of them, PGNFC promotes “wellness, balance and healing. In terms of the medicine wheel, balance means being strong emotionally, physically, mentally and spiritually” (Prince George Native Friendship Center), whereas with the guidance of elders, CKFS provides for healing and empowerment of Aboriginal families. Similarly, CINH follows a holistic approach to healthcare by promoting “physical, spiritual, emotional and cultural harmony within all Aboriginal Peoples who reside in North Central British Columbia” (Center Interior Native Health). It may be mentioned that the use of such community resources
imparts cultural sensitivity to the NH ACT program. This also addresses the limitations affecting non-ACT models of treatment, as explained in the literature review section.

The staff informed that the team is fortunate enough to consult with the ACT peer support worker who has lived in Aboriginal communities for many years and as such, the team strives toward cultural awareness and competency. The staff also shared that a client not making eye contact was a clue that it was sometimes a cultural determinant of behaviour. The staff aptly stated that culture is something not a book that one can read. As such, cultural competence demands observation and patient understanding of norms and of the ways people of different cultures act and behave. They gave an example that the team members struggle with knowing how First Nations clients handle their money. Some of the clients receive money and give it away to families or friends. So the team gets to understand that it is because First Nations people believe in sharing- if they can share food and clothes, they can share money as well.

The staff said that factoring cultural considerations into intake and assessment is “fact-finding”. This is possible by contacting families to learn about cultural norms and values and by exploring the sources that can be useful. For example, if the client is raised on an Indian reserve, the ACT team goes there to seek their help in determining how the client can be served better. Thus, I learned from the experience of social workers that connections are extremely valuable while you are working in a community. Also, one needs to refrain from assuming that the client’s way of living is the same as that of the practitioner’s. For example, the staff stated that often First Nations attribute illness to the spirit of a demon and they might prefer traditional healing methods such as sweat lodges.

Apart from interviewing the team, I gained a deeper understanding of cultural competence through research (explained in chapter one and two). I understand that real life situations
challenge application of theoretical knowledge, but I believe in expanding the horizon of my understanding so that I may overcome the constraints faced by practitioners. I agree that simply knowing about cultural competence is not enough, but knowledge is the first step toward it. At the same time, I also believe that social workers should steer clear of the risk of generalization. Just because a society is culturally diverse, culture-based intervention does not automatically lend itself to efficacy unless practitioners understand their clients well. It is to be borne in mind that social workers should not proceed with any preconceived notions but should always take the opinion of the client into account. In other words, if an Aboriginal client is not interested in or is indifferent to the use of cultural practices, then a mainstream treatment approach is appropriate. In this regard, staff’s viewpoint strikes a chord with my thinking that it is crucial to ascertain or understand identification of First Nations clients’ to their culture rather than assuming that every Aboriginal client prefers sweat lodge ceremonies. After that, the people or organizations that could provide support in traditional healing can be located and partnered with.

ACT and Community Work

Interaction with ACT team members as well as personal observation revealed what skills or aptitudes are needed for a social worker to operate successfully in communities. The skills include: the ability to form bonds with the community and different agencies such as shelter and housing; communication skills that convey the ability and willingness to collaborate with community organizations; and keeping oneself updated on ongoing development in communities where one serves.

Below are some of the paraphrased statements of staff in this regard:

- Flexibility is one of the skills required since once team members leave their office and are in community, they are in a different environment and do not know what situation or
circumstances they will find themselves in. Flexibility connotes the ability to provide services as per the situation, which could be different from the mode or nature of service which was provided previously. Further, good communication and assessment skills are critical to community work.

- Building relationships is required; networking is important.
- When team members interact with the staff of the agencies (such as a shelter) in communities as representatives of the ACT team, it is very important to form a good working relationship with them. With this, the team can expect to get agencies' help in serving the clients better.
- Community skills include patience; knowing the community; awareness of the resources; empathy; and being realistic, kind, persistent, assertive, and genuine.

I asked the staff whether they faced challenges working in communities. They responded that there was largely no challenge or issue involved except for personal safety for which the team had safety measures in place.

**Community Resources.** The resources listed below indicate that community resources are wide in scope in terms of diverse services that takes into consideration needs pertaining to gender, sexual orientation, and age differences. I think it is equally important that clients benefit substantially from the available resources. As such, clients’ needs, mood, and personal interest should be ascertained, so that the client may be introduced to the best of the resources.

a) Men’s Shelter: Ketso Yoh Center (24 hour emergency shelter for any male, 19 years and older), St. Pat’s Transition House (addictive recovery), Activators Society/Half Way House Forensics, and Active Support Against Poverty (ASAP).

b) Women’s Shelter: Active Support Against Poverty, Phoenix Transition House-supportive recovery beds, Elizabeth Fry Society, and Quebec St. Women’s Shelter.
c) Youth Shelter: Reconnect, and Melville House.
d) Food/Clothing: St. Vincent De Paul, Soup Bus; Soup Line; Good Food Box Program.
e) Northern Health Authority Residential Adult Housing: Iris House, Davis Drive, Urquhart House, and Hazelton Street Residence.
f) Youth Housing: NH has no current youth housing. All housing access for youth is via the Ministry of Children and Families.
g) Community Resources for Youth include Intersect Youth & Family Services, Teen Mothers Resource Program, Sexual Abuse Intervention, and New Hope Society (support and assistance for street involved women)
h) Community Resources for adults include AIMHI (support for persons with disabilities), Sexual Assault Center, Ace Center for Empowerment, and BC Schizophrenia Society, Education and Support Services, Seniors Outreach Program, Gay and Lesbian Association, Native Friendship Center, and CMHA (Canadian Mental Health Association) Connections Clubhouse.
i) Emergency Crisis Intervention resources include Community Response Unit (CRU).
j) NHA Community Follow Up resources include Community Acute Stabilization Team (CAST), Eating Disorder Team, and Community Outreach and Assertive Services Team (COAST).

Visit to Northcoast Behavioral Healthcare System (NBHS), Ohio

Located in Northfield in Cuyahoga County, Ohio, NBHS provides ACT treatment that falls under the Community Support Network (CSN). CSN delivers a full range of consumer-oriented mental health outpatient services. NBHS is one of the six psychiatric hospitals operated
by the Ohio Department of Mental Health (ODMH), and has the mission to make “recovery reality”, with the vision of “partnering to achieve wellness.”

My first day at NBHS began with the Learning Associate Center Orientation, one of whose elements was cultural competency with the following five components:

- Understanding one’s own cultural background.
- Acknowledging the client’s different culture, value systems, beliefs and behaviours.
- Recognizing that cultural difference is not synonymous with cultural inferiority.
- Learning about the client’s culture.
- Adapting optimal health delivery to an acceptable cultural framework (The Learning Associate Center Orientation, p.17).

After orientation, I was given self-defence training that is provided to new hires/students so they may know how to defend themselves in cases of emergency. I also visited residential services of the CSN and met with ACT clients, as well as the Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board of Cuyahoga County, which is responsible and accountable for planning, funding and monitoring of addiction and mental health services. I interacted with ADAMHS’s review specialist to know about the funding process for ACT programs since some programs had been closed because of the lack of funds.

I learned that the NBHS ACT team is an interdisciplinary team that is “designed to provide aggressive outreach, maximizing community living and reducing episodes and duration of inpatient stays. Services include Community Psychiatric Supportive Treatment (CPST), Pharmacological Management, Counseling and Support Services” (NHBS Brochure, n.d.). Consisting of 6 case managers, 2 nurses, and 1 psychiatrist, the team is entrusted with transitioning the patients out of hospital, where they have lived most of their life, to community.
It is currently serving 86 clients, of whom 50 percent are African Americans, 45 percent Caucasian Americans, with the rest 5 percent falling in the “others” category.

The NBHS ACT staff introduced me to an interesting tool called Solutions for Ohio’s Quality Improvement and Compliance (SOQIC) which is a standardized format used for mental health assessment, individual service plans, annual health histories, annual health assessments, and progress notes of case managers, nurses and doctors. In other words, all assessments including filling of forms are based on SOQIC that provides an “integrated documentation system” for mental health and addiction treatment and simplifies paperwork.

In regards to client-centric assessments, the staff informed me that the initial mental health assessment takes into account the comprehensive history of the client in terms of such components as living situation, family, origin, religion, culture, ethnic history, developmental issues history, sexual history, learning difficulty, medication history, legal history, and substance use. The client’s family is also contacted to gather information for assessment. The clinician then summarizes the information. Afterwards, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is used for diagnosis, followed by the team’s recommendation for treatment. This is for the initial service plan. The second assessment for the client is done for psychiatric evaluation, which includes questions related to the cultural aspect. This apart, there is a nursing assessment. All these assessments are followed by the formulation of a client-centric, Individualized Service Plan (ISP) within 30 days of the client’s introduction to the ACT team, and is reviewed with the client every 90 days. I reviewed the format of ISP that was helpful in knowing what makes up such plan or what its components are. For example, it contains: the goal and the objective stated in collaboration with the client; desired results (in client’s words); client
strengths and how they will be used to meet this goal; skills/knowledge needed; and natural/community supports needed.

Besides, weekly clinical supervision meetings take place on Wednesdays at which team members hold in-depth discussions on client cases. I learned that there was no overlapping of functions of the team members.

In respect of cultural competence, I learned that CSN captures the ethnicity of the client. This apart, the NBHS ACT team is in the process of incorporating a form, which uses race, ethnicity, gender and age, in the intake process. Interestingly, 45 out of the 86 clients do not know how to speak English fluently. Therefore, language interpreters assist with communication with clients.

Besides, the hospital has a Cultural Awareness Committee that meets once a month, takes ethnicity data, and comes up with survey summaries to provide culturally competent treatment. Moreover, hires are provided training in cultural competence within 30 days of hire in order to provide effective patient care. It is known as “Cultural Competence 101” taught by Professional Development Program Specialist from the Diversity Center of Northeast Ohio. As per the course’s learning objectives, the participants will be able to:

- Review participant sensitivity and awareness about various aspects of diversity and culture and how differences impact communication.
- Discuss effectiveness of employees in communicating cross-culturally.
- Recognize awareness of unconscious bias and how it effects relations with clients and colleagues.
- Identify skills to help create a more inclusive workplace environment.
What is striking is that when asked about the challenge involving client-centric services, the staff pointed to the similar challenge as faced by the ACT team in Prince George: clients sometimes ask for something that is not healthy for themselves. Further, when the clients are at risk of harming themselves or others, they are given a pink slip by the psychiatrist because of which they are checked out at the hospital against their will.

Overall, my visit to NBHS enlightened me on ACT considerably.

In the next chapter, I will discuss the issues and challenges associated with ACT as well as my personal reflections.
Chapter 4

Issues and Challenges

The practicum enabled me to understand the external and internal issues and challenges ACT team members can encounter, which are described below:

1. Divergent Ideologies of Team Members: Since an ACT team is multidisciplinary, its members with different training backgrounds tend to hold different viewpoints or ideologies in respect of client care. According to the staff, the social work code of ethics states that the client is the social worker’s foremost concern, while other professional bodies do not subscribe to this viewpoint. This can lead to conflict among team members as to how clients should be treated. Some members think that rules and schedules are needed and clients are expected to abide by them, for example in terms of arriving at the NH office at a particular time. On the other hand, members with a different background feel that the team could be more flexible in serving clients with severe mental illnesses who sometimes could not figure out what time it was or how to get an appointment. Further, those with a social work degree tend to focus a lot on the cultural aspect of healthcare and on structuralism, in contrast to members from other disciplines whose focus is quite different (Personal communication, July 30, 2013).

Thus, the staff suggested holding more workshops that will enable the team members to orient their mindsets to client perceptions of healthcare.

2. “Fine line” between Client Needs and Service Providers’ Perceptions about Their Needs: I learned how social workers come across situations when clients desire or demand things that are not in clients’ “best interest”. For example, while clients have a right to their money, addicts among them might spend it on buying drugs and alcohol. Similarly, a client who is depressed and suicidal might ask for something that will cause him or her harm. In such cases, social workers
have a reason not to give in to clients’ needs. Thus, the staff stated that there is a fine line between the perceptions of the client and the team as to what is best for the client.

Further, the staff shared that there could be an issue of paternalism when a team member sought an excuse not to give the client his or her own money if it could be used to buy drugs, and thereby, seeking to prevent the client from harm. The staff added that practitioners should refrain from enabling clients to make bad decisions in the name of client-centered practice by drawing boundary lines. For example, the staff that accompanies a client for grocery shopping with an allotted grocery budget, refuses to buy him Gravol since the client has a history of abusing it. Interestingly, the staff summed up this story with a powerful statement that though clients may get mad when faced with such situations, honesty and professionalism eventually contribute to a better client-social worker relationship.

Similarly, the staff pointed out a “huge” issue related to Form 20, which is a community committal form, which requires certain tasks for the client such as taking medications, living in appropriate accommodation, staying away from drugs and alcohol. As mental health workers, the team members are required to ensure compliance with Form 20, but clients might not like that, which affects workers’ relationship with clients.

Such cases involving dilemmas around client empowerment reminded me of the models of resolution of ethical dilemmas that I learned during my MSW course. For example, Miller (2007) presents the Ethical Principles Screen (EPS) framework developed by Dolgoff, Loewenberg, and Harrington, which prioritizes protection of life as the primary ethical principle, enabling practitioners to make decisions when conflicts arise between principles embedded in a professional code of ethics.
3. **Staffing, Workload, and Overlapping:** I learned that a lot of clients need help with activities of daily living such as shopping and laundry, which requires more staff. Further, because of workload resulting from overlapping of functions, staff desire more distinct roles. For example, the staff indicated the need for a better delineation of individual roles as well as hiring more workers to offset workload.

In this regard, I think quick recruitment to an ACT team is also quite important for effective client care. For example, the psychiatrist's position fell vacant during my practicum.

On positive note, however, the staff stated that overlapping was usually not a problem and that there were sometimes situations when they had to discuss resolving issues arising from the use of different approaches to client care.

An interesting and thought-provoking explanation was put forth by the staff that attributed overlapping to generosity of members, which issued from the integrated nature of ACT services, and which is what makes ACT unique. As a result, sometimes a social worker dispenses medication, which is typically the role of nurses, though specifically their roles are quite distinct.

4. **Culturally Competent Services:** The staff stated that culturally competent care could definitely be improved and there is a need for a better understanding of diversity of culture in the community the ACT program serves. Also, the staff stated that the First Nations clients needed more than medication and that strengthening culturally competent care demanded more time since the team members are faced with a "fast paced" job.

Additionally, the staff was quite forthright in suggesting that the cultural aspect of care begins with the environment at the workplace and said that Aboriginal culture should be reflected in the office environment, while pointing to the lack of a poster related to this culture.
The staff believed this was a step toward bridging the cultural gap between service providers and the clients.

5. Clients with Long Histories: In conversation with the staff, the staff indicated that the biggest challenge was helping the clients, who had long histories with poor outcomes and failures, to overcome their belief that they could not succeed.

   In other words, social workers need to be prepared for assisting a diversity of clients whose cases may vary, to the extent of clients' having fixed mindsets about recovery or their lack of faith in recovery owing to previous failures in life.

   It is pertinent to mention what staff suggested for improvements in the interest of clients. One of the areas where clients can be served better is that of corrections and forensics, apart from cultural competence and a clearer delineation of roles. Besides, the staff suggested that there be a provision of seeking client feedback on satisfaction with services and program.

Personal Reflections

At the outset, the integrative nature of ACT—because of which effective treatment does not hinge on a predominant role of any particular discipline—makes me visualize the position of a social worker as part of an orchestra. Any preparation for assuming the role of social worker on such a multidisciplinary team requires not just training or an orientation session but a mindset that is receptive to both client-centric care and teamwork. In other words, just being a good social worker in terms of aptitude and skills is not enough, but an understanding and appreciation of the roles of other team members and a willingness to accommodate their concerns and compulsions, arising from differences in backgrounds, are equally necessary. In this regard, I admire the professionalism and maturity of the Prince George ACT staff who, in response to my interview questions, exhibited an understanding of the ideological differences stemming from the
differences in their individual training, rather than any attributing issues or concerns to personal differences. In fact, the staff stated that they work as a team, and therefore, when one member is away, the other member picks up the required task.

I also realize that performance of the social worker’s role while being on a multidisciplinary team is challenging. It is not enough to know one’s code of conduct or professional duties. While on a team, team skills are also required especially when the team members differ with you in terms of dealing with a client. Thus, the ability to work on a team is I think an additional requirement that goes beyond one’s typical role as a social worker. Besides, composure and tact are also needed since as a professional one might know one’s job well, but the external constraints in terms of inadequate staff or workload could be disappointing, especially when you are highly motivated and you feel constrained by the external forces to deliver the best to the client. Thus, one does not operate in a vacuum. And one needs enough patience and maturity to be able to work in different circumstances that are beyond personal control, and at the same time, one should be ready to advocate change or reform when an opportunity arises. In this regard, I appreciate the straightforwardness of the ACT social workers who aired their views when I interviewed them.

I found that staff were keen to deliver the best in terms of client-centric and community care. However, a client-centered approach is beset with challenges, stemming from the lack of adequate staff and time. For example, though ACT involves work in communities, on some occasions clients have been asked to come to the ACT office for injections. Besides, clients who are assisted with grocery shopping once every two weeks might need more frequent shopping for such perishable items as milk and yogurt. But I feel that such challenges can be handled by addressing the constraints and that team members appear quite willing for improvements. In this
regard, it must be mentioned that the capacity for improvement should not be seen in negative terms, since efforts at consistent improvements reflect commitment.

Besides, I noticed that most of our clients were male, and we do not have male staff except for a couple of casual frontline male workers. Gender of the practitioner can be an important determinant for a client to be more open in interactions. For example, male clients might prefer discussing a problem with male practitioners. I give an instance related to the practicum. The other day, I went to deliver medications to the clients along with the front line worker who was surprised to find that a male client interacted with me so well and easily got along with me. The colleague opined that the client might be feeling comfortable since I am a male.

Overall, the practicum enriched my understanding of a client-centred approach- a practitioner needs to exercise prudence when faced with ethical dilemmas by knowing when and how to draw a line between client-centeredness and client interest. The staff clarified how new workers in the mental health field could misconstrue being client-centered as denoting listening to and validating clients' delusional thoughts. Thus, I learned how and when social workers can "gently challenge" such thoughts by redirecting the client to a different topic. Further, what I find striking is that the limitations of healthcare systems which are devoid of cultural competence, as discussed in the literature review section (especially p. 22), are substantially addressed by the NH ACT program which is marked by client-centricity and cultural sensitivity. For example, the elaborate recovery planning process is constituted of steps such as comprehensive assessment, client strengths, sharing and revision of the plan with the client, and assessment of the client's overall satisfaction with his or her goals every six months. Further, as mentioned in the literature review section, Aboriginals have been found avoiding mainstream treatment because of such issues as racism. In contrast, the community outreach program and
psycho-social rehabilitative ACT (person-centered approach) serve to assuage any such concerns of Aboriginal clients.

I now briefly share my thoughts on a comparison between the NH ACT program and the Ohio-based NBHS ACT program. While the NH program is excellent in terms of outreach and teamwork, I liked that NBHS has a cultural awareness committee that lays emphasis on cultural competence of service providers. I think that NH should have such committee that can discuss issues related to cultural competence of team members, listen to their viewpoints, understand their challenges and compulsions, if any, and offer recommendations for the necessary improvements on this front.

An important takeaway for me is the statement by the staff in regards to client-centric treatment, according to which it is important for a clinician to understand the best practices and incorporate them into the treatment, but this should be inclusive of clients' right to self-determination and their willingness to accept those treatment approaches. Indeed, this viewpoint and the other statements by the staff, as stated earlier, echo anti-oppressive social work practice that I read about in my pre-practicum classes.

This practicum introduced me to the challenges that I was unaware of. As I step out in the field of ACT, I feel myself confident since I am aware of operational aspects of ACT, even though I understand it is a challenging task and the level of work that I did during practicum was at the level of learning as an MSW student, not as an actual ACT professional.
Chapter 5

Conclusion

My practicum at Northern Health was a great enlightening experience in terms of gaining skills such as conducting mental health assessments, acquiring knowledge of ACT and related aspects, and becoming aware of the operational side of ACT. What I find extremely helpful is the interaction and working with team members who come from different disciplines and gave insightful responses.

What I learned about client-centric services will be beneficial for my future practice with communities. Though my previous experience in the social services field made me aware of the dilemmas and challenges to which I responded using my judgment, this practicum was more comprehensive as I not only gained knowledge of procedural aspects but learned how team members responded to dilemmas around clients’ right to self-determination. My familiarity with the issues and challenges, as described in the preceding chapter, will indeed help me prepare for delivering ACT services as a social worker. I am eager to sharpen the skills I acquired, especially on the assessment and crisis intervention front.

I discerned a linkage between ACT and anti-oppressive social work practice, which I had read about in MSW courses, in terms of emphasis on client empowerment. In practice though, there could be challenges to client empowerment, such as a clash between client need and workers’ perception of client interest. However, the practitioner should be able to use good judgment in resolving such cases. And I personally feel that in some situations, models of ethical dilemmas can be helpful. In this regard, I am glad that the MSW program introduced me to a number of perspectives, topics, and theoretical frameworks. Above all, it also provided opportunities for gaining practical experience.
I understand that in a different regional setting, I may encounter a different experience if I work as an ACT professional. However, this practicum carries great value for me in laying a strong foundation.
References


Appendix

Appendix A: Interview questions for ACT social workers

ACT and Clinical Social Work Practice in a Particular Context of Northern Health

1. Please explain your role and function, and the range of services offered to the clients.

2. What are the parameters you use in conducting assessments and what issues or challenges do you face in conducting assessments?

3. How do you engage family members of clients and/or provide family support in conducting assessments for Northern Health clients in particular and in general? Do you encounter any difficulties in this process? If yes, what are they?

4. Is there any overlapping with the functions of other ACT team members? If yes, does it create any problems in fulfilling your roles?

5. How do you coordinate your activities with the ACT team?

6. According to BC Standards: “All ACT team members shall assess and document the client’s mental illness symptoms and behaviour in response to medication and shall monitor for medication side effects.” Please describe how you assess and document that.

7. What are the crisis-intervention skills employed to deal with potential crisis situations such as suicide (just as an example)?

ACT and Cultural Competence

8. How are cultural considerations factored into intake, assessment, treatment, and discharge? How do you deliver culturally competent services?

Client-centred Treatment/Services/Support

9. Since ACT involves client-centered treatment services and support, how do you ensure this in fulfilling your roles? What are your practices in this regard? For example, according to BC
Standards, the client and the team “work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the [treatment] plan.” Is this your approach or that of the ACT team to make the treatment client-centered?

10. Do you face any issues in providing client-centered treatment/services?

ACT and Community Settings

11. What are the skills required to serve in communities?

12. Do you encounter any difficulties or face any issues in working in communities?

Overall Inputs

13. What are your general observations and experiences in regard to ACT, especially in the context of serving Northern Health clients?

Appendix B: Questions for other ACT team members

ACT and Clinical Social Work Practice in a Particular Context of Northern Health

1. Please explain your role and function, and the range of services offered to the clients.

2. According to BC Standards: “All ACT team members shall assess and document the client’s mental illness symptoms and behaviour in response to medication and shall monitor for medication side effects”. Please describe how you assess and document that.

3. What are the crisis-intervention skills employed to deal with potential crisis situations such as suicide (just as an example)?

ACT and Cultural Competence

4. How are cultural considerations factored into the treatment/services you provide? How do you deliver culturally competent services?

Client-centred Treatment/Services/Support
5. Since ACT involves client-centered treatment services and support, how do you ensure this in fulfilling your roles? What are your practices in this regard? For example, according to BC Standards, the client and the team “work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the [treatment] plan.” Is this your approach or that of the ACT team to make the treatment client-centered?

6. Do you face any issues in providing client-centered treatment/services?

**ACT and Community Settings**

7. What are the skills required to serve in communities?

8. Do you encounter any difficulties or face any issues in working in communities?

**Overall Inputs**

9. What are your general observations and experiences in regard to ACT, especially in the context of serving Northern Health clients?

**Appendix C: Summary of steps to make and carry out recovery plans**

1. Comprehensive assessments, including ALL past records.

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2. Fill out face sheet (page 1)

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3. Fill out draft of client strengths on top of page 2

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4. Present Comprehensive Assessment at Clinical Team Meeting

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5. Mini Team and Client have Recovery Planning Meeting
FOCUS AREAS: use client’s overall goals/needs and the clients responses to several questions (on the template) to describe priority focus areas

GOALS: transform overall goals/needs into specific 6-12 month goals

PLANS: list actions to attain each specific goal:

1. 1st draft recovery plan

6. Full team Recovery Planning Meeting: all ACT staff provide input. Client is invited to this meeting, if they wish to come

7. 2nd draft recovery plan

7. Client and care coordinator discuss 2nd draft. Client provides input and changes are made accordingly

8. final version of recovery plan

8. Client & care coordinator make a client weekly schedule which includes all of the staff and client actions and activities that are listed in the recovery plan

9. Client weekly schedule is used to make the daily staff assignment sheet for every day of the week (with specific staff assigned to every action/activity).

10. At the daily am ACT team meetings, the shift manager for that day makes sure that the specific assigned staff (or another staff) remembers to carry out the actions.

11. Client and ACT staff carry out the plans and activities as specified in the recovery plan
12. Ongoing assessment of goal attainment

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13. At 6-12 months: assess overall goal attainment and reassess as needed

>>>>>>>> repeat steps 1-12