

REPORT 2021

Repositioning Social Work Practice in Mental Health in Nova Scotia



CATRINA BROWN | MARJORIE JOHNSTONE | NANCY ROSS

Acknowledgments

We acknowledge that we are located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq. We are all treaty people. Decolonization and reconciliation are our collective responsibility and are integral to our vision for greater mental well-being.

We would like to acknowledge the work of the NSCSW's Social Justice Committee which brought this project to life through its concern for the health and well-being of all Nova Scotians.

We would like to acknowledge Kaitrin Doll for her significant contribution to this work.

Welcome

We welcome all readers to this NSCSW mental health paper. It is being introduced at a time when many are reflecting on how the COVID-19 pandemic has shaken our society.

More people in this province have reported higher rates of anxiety levels than anywhere else in Canada, according to a national poll commissioned by Mental Health Research Canada. About 27 per cent of Nova Scotians described their anxiety level as high since the pandemic began, a 20 per cent jump from pre-pandemic levels. That's five points higher than the national average of 22 per cent who reported high anxiety levels during the pandemic. Also, about 16 per cent of Nova Scotians have reported high levels of depression since the pandemic, more than double the pre-pandemic number of seven per cent. That compares to 13 per cent nationwide and six per cent respectively (McPhee, 2020). Alongside these numbers are also the long-standing calls by Black and Indigenous Nova Scotians for systemic reform to address both colonial and racist policies that continue to harm.

What we must come to realize is that each person's mental health is shaped by various social, economic and physical environments operating at different stages of life. Risk factors for many common mental health issues are heavily associated with social inequalities: the greater the inequality, the higher the risk. We must recognize that the impact of the last 7 months will have a long-lasting effect if we do not respond with policies and programs that view mental wellness as a life long journey fostered by healthy communities. If we fail to respond in a timely and robust manner then this impact will grow more and more severe in the coming years.

With this paper the NSCSW aims to create a critical discourse on the political, economic and social issues that impact the mental wellness of Nova Scotians. Through this paper and the campaigns to follow, it is our goal to *reframe* how we view mental health, and to present new models of care and social policies that can create meaningful change in this province towards greater mental wellness. As social workers we have the tools, and vision to support this change.

Our professional values — embedded in the respect for the inherent dignity and worth of persons, pursuit of social justice, service to humanity and integrity in professional practice — call on each of us to take action towards a better mental health and addictions system.

THROUGH THIS PAPER WE WILL ARTICULATE THE CORE VALUES AND PRINCIPLES THAT SHOULD FRAME AND DRIVE POLICY DECISIONS TO FOSTER GREATER WELLBEING AND MENTAL WELLNESS.

The paper will allow the NSCSW, its stakeholders and allies to set future advocacy direction, set priorities for action and act as a platform for collaboration to challenge and engage the current worldview on mental health. More specifically,

The advocacy paper has three main goals:

- To influence and guide NSCSW decision-making to promote greater well-being and mental health.
- To provide a formalized tool for the NSCSW, members and stakeholders to utilize in order to provide critical analysis and provide a public discourse for mental health policies and political positioning in Nova Scotia. The paper will be a tool that social workers and allies can use to highlight alternatives to the dominant discourse on mental health.
- To co-ordinate information and activities between NSCSW, community, stakeholders and all levels of government in order to effectively advocate for fundamental changes to mental health systems.

We hope that you find this useful and see your voice reflected in it.

In Solidarity,



Alec Stratford MSW, RSW
Executive Director/Registrar
Nova Scotia College of Social Workers

Forewords

Senator Wanda Thomas Bernard

There is a growing body of research in Nova Scotia which recognizes the pro-found and harmful effects of racism on the health and well-being of individuals and communities, with calls to address disparities and inequities in health care, including the provision of mental health services (Began et al 2012; Bernard et al 2014; Etowa et al 2017; James et al 2010). In one research study, participants called for major systemic changes necessary for effective intervention and treatment to reduce the harms of mental health and addictions issues in the African Nova Scotian community (Willis, Berry & Bernard forthcoming). Many of the suggested changes focus on breaking the silence about these topics and reducing stigma. Furthermore, research findings have highlighted the need for more community-based supports and services to provide outreach, intervention and treatment for African Nova Scotians throughout the province. The Association of Black Social Workers has been attempting to fill the gaps in service provision for over forty years, yet the stigma prevails and efforts to ensure more culturally relevant mental services have not been realized.

As I read this research report, I became excited about the potential for systemic changes in mental health and addictions services at this time in our collective history. I was especially drawn to the principles that have been identified for guiding mental health policy and approaches to clinical services. On their own, these principles could lead to a transformation of mental health and addictions services. The outcomes of the study *Repositioning Social Work Practice in Mental Health in Nova Scotia* clearly highlight the sense of urgency for structural change that my colleagues and I have been advocating for over many years. The study is comprehensive, inclusive and multifaceted, with multiple sources of data collection and analysis. The review of the literature is extensive and provides a rich context for the current study.

In *Repositioning Social Work Practice in Mental Health in Nova Scotia*, Drs. Catrina Brown, Marjorie Johnstone and Nancy Ross bring to light many of the problems with mental health and addiction services in Nova Scotia. It aptly points out ways in which the neoliberal government agenda has failed to adequately fund services that address some of the root causes of mental health issues as identified in the social determinants of health that are essential to health and well-being. In addition, the push towards victim blaming, pathologizing and individual responsibility, with little to no emphasis on culturally and socially specific services is very problematic. Critiques of the ‘bio-medical model’ and the adoption of managerial practices that promote efficiency, but are not trauma-informed, are clearly articulated through the voices of social workers, service users and supervisors who contributed to the research. The data analysis reveals the hard truth that social workers are undervalued and disempowered in mental health and addiction services.

Furthermore, it is noted that social workers lack a strong voice to address the shortcomings that they are left to address in their work when caught at the intersection of the ‘dissonance between the dominant bio-medical and DSM-based model and the bio-psycho-social social justice-based social work approach.’

Repositioning Social Work Practice in Mental Health in Nova Scotia concludes with a strong set of recommendations that are intended to transform the provision of mental health and addictions services in Nova Scotia. The recommendations cover a range of themes, including the need to reposition social work, to provide a guaranteed livable income and to integrate a more social justice-oriented approach in mental health and addictions practices. It is anticipated that the study’s findings will influence policy, practice and education in Nova Scotia which, if implemented, will certainly transform mental health and addiction services. There is significant emphasis on the need for a paradigm shift away from a bio-medical model towards a ‘bio-psycho-social model,’ that is rooted in social justice and the social determinants of health, for both prevention and service delivery.

In essence, this study can serve as a guidebook for actions that will improve conditions that will help to address some of the root causes of mental health and addictions issues. However, it can also be considered a blueprint for changes in policy and practices that reposition social workers in the service delivery models in Nova Scotia. Most importantly, it will provide clear direction to the Nova Scotia College of Social Workers Social Justice Committee to develop strategic priorities and directions to advocate for the desired outcomes.

As you read *Repositioning Social Work Practice in Mental Health in Nova Scotia*, consider actions that you can take, based on the position you hold. What will you

do to help the Nova Scotia College of Social Workers move this work from research to action for change? As a social worker, and a founding member of ABSW, who happens to be moonlighting as a Senator, I look forward to continuing the essential dialogue needed to help shift the paradigm. I am deeply committed to help lead policy changes in mental health and addictions to more bio-psycho-social social justice-based social work practices.

Wanda Thomas Bernard

Senator for Nova Scotia (East Preston)

Jim Morton

This report represents a major milestone on a journey that began in late 2017. During that time many social workers contacted the Nova Scotia College of Social Workers to communicate distress about the state of mental health and addiction services in our province. A subsequent symposium, organized by the College's Social Justice committee, and drawing on the participation of social workers, service consumers and mental health advocates, validated these concerns. The symposium helped the College construct principles for guiding mental health policy and approaches to clinical services that, in turn, led to commissioning the research described in *Repositioning Social Work Practice in Mental Health in Nova Scotia*.

Drs. Catrina Brown, Marjorie Johnstone and Nancy Ross have produced an impressive piece of work. Gathering evidence from social workers who deliver mental health services, social work supervisors and service users, and using survey, interview and focus group methodology, they have assembled data that reflects the experience of those on the front lines of mental health and addictions work in Nova Scotia. The professors' exploration of workplace experience was augmented by an extensive literature and jurisdictional review and their decision to highlight the voices of informants strengthens the document you are about to read.

Repositioning Social Work Practice in Mental Health in Nova Scotia is an indictment on the state of mental health and addiction services in Nova Scotia. It identifies the failure of neoliberal governments to adequately invest in services or in the social determinants of health (like housing, income and food security) that are critical to human well-being. The report also provides critiques of the bio-medical model and managerial planning that adopts evidence-based practices that favour efficiency and cost savings at the cost of individualizing and pathologizing human experience.

And it draws the highly troubling conclusion that social workers have become invisibilized in the mental health and addiction service delivery environment.

Repositioning *Social Work Practice in Mental Health in Nova Scotia* makes twenty-nine recommendations including significantly increasing financial investment in the social determinants of health and in mental health and addiction services.

It points out the need for authentic community collaboration and for a much more effective integration of mental health and addiction services.

The research also underlines the need for strengthening social work identity, although as the authors point out, “it is not social work that is limited; it is the neoliberal, bio-medical delivery approach itself.”

Almost half of the report’s twenty-nine recommendations focus on the importance of shifting thinking about mental health and addictions toward a bio-psycho-social model for understanding symptoms and delivering services. A *bio-psycho-social model* recognizes that individual humans are not only biological beings; we are social beings who are part of the systems in which we live. We can’t separate our brains, our thinking – or our health - from the influences of our immediate and larger social environment.

A bio-psycho-social model recognizes that clients and their families are best positioned to guide service delivery priorities. Additionally, client and family-centred practice has particular relevance to social workers. Social work is about understanding individuals at the intersections of their relationships. These relationships include social and cultural systems. Moreover, family and other close relationships – those relationships that engage our behaviour, emotional reactivity and thoughts on an everyday basis – are pivotal to the issues and symptoms that bring clients to the offices of mental health and addictions professionals. As the report points out, “each person’s mental health is shaped by various social, economic, and physical environments operating at different stages of life.” Grasping this central idea will transform mental health and addiction services. Social workers are well placed to help colleagues on interdisciplinary teams attend to the social systems component of a bio-psycho-social model.

Repositioning Social Work Practice in Mental Health in Nova Scotia is not a conclusion, rather a milestone in NSCSW’s much larger effort. The reactions the report will stir are still before us. The work involved in realizing its significant recommendations will take concerted advocacy. It will no doubt call on our courage. It will certainly require all hands-on deck. We need social workers from across our profession, col-leagues from other disciplines who care about these ideas, and clients and family

members who know something better is possible, to share our resolve to achieve optimum mental health for Nova Scotians.

I hope you will read *Repositioning Social Work Practice in Mental Health in Nova Scotia* carefully. I hope you'll join us to help create the next steps in this critical work.

Jim Morton, Chairperson

Social Justice Committee

Nova Scotia College of Social Workers

Judy MacDonald

Repositioning Social Work Practice in Mental Health in Nova Scotia, authored by Brown, Johnstone and Ross (2021), is a comprehensive examination of the current state of service delivery in mental health and addiction within the province. Within this report the voices and experiences of social workers providing frontline services are heard, coupled with the lens of their supervisors, and the lived experiences and critical voices of service users.

Provincially, Nova Scotia has the largest percentage of its population living with (dis)Abilities (30.4%) of all provinces in Canada, well exceeding the Canadian average of 22.3% (Devet, 2018). Pain, flexibility and mobility were among the top three experiences of (dis)Ability related impairments, followed closely by mental health related (dis)Abilities (Morris, Fawcett, Brisebois, & Hughes, 2018). In examining age distribution, youth aged 15 to 24 years identified mental health related (dis)Abilities as their number one impairment (Morris et al., 2018). The statistics alone suggest a pressing need for a thorough examination of mental health services within Nova Scotia. This report provides a critical gaze into mental health services aligning with the exploration of accessibility and the identification of barriers to inclusion being examined and acted upon through our new *Accessibility Act* (2017). Further, like no time in our recent past have mental health concerns been more publicly acknowledged and generically experienced than in 2020 with the COVID-19 pandemic and its impact on isolation, loss and loneliness resulting in increased rates of anxiety and depression (Center for Disease Control and Prevention, 2020). So, we are in a pivotal time where it becomes critical to hear the voices of service users and social workers working within the systems and to envision progressive change thereby strengthening our service delivery. Nova Scotia has an opportunity to truly transform mental health

services, to draw on the strengths of our existing system and to implement change where we are clearly hearing it is needed. Our province is only the third province in Canada to pass an Accessibility legislation and in so develop standards of inclusion that we are so desperately needing.

One of the predominate findings within the report was the overarching emphasis on a bio-medical model of intervention which is based upon a medical diagnosis and a defined pathway of treatment that is individualized, time limited and often results in a pathologizing of service users' experiences or at a minimum a disregard of service users' voice. Within the medical model the emphasis is placed upon returning the individual to a relative state of normalcy, highlighting functionality as the primary goal. The medical model is deficit based and cure focused (Carter, Hanes, & MacDonald, 2017). (dis)Ability is not a fixed identity, as experiences of impairments vary dependent upon access to services, coping strategies, physicality, environmental stressors, community supports, access to adequate housing, food security and so forth. Ableism is "the belief that impairment is inherently negative... and should be ameliorated" (Carter, et al., p. 155). People living with mental health and addiction (dis)Abilities need flexible and accessible services that they can access when they need the support. Statistics Canada in its most recent survey has taken a new lens to (dis)Ability whereby they explore limitations within four categories; progressive, recurrent, fluctuating and continuous, recognizing that (dis)Ability takes on many embodied and experienced forms (Morris, Fawcett, Timoney, & Hughes, 2019).

"As social workers we need to destabilize, take apart and challenge dominant ways of knowing (dis)Ability. Through the process of coming to understand the different ways of knowing by those on the margins, we begin to redefine normalcy" (MacDonald, 2016, p. 141) and "remake the centre's norms" (Titchkosky & Michalko 2009, p. 6). Within this report a service user identifies the need for "more of an active voice for service users in designing and creating services" (p. 122). Another service user stressed "listen, really listen", as social workers called for more transparency in service delivery and the inclusion of staff and the communities in developing policy, along with a renewed emphasis to "consult with and include first voice in planning and organizing services" (p. 113).

The meta-narratives in mental health and addiction assessment and treatment which reinforce contraindicated dualisms, such as service user voice versus medical knowledge, or physiological/behavioural symptoms versus psychological pathology, need to be disrupted and replaced with a collaborative approach that has social workers and service users recognized as essential members of the care team.

Social workers bring a critical lens to service delivery with knowledge of a broad spectrum of social determinants of mental health. They are great networkers and advocates and will now be educated in critical clinical assessment and intervention at a graduate level from the School of Social Work at Dalhousie University.

The School of Social Work at Dalhousie University has listened to the health communities in recognizing that we needed to strengthen our clinical curriculum. The School, formerly the Maritime School of Social Work, has an impressive history of progressive social work, anchored on evolving social justice theories, such as feminist social work, structural social work, anti-racist and anti-oppressive social work. While keeping our firm beliefs in social justice at the base of all that we teach, we have moved into a stronger clinical focus with the development of critical clinical social work. I am very proud to say we have come together as faculty to write a newly published book, *Critical clinical social work: Counterstorying for social justice* (Brown & MacDonald, 2020) which was released in May 2020 by Canadian Scholars Press. Within this book there is a significant focus on critical clinical practice and mental health, with many specific case examples highlighting critical clinical skills.

Social work is ready to be a key player in the transformation of mental health services within the province of Nova Scotia. Our knowledge base and skills are vital to a progressive transformation: “Social workers are trained to focus on the development of strong, collaborative, and respectful therapeutic or clinical alliances with their clients. Ethical practice includes transparency, client self determination and choice, and an understanding of the overall context of people’s lives and struggles, including attention to their basic social needs” (Brown, Johnstone & Ross, 2021, p. 193).

Judy MacDonald, PhD

Director, School of Social Work
Assistant Dean, Equity & Inclusion
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Author Bios

CATRINA BROWN, PhD is an Associate Professor and Graduate Coordinator at the School of Social Work and cross-appointed to Gender and Women's Studies at Dalhousie University. Her teaching, research and writing focuses on integrating critical theory and critical practice with a focus on women's health and mental health issues, including "eating disorders," substance use problems, depression, sexualized violence, trauma and post-trauma. She has co-edited three books: *Critical Clinical Social Work: Counterstorying for Social Justice* (with Judy MacDonald); *Narrative Therapy. Making Meaning, Making Live* (with Tod Augusta-Scott) and *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders* (with Karin Jasper). She is a private practice psychotherapist adopting a feminist, narrative, discursive and collaborative approach.

MARJORIE JOHNSTONE is an Assistant Professor in the School of Social Work, Dalhousie University. She completed her PhD at the University of Toronto in 2015, following thirty years of social service work in adolescent residential treatment, institutional and community mental health, school and college counselling with children, adolescents, adults and families. Her research interests include the history of Canadian social work, feminisms, mental health and social activism.

NANCY ROSS is an Assistant Professor in the School of Social Work, Dalhousie University. Her previous work as a clinical therapist in Mental Health and Addiction Services motivates her research interests in calling attention to the prevalence and impacts of adverse childhood experiences and gendered violence and in defining better measures of intervention and prevention. She applies a feminist peacebuilding and trauma-informed lens that acknowledges structural and cultural forms of violence are inseparable from direct forms of violence. This analysis moves from a narrow focus on individual responsibility to encompass a wider analysis of the social, cultural, economic, and political origins of violence to ultimately compel community responses. How might justice systems, healthcare responses, mental health and addictions services and educational institutions better respond to trauma to support individuals and families are questions central to her research. She has produced a short film titled *Women of Substance* that profiled stories of women meeting challenges of substance misuse and coproduced a second film titled *I Work for Change* which explored the complexity of social work while celebrating the profession.

Executive Summary

NSCSW MENTAL HEALTH COMMUNITY CONSULTATION 2021

Dr. Catrina Brown, Dr. Marjorie Johnstone and Dr. Nancy Ross
School Of Social Work, Dalhousie University

Background

The NSCSW's concern about mental health and addiction services, and the role of social work within those services, led to the contracting of this study; they requested a research report that could inform and guide their mental health advocacy efforts. We conducted a community consultation with mental health stakeholders that included interviews with service users, service providers, and service provider supervisors. We explored their experiences of mental health and addiction care services in Nova Scotia including perceived strengths and limitations of services, such as barriers, equity, access, funding, infrastructure, dominant mental health discourse, impact of marginalization and discrimination on mental health and mental health services, and alternative service delivery models. We interviewed 50 participants, conducted focus groups among service providers (one in Halifax and two in rural locations), and conducted an online survey with 115 respondents.

Literature Review

The research literature is very consistent with the findings of this consultation.

Neoliberalism, the dominant socio-political and economic ideology today, emphasizes both fiscal constraint and individual responsibility. This ideology is evident in cuts to the provision of social welfare services. Under neoliberalism, the social welfare state encourages individuals to be responsible for themselves while simultaneously limiting supports and services. However, with an increase of social inequities – such as poverty, inadequate affordable housing, food insecurity, and social discrimination resulting in marginalization (all of which are key social determinants of health) – there is a growing need for mental health services.

Mental health services are currently characterised by barriers and inequities. Within these structural obstacles, social workers are constrained from practicing in a manner consistent with their professional ethics and training: first by fiscal constraint, efficiency priorities, and managerialism, and second by the unquestioned hegemony of the bio-medical model.

Throughout Europe, Britain, and Canada, there is a growing crisis in the professional identity of social work as we grapple with working in structures of mental health care and the more encompassing bio-medical model: a model which focuses on the individual, pathology, and diagnosis, with little to no regard for the social contexts and realities of people's lives. Social workers often feel devalued in the hierarchy of mental health care provision and are often supervised by non-social workers.

In this report when we refer to social context we are including the social determinants of mental health, which are discursive, systemic, structural and relational (i.e., gender, race, class, sexual orientation, family, work, community).

In Nova Scotia the goal of transforming mental health and addiction services has been grounded through a tiered framework; services are organized into stages that gradually escalate in intensity and intrusiveness, in order to prioritize efficient use of system resources. To support this transformation the choice and partnership approach (CAPA) was adopted in some parts of Nova Scotia as a model for mental health service delivery. However, in Nova Scotia this service delivery model has been tailored to fit the existing bio-medical model and to reflect neoliberal economic and social philosophy.

In Nova Scotia, the use of a CAPA service delivery model within a tiered framework produces a paradigm that emphasizes a short number of sessions; prefers brief practice approaches, such as cognitive behavioural therapy and solution-focused therapy; limits who can receive services; and imposes long wait times to receive counselling support after an initial intake. The integration between the framework and the model is severely impaired when some tiers of service are under resourced and underdeveloped, and the choices the CAPA-based processes can offer to clients are severely limited or simply do not exist.

The way CAPA is being used in this province constrains the use of a bio-psycho-social approach, as it fragments service delivery into an assembly line process which does not favour holistic relational client-centred work. Under the current paradigm, limited opportunity exists to develop a strong relational approach with individuals

and families struggling with mental health and addiction issues. Many barriers to accessibility persist, particularly a lack of culturally appropriate services for diverse populations. The research literature has also strongly established that mental health issues such as depression and anxiety are directly connected to adverse childhood experiences and/or experiences of violence and trauma throughout life, and that substance use is often a way to cope with these experiences.

Consultation Findings

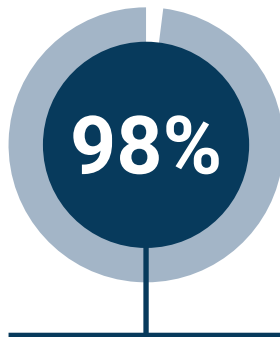
The literature and consultation findings are overwhelmingly consistent. All service users, providers, and supervisors critiqued the current implementation of CAPA as a service delivery model and the standardization of approaches through a strict bio-medical framework. Their critique included identification of the shortcomings of the bio-medical framework; the unacceptable wait times for seeing a counsellor; the prescriptive use of short-term modalities, which includes the limited number of sessions; inadequate time to develop therapeutic relationships; the devaluation of addiction-specific knowledge; increased paperwork; and management by non-social workers with little opportunity for clinical supervision. The current implementation of the CAPA service delivery model itself was seen to produce many barriers and inequities; a streamlining individualised one-size-fits-all approach not only disregards social determinants of health and the social context in which mental health and substance abuse struggles often emerge, but also responds poorly to the particular issues of diversity.

These findings were identified in both urban and rural settings but were even more pronounced in rural communities. The findings indicate that there is very little community-based work or commitment to providing culturally and socially appropriate services, for example to African Nova Scotians, Indigenous communities, and 2SLGBTQIA+communities.

While urgently needed, social advocacy and community work is not a part of the bio-medical mental health service delivery approach. The professional and ethical paradigm of social work is often in conflict with the dominant bio-medical model and this dissonance is reflected in this research.

Social workers noted the devaluation of social work alongside a sense that other professions don't know about – or fail to recognize – the scope of social work practice. Overall, participants were clear that social work did not have a strong enough voice or opportunity for input in the provision and policy of service delivery.

Among Survey Participants

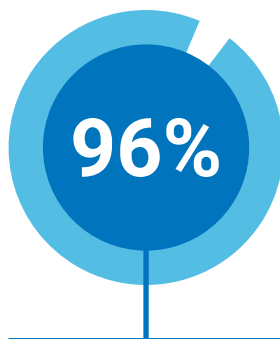


98% believed that there need to be changes made to the current provision of mental health services.

97% indicated that they did not believe there were adequate resources in the community to support the well-being of their clients (i.e., affordable daycare, affordable leisure, affordable housing).



85% believed there are not sufficient day programs or services available within the community for their clients such as drop in programs, faith-based group activities, or volunteer work support.



96% responded that they experienced barriers to providing services which include a lack of resources, lack of control and lack of opportunity to implement change.

82% reported that their training and perspectives do not have enough recognition in the current service delivery system.



Only 35% of social workers indicated they were satisfied with their current role.

The majority of those interviewed acknowledged that most people seeking addiction and mental health services had prior experiences of trauma and that a social work response would include a recognition of ‘what had happened to them’ as opposed to ‘what is wrong with them.’ This focus, central to social work practice, recognizes the importance of family relationships, community supports and the influence of structural and cultural factors that can contribute to experiences of oppression that is often unrecognized within a bio-medical model. Some social workers choose private practice as a way to maintain consistency with their ethics and training, but these social workers are aware that there are often economic barriers to private mental health services.

Different strategies are needed to respond holistically to the co-existence of mental health, trauma, and substance use issues. The attempt in Nova Scotia to amalgamate mental health services and addiction services was widely critiqued by participants of this study, as not only an inadequate strategy for service provision, but also for subordinating addiction services to mental health services, leading to the demise of addiction services and the corresponding increased privatization of addiction services to fill the gap.

Achieving the Full Continuum of Care

Our report describes how we as a profession can provide services that are rooted in a critical clinical approach that can supplement and enrich existing bio-medical services without requiring compliance to them. This report contributes to a culture that emphasizes and values mental health and well-being by emphasizing that individual mental health and wellness cannot be separated from the social determinants of health, including experiences of social oppression and marginalization. Therefore, this mental health advocacy report focuses on mental health, equity, and social justice and concludes that social work needs to be repositioned as an active advocate for social justice in mental health care services.

A range of interventions should be available in the provision of mental health services, including individual, family, and group counselling, as well as community, financial, housing, and social supports. Individuals struggling with more severe mental health issues such as schizophrenia, bipolar “disorder” or major depression should be supported in a holistic manner that complements bio-medical supports and address their overall well-being, to avoid or reduce stigmatizing a person to a diagnosis. Supports should be ongoing as needed rather than focusing on short term interventions. The provision of mental health social services should address the continuum of mental health struggles people experience, and not only focus on the more severe experiences.

Government Is Falling Short of Its Own Goals

Nova Scotia released its first-ever mental health strategy, *Together We Can*, in 2012. The strategy was set to be completed within five years and outlines a number of action items within five different priority areas. In 2017, the Office of the Auditor General of Nova Scotia (OAGNS) completed an audit of mental health services provided by the Nova Scotia Health Authority, the IWK, and the Department of Health and Wellness. The Auditor General concluded that, at that time, the health authority lacked a province-wide plan for mental health services and policies, that the 2012 mental health strategy was poorly managed, and that there remained 10 strategy items not completed. The Auditor General also found that there was no plan by the province to evaluate the 2012-2017 mental health strategy to assess whether mental health services have improved (Office of the Auditor General of Nova Scotia, 2017).

The current strategic plan being implemented by the NSHA and IWK, *Milestones on our Journey* (2017), provides 10 strategic principles to improve the mental well-being of Nova Scotians. They include commitments to:

1. Collaboration.
2. Full continuum of wellness, care, treatment and support across the lifespan for people and their families.
3. Promotion of positive mental health for all people, families and communities
4. Actions and decisions informed by research and evidence-based practice.

This paper shows that very few of those principles have been actualized, as;

1. Decisions on programs and polices focus on standardized procedures, rather than collaboration.
2. Full continuum of wellness and care has not accounted for the social determinants of health, causing care to be symptom-focused.
3. Neoliberal ideology has forced cost containment and efficiency to be the driving forces of policy and program choices, causing supports and treatments to be individualized rather than working with individuals' families and communities to promote positive mental health.

4. Evidence based decisions made by the NSHA and IWK are narrowed to legitimized neoliberal and bio-medical approaches, and ignore the evidence that recognizes the importance of family relationships, community supports and the influence of structural and cultural factors that can contribute to experiences of oppression and mental well-being.

Repositioning Social Work to Achieve Strategic Goals

If the province is to achieve its goals, addressed in its strategic plans, that the Department of Health and Wellness and the health authorities are striving to implement, then the unique worldview and skills sets and scope of practice of social work must be actualized within the current approach. Repositioning social work to employ its critical clinical approach can enrich the existing bio-medical approaches and offer real choice to Nova Scotians. A choice that values mental health and wellbeing by emphasizing that individual mental health and wellness cannot be separated from the social determinants of health, including experiences of social oppression and marginalization. By employing the full scope of social work practice into the current strategic framework, Nova Scotians would receive mental health and wellness supports that would better align with the strategic goals of the province. This would create a system that is driven by:

1. **Authentic collaboration** which would recognise that the unit of treatment isn't just the person it is the set of relationships in which the person is embedded, and would move away from standardized decision making to allow for treatment and support to be reflective of the context and environment in which the person is embedded.
2. **Full continuum of wellness and care** would come to life through assessments, supports and treatments that account for the various social, economic, and physical environments that impact mental health throughout the stages of life.
3. **Promotion and support towards positive mental health** would focus on deconstructing social power and its impacts on mental health.
4. **Decisions informed by research based on inter-disciplinary worldviews** would go beyond a bio-medical analysis of mental health, and would include a bio-psycho-social analysis.

Bio-Medical Model



CLINICIAN IS THE "EXPERT"

A clinician determines diagnosis, treatment, the amount of service available, and when you are "well."



INDIVIDUALIZED

Treatments are focused on individuals who are ultimately held accountable for their own recovery.



PROCEDURAL

Mental health disorders are reduced to their simplest forms to provide standardized treatments.



BIOLOGICAL

Mental illness is viewed as a biological disease of the brain: inevitable, incurable, and genetically determined.



SYMPTOM DRIVEN

Focuses on treating those who are most symptomatic.



Given the failure of the province to implement, monitor and evaluate its own strategy, the health authority's inability to actualize their own strategic principles; and in the wake of a global pandemic that has impacted the overall wellness of Nova Scotians, specifically the most marginalized, new action is needed. Repositioning social work within the provision of mental health services as a unique discipline with the skills, values and evidence-based practices would provide Nova Scotians with the mental health services that they require to be well.

Recommendations

The consultation produced 29 recommendations. Our recommendations are informed by relevant literature and reflect the overall consultation and recommendations of the participants. The recommendations fall within a number of broad themes:

- Ensure that Mental Health and Addictions funding represents 10% of the total Department of Health and Wellness spending.
- Reposition and establish the values, identity, and professional training of social work within mental health care services.
- Develop strategies to address the dissonance between the dominant bio-medical and DSM-based model and the bio-psycho-social social justice-based social work approach.
- Protest the limitations of one-size-fits all-approaches to mental health service delivery, including accessibility, number of sessions, and restricted and prescribed clinical approaches, and advocate for increased accessibility and appropriateness of services for diverse communities.
- Redefine social work job descriptions to reflect a more fulsome and unified scope of practice that includes community advocacy, policy development, and health promotion and ensure that social workers receive clinical supervision from social workers.
- Examples that might be reconsidered and instituted include the Women Services Coordinator and the Problem Gambling Specialist positions which included 60% community development/health promotion focus and 40% clinical.

Bio-Psycho-Social Model



PERSON IN ENVIRONMENT

Mental health is shaped by various social, economic, and physical environments throughout the stages of life.



COLLECTIVE RESPONSIBILITY

We share responsibility for creating a strong, connected, and supportive society.



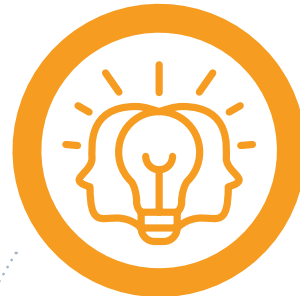
CRITICAL CLINICAL FOCUS

Assumes bio-psycho-social factors and focuses on deconstructing social power and its effects on mental health.



RELATIONAL

Recognise that the unit of treatment isn't just the person - even if only a single person is interviewed - it is the set of relationships in which the person is embedded.



COLLABORATION

Each client is the expert on their own life; both the practitioner and the client bring expert knowledge to therapeutic conversations and share responsibility for treatment in collaborative practice.



- Re-examine how the NSHA and IWK utilize CAPA, given the barriers and inequities created by the current implementation, and shift mental health provision from an efficiency-based approach to a quality-of-care and community-based approach.
- Promote the further development of training in critical clinical practice approaches that include dyadic individual work in tandem with group and family approaches, advocacy, non-profit services, and community-centred accessibility.
- Develop a social justice person-centred (individual and/or family), relational, and harmreduction approach that can address the complexity of co-existing mental health, trauma, and addiction concerns.
- Increase public education on mental health, trauma, and substance use with attention to decreasing issues of stigma and discrimination.
- Advocate for and work towards increased funding for training and resources in mental health and addiction services
- Create a guaranteed income for all Nova Scotians to reduce poverty, which is a major determinant of health.
- Promote social workers' unionization to protect their professional identity, values, and role in service protection, which will reposition social work within mental health care in Nova Scotia.

Conclusion

Mental health and addiction care in Nova Scotia is not working.

The failure to respond adequately to the mental health problems of our citizens results in increasing physical health issues, acute crisis care requirements, and lowered employment and daily living capacity. The current focus on fiscal constraint, efficiency, rationalization, and managerialism at the expense of the quality of care for the mental health and well-being of Nova Scotians will ultimately be a greater cost to the citizens and the province. The CAPA service delivery model has not been implemented well and the current tiered framework lacks a clear strategy for implementation with a disproportionate focus on bio-medical treatment. This has created a mental health and addictions system that inadequately addresses the mental health needs of the province. The current strategies and tactics embedded in the tiered framework require greater accountability, oversight, and resources, with a stronger focus on localised, community-based approaches to care. Increased financial commitment to mental health and addiction services is a necessity, and is an important long-term social investment.

Social work as a profession needs to be repositioned within mental health care in Nova Scotia so that social work can be centred in social justice and rooted in a critical clinical approach that can supplement and enrich existing bio-medical services without requiring compliance to them.

Adopting the recommendations of this consultation will require co-operation among the Dalhousie School of Social Work, Nova Scotia College of Social Workers, and Nova Scotia Government; policy and program development; and the unionization of social work as a profession. We need an integrated, collaborative approach to social work practice in the field of mental health and addiction that puts well-being and the alleviation of mental distress first.

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BACKGROUND

PURPOSE OF THE STUDY

The purpose of this study was to develop a mental health advocacy paper to articulate the core values and principles that should frame and drive policy decisions to foster greater well-being and mental wellness for the NSCSW. The NSCSW's concern about how current mental health and addiction services are serving the public interest and the role of social work within those services led to the contracting of this study. To address this issue, we conducted a community consultation that consisted of three components: individual interviews, focus groups, and an online survey.

Interviews were held with mental health stakeholders including service users, service providers, and service provider supervisors. For the purpose of this study: service users are those individuals who access mental health programs and services in Nova Scotia; service providers are social workers that work for community services, organizations, or health professions that provide services to support community mental health needs; and service provider supervisors are social workers who directly supervise the social work providers.

We also conducted focus groups with service providers in three different locations across the province including two rural and one urban settings.

The community consultation also included an online survey to learn what mental health stakeholders believe are the barriers to accessing mental health services and to gather information related to the social determinants of mental health, including gender, race, class, ability, sexual orientation, education, and migration.

Key objectives of this consultation were to:

1. explore the experiences of adults who have received mental health care from social work practitioners;
2. explore the experiences of social workers providing mental health and addiction services in Nova Scotia;

3. explore the experiences of supervisors and managers who supervise social workers providing mental health and addiction services in Nova Scotia;
4. determine the strengths and limitations of social work mental health and addiction services practice in the province;
5. determine the contextual circumstance of social work practice in the province, including access, barriers, funding infrastructure, equity, and dominant mental health discourse;
6. explore the participants' views on the impact of marginalization and discrimination on mental health and mental health services; and
7. explore and consider alternative service delivery models nationally and internationally.

A literature review was conducted which focused on approaches to mental health, with a particular focus on social justice in mental health and non-biomedical model approaches. These models assume a relational approach that recognizes the importance of family and community connections. This review also included an exploration of international approaches to mental health service delivery. We have integrated those findings into this final report for the NSCSW.

This report identifies a strong standpoint among participants for repositioning Nova Scotian social workers within mental health services in the province in a way that would be distinctive to the social work profession. Our report also describes how we as a profession can provide services that are rooted in a critical clinical approach that can supplement and enrich existing bio-medical services without requiring compliance to them.

This mental health advocacy report is meant to assist the NSCSW in guiding and promoting models of mental health service delivery that embrace a holistic bio-psycho-social model. This report can then offer a formalized tool that aids critical analysis and public discourse of mental health policies and political positioning within Nova Scotia.

Prioritizing the Mental Wellness of Nova Scotians

This report will help co-ordinate communication between the NSCSW, community stakeholders, and all levels of government to effectively advocate for fundamental changes to our mental health care system, including greater financial resourcing.

Adequate funding is a foundational requirement for effective mental health and addiction services for all Nova Scotians. We conceptualize inadequate funding as one of the harmful consequences of the dominance of a neoliberal philosophy that results in reduced public funding and the provision of only skeletal services. This is a very short-sighted approach as there are enormous costs accrued through inadequate services and by ignoring the impact of the social determinants of health. We consulted with a Dalhousie University health administration economist who specializes in health equity to learn about financial liability in failing to meet the social and mental health needs of Nova Scotians. This guidance allowed us to put forward more socially responsible approaches to mental health and addiction that are also fiscally intelligent.

However, for our recommendations to be adopted – and for the subsequent improvement in the well-being of Nova Scotians to be achieved – the budget for mental health and addiction services needs to be increased.

In this report, we have produced 29 recommendations that we believe are economically sound in that costs are forestalled in the long run if adequate provisions for mental wellness are in place.

This report is part of a broader agenda of mental health advocacy in Nova Scotia. Our research included examination of models from other provinces and countries that have shown greater commitment to mental health and well-being and ensured financial resources were prioritized to support this goal.

Addressing Social Inequities

This report emphasizes the important influence of the social determinants of mental health. The goals articulated by the NSCSW are comprehensive and long-term responses to current social inequities. Goals they identified centred on ways to improve mental health care services in Nova Scotia, such as addressing the dominance of the bio-medical model; the type of services offered; access to services; culturally appropriate and community-based services; mental health inequities, stigma and discrimination; the impact of trauma; necessary increases to mental health resources; and funding and prevention strategies.

We support advocating and striving for these fundamental social justice principles to improve access to quality mental health care among all. Improving the social determinants of mental health among Nova Scotians is a critical aspect of early preven-

tion and well-being. Vulnerability for mental health and substance use problems are associated with social inequities for example of class, race, gender, sexual orientation and age as well as childhood trauma and gender-based violence.

Our community consultation structured questions to explore the objectives listed above and to collect information from which we derived our recommendations. Thus, we gathered information related to resources, barriers, and accessibility of services. We explored the impact of gender, race, class, ability, sexual orientation, education, and migration on mental health and well-being.

This report includes information derived directly from our research participants and is supplemented by our literature review of health equity research and the availability of and access to mental health services within the province.

Mental Health Programming and Services, and Community Collaboration

As outlined above, this report uses community consultation as a core method of collecting data.

This authentic community collaboration was vital to making recommendations that reflect the conditions, opinions, and experiences of Nova Scotians. This meant consulting with people in different geographical locations – urban and rural – as well as holding consultations with different actors in the health care system, in order to build a comprehensive understanding of the current context and effectiveness of service provision from multiple perspectives. We explored perceived gaps in service and barriers to effectiveness, such that the resulting empirical data would inform our recommendations for change. The consultation collected socio-demographic information and explored and compared differences between rural and urban contexts in terms of population needs, types of mental health service availability, accessibility, and wait times.

Mental Health Policies: Person-Centred

The bio-medical model of mental health and addiction services is deeply rooted in providing treatment which focuses on individual pathology, deficit, and disease. A major limitation of the bio-medical model is its emphasis on the biology of the individual, which often results in disease-based, diagnostic labelling with little at-

tention to the actual lives of people and the influence that their social context has on their well-being.

A person-centred social justice approach emphasizes the client's knowledge, values, preferences and experiences, and highlights the importance of their voice. This approach is not expert driven, is non-pathologizing, and situates mental health and substance use concerns within the context of people's lives rather than focusing on individual deficits.

Social determinants of mental health issues are clearly associated with systemic, structural and historical violence and oppression, alongside barriers and access to appropriate mental health services. In addition, individual, familial, and community relationships impact upon mental health.

As part of our consultation, we explored participants' views on the bio-medical approach.

Through our literature review, we also investigated core structural factors that play a role in shaping mental health and addiction issues, and that impede access and delivery of mental health services such as poverty, gender, race, and sexual orientation. In addition, we explored mental health wellness beyond the bio-medical model by using a strengths-based appreciative inquiry styled interviewing strategy that focused on identifying challenges and sources of support which extend into the family and community of the service user. That is, during interviews we explored the perceptions of mental health care support systems. Our consultation approach is premised on a critical clinical structural and constructionist approach to collaborative person-centred practice.

In this report, we support individual, family and community-centred practices that are nonpathologizing and acknowledge issues of power and oppression.

These views are reflected in our literature review and the report recommendations.

Life-Long Mental Wellness and Healthy Communities

This report will contribute to a culture that emphasizes and values mental health well-being by moving away from an approach that interprets mental health within narrow abnormal/normal binaries and situates problems in the individual. Individual mental health wellness cannot be separated from the social determinants of health, including experiences of social oppression and marginalization. Therefore, this mental health advocacy report focuses on mental health, equity, and social justice and concludes that social work needs to be repositioned as an active advocate for social justice in mental health care services.

LITERATURE REVIEW

THE PREVALENCE OF MENTAL HEALTH ISSUES AND THE NEED FOR CARE

Most people have directly experienced mental health and/or addiction challenges, or have known and supported friends or loved ones who struggle with mental distress. According to the Nova Scotia government's 2016 report *Together We Can*, a progress update on the five-year mental health and addictions strategy, one in five Canadians will face mental health or addictions issues.

It is estimated that in any given year, one in five people who live in Canada will experience a mental health concern and that by age 40, 50% of Canadians will have experienced a significant mental health problem (Ahmad et al. 2011). Additionally, approximately 21.6% of Canadians (about 6 million people) meet the criteria for a substance use disorder during their lifetime (Statistics Canada, 2013). Within Nova Scotia, lifetime prevalence rates of mental health disorders are one of the highest in the country, sitting at 41.7%, compared to the national rate of 33.1% (Nova Scotia Health Authority & IWK, 2017). The suicide rates for men aged 20 to 44 went up 60 percent between 2012 and 2018, and suicide rates across most demographics also increased (Beswick, 2020). An overstressed mental health system in this province is failing to provide prompt, effective care to many people, especially for those living in rural communities.

The province of Nova Scotia website (2019) reports that wait times for mental health services is up to 227 days (for 90% of the population) at the Lower Sackville clinic, and 195 days at the Bayers Road clinic in Halifax for non-urgent mental health care. This is unacceptable as people are needlessly suffering to try and manage their mental distress alone while they wait for access to care.

Something needs to change.

Given the above figures, it is evident that mental health is a concern relevant to both federal and provincial levels of government, and to Canadians themselves. In

terms of economic impact, it is estimated that approximately \$50 billion is spent both indirectly and directly on mental health treatment, care, and support services per year in Canada (Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008; Smetanin et al., 2011). The Mental Health Commission of Canada has made the case since 2010 that Canada needs to invest in mental health for both the well-being of Canadians and the economy. Yet, Canada lags behind developed nations in mental health spending (Mental Health Commission of Canada, Framework for Action, 2017). Five hundred thousand Canadians miss work every week due to mental health problems and illnesses suggesting, if nothing else, fiscal motivation should compel governments to increase spending in mental health (Mental Health Commission of Canada, 2017). In response to the growing recognition of the prevalence and impact of mental illness, both the federal and provincial government have released strategies that outline their commitments to providing better prevention, intervention, and treatment as further discussed in the section on policy below.

EFFECTS OF NEOLIBERALISM ON SOCIAL WORK

Neoliberalism and the Individual

Neoliberalism, which has been influential in Canada since the 1970s, is a political-philosophy and set of practices of late capitalism that centres on the logic of a free-market economy and reflects a small-government approach, reducing the welfare state and its responsibilities. From the 1990s, there has been an intensification of neoliberalism and its effects are evident in labour market restructuring, privatization, and reduction in the provision of social welfare spending (Terris, 1999; Wallace & Pease, 2011). Critiques of neoliberalism and neoliberal perspectives often focus on the impact of market principles on economic and social distribution of goods (Gazso, 2012; Shamir, 2008) and the intensification of social power differences based on gender, race, and class (C. Brown, 2019a).

However, Stark (2018) refers to the economization of social work, whereby it too has been subject to the logic of the market and capital accumulation. Drawing on Chomsky, Stark (2018) argues that capitalism emphasizes “the privatization of profit and the socialization of cost and risk” (p.46). Neoliberal thought and market principles now penetrate all aspects of social life, influencing how we construct ourselves and live our lives (Braedley & Luxton, 2010).

The individual, rather than the state, is *responsibilized* for social risks such as illness, (dis)Ability, unemployment, and poverty, with a focus on the individual's ability to be self-managed and regulated and ultimately responsible for their own recovery (C. Brown, 2007b, 2019a; Morrow & Weisser, 2012; Weisser, Morrow, & Jamer, 2011). According to Stark (2018) the state and business enterprises have no social responsibility. Their only responsibility is to the accumulation of capital and to the shareholders, therefore unemployment, poverty and social inequity are seen as inevitable fall out of the free market (p.44). As such, the notion of "entitlement" of support within a strong social welfare state with a reliable social safety net has been diminished (Gazso, 2012; Shamir, 2008). We concur with critical scholars who argue that the impact of neoliberalism on social justice in mental health is reflected in dominant bio-medical model approaches to mental health that reinforce social injustice through a decontextualized, individualized emphasis on disorders and mental illness which, in turn, emphasizes personal responsibility for the causes and treatment of their problems (Lemke, 2001; Morrow & Malcoe, 2017; Marecek, 2006). Individual choice, determination, strength, resilience, and recovery – concepts important to empowerment and strengths-based social work – have been co-opted to focus on individual responsibility for mental health and well-being in general rather than social welfare services.

Not only does neoliberalism emphasize market rationality located in regulatory and state structures, it also emphasizes a corresponding ideal citizen (Haydock, 2014). This mechanism of power works by encouraging individual participation and belief in their responsibility by focusing on disciplinary practices that emphasize self-care, self-improvement, and misleading notions of choice and resilience (C. Brown, 2007b). The cultural imperative of self-help and self-management reflects a normative expectation that individuals discipline and control themselves (Bordo, 1993; C. Brown, 2007a, 2007b, 2014). Individual focus on self-discipline has intensified as a normalization process of self under neoliberalism and reflects the corresponding imperative of self-management discourse (Foucault, 1980a; Gremillion, 2003) that also requires a tightly controlled sense of self (C. Brown, 2014; 2019a). Subsequently, individuals blame and shame themselves if they are unable to cope or are struggling. Within this neoliberal culture, the stories people tell themselves about their lives often reflect this discourse of individual responsabilization and the imperative of self-management. Neoliberalism holds no responsibility for individuals while simultaneously deploying these discursive indirect techniques to control them.

Today, neoliberalism demands significant individual focus on self-management, self-discipline, and regulation through "rational choices" (C. Brown, 2007a, 2007b,

2014; Haydock, 2014; Liebenberg, Ungar & Ikeda, 2013). Individualized, decontextualized, and pathologizing approaches fail to address the social and political contexts in which people live and the state's responsabilization of individuals and families to solve their own problems is reflected in the increasingly reduced provision of adequate social welfare services and supports (Baines, Bennett, Goodwin, & Rawsthorne 2019; Baines & Waugh, 2019; C. Brown, 2016; Pease, Goldingay, Hosken, & Nipperess, 2016; Pease, & Nipperess, 2016). According to Morrow and Malcoe (2017) the dominant discourses of mental health are limited:

Absent from this official story are perspectives and forms of evidence that start with an analysis of power and consider the social, political, cultural, and economic production of mental health problems and solutions. Absent too are the diverse voices of experience - psychiatric survivors and those who have lived with various forms of social marginalization and (not unrelated) emotional suffering and thus have important knowledge regarding the utility of mental health reforms, supports, treatment and care. (p. 6)

Co-optation of Concept of Recovery

The concept of recovery arose with the psychiatric survivor movement in the 1970s with an emphasis on empowerment and resistance to the pathologizing determinism of the bio-medical model. However, as we discuss further in the section on models of service delivery below, the concept of recovery has been co-opted and shaped by the bio-medical worldview in the context of neoliberalism. The psychiatric survivor movement used the metaphor of a journey rather than a life sentence imposed through a DSM diagnosis. The movement introduced a language and conceptualisation of choice, empowerment, and ownership. However, only the language and not the concepts were adopted into bio-medical mental health service delivery systems which then continued unchanged to focus on individual responsabilization rather than the sociopolitical context and inter-locking forms of oppression in people's lives. Morrow and Weisser (2012) explore this application of neoliberal principles on the re-framed application of recovery in mental health and well-being, and argue that we must honour the original principles of the recovery movement and address power and the social and structural impediments to recovery. They suggest that:

these social and structural aspects are articulated and enacted through a number of dimensions of power such as medicalism, racialization, sanism, sexism, ageism, heterosexism, etc., calling out for an intersectional social justice analysis of recovery. That is, an analysis that foregrounds an understanding of power as it is distributed in the mental health care system, and the accompanying interlocking forms of oppression through which it operates. (p.28)

C. Brown (2020a) further suggests:

Today, the focus on “recovery” involves a self-management expectation that one will comply with the medical expert and the best practices of healthism advocated (i.e., regulating eating, substance use and exercise). The imperative to recovery co-exists with the imperative of self-management and responsabilization. (p. 61)

Indeed, many scholars have emphasized the need to question this reinvigorated focus on recovery in mental health under neoliberalism and address power and the social and structural impediments to recovery (Baines et al., 2019; C. Brown, 2016, 2019a; Morrow & Weisser, 2012; Pease et al., 2016; Weisser, Morrow & Jamer, 2011).

In her study of mental health recovery in Ontario, Jennifer Poole (2011) conducted a comprehensive inquiry by interviewing service providers and service users in a range of settings and concluded that there were multiple conversations developing on recovery, including the shift from the original survivor-based formulation of the approach to an institutionalized marketed and business application by bio-medical model pharmaceutical interests and the self-help industry (Poole, 2011). She noted that the rhetoric of recovery was increasingly being used to legitimate neoliberal and bio-medical strategies and approaches. Rose (2014) describes this as the “mainstreaming of recovery.” Marina Morrow (2013) also studied the application of the recovery model in Canadian mental health service delivery. She noted that “the social and structural determinants of mental health continue to be marginalized in research, policy and service provision even as debates in Canada about the failings of the current mental health care system abound” (p.323). She argued that when the recovery model is instituted in a neoliberal political regime it becomes part of the “healthification” of social problems where poverty and homelessness are submerged in a discourse of mental illness and addictions and the solution is individualized to a

personal journey of recovery. Nevertheless Morrow notes that the recovery model as originally articulated by psychiatric survivors had a social justice approach to mental health, as there was a conceptualization of the importance of income security, housing, and employment in ameliorating mental distress. She does articulate the tension between the individualism inherent in the personal journey metaphor, which is central to the recovery model, and the structural and political analysis which is central in a social justice approach. Social justice approaches emphasize the importance of situating individuals and their struggles within a social context rather than simply focus on the individual. Problems are seen to be inseparable from our social histories.

Neoliberalism and Managerialism

According to Ramon (2008), the focus on risk avoidance has resulted in a professional blame culture which further discourages social work practitioners from taking risks through autonomous decision making and practice, in order to maintain compliance with workplace expectations and avoid the repercussions of non-compliance. Baines and Waugh (2019) argue: “One of the main victims of this rationalisation of practice has been the hallmark trust-based, dignity-enhancing, time-intensive relationships generally thought to form the impetus and means for change within social work endeavour” (p.250). Arguably, accepting the neoliberal hegemonic discourse – and the larger political economy that shapes and demands it – does not and cannot produce the best social work practice for clients or society at large (Baines & Waugh, 2019; C. Brown, 2003, 2013, 2016, 2017). The bio-medicalization of social life within neoliberalism serves to hold people individually responsible for their own health and well-being regardless of the oppressive and marginalizing circumstances of their lives. The research literature suggests that within a neoliberal context, social workers are required to manage larger caseloads and to see clients for shorter periods of time. The neoliberal context of practice increasingly demands compliance with short-term, directed therapeutic practices, such as solution-focused brief therapy and cognitive behavioural therapy (CBT) (C. Brown, 2018, 2019a; McWade, 2016; Morrow & Weisser, 2012). Many of the struggles people live with, including co-occurring mental health and substance use issues, the aftermath of trauma, and processing the life-changing significance of a DSM diagnosis of a severe mental illness (SMI), cannot generally be dealt with effectively in short durations of time.

As further discussed under “Critiques of the Dominant Discourse” below, despite managerialist pressures, some practitioners resist neoliberal governance, including spending more time with clients and critiquing the expected structure of services with their clients (Gray, Dean, Agllias, Howard & Schubert, 2015; Strier & Breshtling, 2016). Research on the impact of neoliberalism and the demands for austerity and accountability on the practices of directors of Canadian Schools of Social Work was explored by Barnoff, Moffatt, Todd and Parnitch (2019). They found that the directors engage in practices that comply with, negotiate, and resist neoliberalism. They note: “[N]eoliberal governance is sustained on a double truth: it is based on the principle of unbound, free-market relations, while at the same time it calls for increasing regulation of labour within the public sphere” (p.8). This can be seen in forms of governance that operationalize neoliberal market-driven rationales through the new managerialist strategies of performance measurement and output (Gray et al., 2015). Directors in justice-based schools of social work are faced with fiscal austerity due to constant cuts to resources with increasing output demands, a balance that they describe as a constant struggle. These directors face conflicting needs and pressures within university politics, which are also under the influence of neoliberalism. In addition to the university work place, Pollack and Rossiter (2010) argue that social worker regulations are increasingly producing the “professional subject of neoliberalism ...masked as freedom” (p.162). These struggles are similar to those described by mental health social workers whose training and social justice focus is at odds with neoliberal politics that centre on individual responsibility (Pyysiäinen, Halpin, & Guilfoyle, 2017; Teghtsoonian, 2009). According to Stark (2018):

Social Work is a service which needs standards but these standards must be established by social work professionals and not by economists and managers. Social Work performance cannot be standardized like merchandise. Clients are human beings and not standardizable industrial products. (p.54)

The “burnout” that social workers experience as a result of work environments that increasingly demand larger caseloads, decreased control over their work, increased paperwork, and pressure to see people for short periods of time, is framed as the individual problem of the social worker rather than the effect of institutional practices (see Walker, 1986). Weinberg (2010; 2016) raises concern of this ethical dilemma where social workers are seen as individually responsible rather than as part of a much larger process of which they have little control.

As mentioned above, within a neoliberal context, there are often fewer social workers who are required to see more and more clients for shorter periods of time. Many of the struggles people live with, including co-occurring mental health and substance use issues and the aftermath of trauma, cannot generally be dealt with effectively in short durations of time. Yet, social workers are advised that the short-term approaches are evidence-based and these claims are expected to be accepted at face value. Arguably, it is not so much questionable claims of clinical effectiveness that determine the approaches advocated, but their cost-effectiveness (C. Brown, 2016). The consultation described in this report explored the need to provide mental health care that addresses struggles that often arise in tandem with adverse life experiences such as trauma and relational injury and marginalization, oppression, and inequity. In contrast, the current rationalized approach to social work mental health service delivery is often based on an individualized approach that is too narrowly focused and time limited to allow for the development of a strong therapeutic alliance which is needed to adequately address the level of distress and suffering that arises within the conditions of social inequity.

Neoliberalism and Social Work Values

Since the 1980s, the research literature has noted that social workers have been experiencing a fragmentation between “traditional social work values” and those of the marketplace (Carpenter & Platt, 1997). This split can impact social workers’ perception of their professional identity and their own sense of fit within their profession and the institution in which they work (Carpenter & Platt, 1997). The research literature notes that this threat to social work identity has particular relevance to social workers within mental health settings. There is threat to the social work perspective within mental health services as the bio-psycho-social view of health is often diminished relative to a bio-medical perspective that focuses on diagnosis, medication, and evidence-based treatment (McCrae, Murray, Huxley & Evans, 2004; Nathan & Webber, 2010; Yip, 2004).

The lack of focus on the psychosocial can, in turn, take focus away from the client’s environment and the “whole” person, social perspectives that are important to social workers and often entrenched within both their professional and personal values. The role of social workers traditionally has been to focus on social outcomes rather than solely on bio-medical explanations. McCrae et al. (2004) argue that the shift away from the institutionalization of mental health and toward community-based

treatment has further emphasized the social aspects of mental illness as clients remain fully immersed in their environment. However, not having the capacity to fully recognize the impact of one's environment – whether it be unstable housing, poverty, racism, or other systemic barriers – on one's mental health only further marginalizes the social perspective and results in social workers often feeling disenfranchised from their work and sense of professional identity and duty. This also has an impact on social workers' perception of their ability to challenge the hegemony of the bio-medical approach to treatment, and to increase the value of the role of social workers (McCrae et al., 2004; Nathan & Webber, 2010; Yip, 2004).

The medicalization of social work within mental health services in Hong Kong was studied and it was noted that bio-medical dominance often gradually suppressed the social work view, using bio-medical knowledge and rationalization to discount social perspectives (Yip, 2004). In this study, which included completing qualitative interviews with social workers in the mental health field, Yip (2004) found that the gradual and continuous suppression of the social perspectives of mental health by other professionals (such as psychiatrists, physicians, and nurses) resulted in social workers eventually internalizing bio-medical dominance. Social workers who participated in the study started to internalize that the bio-medical perspective may be more important than the social, and that medical professionals were perhaps more effective in treating mental illness than they were (Yip, 2004).

It is a challenge for social work to hold onto a social justice approach, which emphasizes the meaning and context of peoples' mental health struggles, while confronted with the limitations of neoliberalism and bio-medicine, which cultivate notions of personal failure, inadequacy, and deficit. Pollack and Rossiter express concern (2010) that Canadian social workers' participation in social movements for gender, race, and class equality are either ignored or co-opted within neoliberalized social work practices, whereupon the politized focus on the social good is replaced by the economic "good."

Social injustice in mental health co-exists with structural injustice, which occurs when "many policies, both public and private, and the action of thousands of individuals acting according to normal rules and accepted practices contribute to producing unjust circumstances" (Young, cited in Morrow & Malcoe, 2017, p. 9). In this way, no matter how well-intended we are as social workers, we contribute to social oppression and injustice when we simply invoke the dominant and normative mental health and well-being practices centred on bio-medicine and pathologization of the individual. This includes not just the way we interpret people's struggles, but how we have conversations about them as well.

Increasingly, social workers argue that neoliberalism has created a mental health service crisis (Carney, 2008). Ferguson and Lavalette (2013) suggest it is a common belief that social work in Britain is in a state of crisis with morale among social workers being very low. Research on mental health and neoliberalism in the United Kingdom has found that managerialism has had a stifling effect on social work practitioners and has produced conflicts and power struggles between different actors. This has resulted in a fragmented system and ambivalent compliance with constricting work place expectations due to disagreement with the values of neoliberalism and de-professionalization of social work (Ramon, 2008). Thomas and Davies (2005) suggest this is also responded to politically with micro forms of resistance. Social workers describe the professional disempowerment and devaluation of social work which challenge the professional identity of social work (Arnford & Hiybsgiidm, 2015; Hyslop, 2018; Rossiter & Heron, 2011). A study comparing the impact of neoliberal managerialism on social work in Sweden and the United Kingdom found a focus on the economy, efficiency and effectiveness while emphasizing ‘evidence-based’ approaches (Harlow, Berg, Barry, & Chandler, 2013). A six-country study that explored the implications of neoliberalism for social work and inequality noted that levels of economic inequality have increased under neoliberalism (Spolander et al., 2014). The authors argued for increased recognition of the interconnection and interdependence of individuals within society, stressing that private troubles and public issues are inseparable and that while social work faces challenges and conflicts internationally, “it is important for the profession to find its collective voice to understand, analyse, promote and develop strategies to deal with the impact of neoliberal reform if it is to remain relevant” (p.309).

Social Work and Evidence-Based Health Care

It has been documented that the role of social workers within health care setting is increasingly being filled by other health professionals (Nathan & Webber, 2010; Pecukonis, Cornelius & Parrish, 2003). Nathan & Webber (2010) note that the field of psychiatry in the UK has shifted toward a bio-medical model and marketization, a shift that has impacted the role of social work within psychiatry. The focus of this model is often to provide mass and “efficient” services in which the professional role is gatekeeping and data collection (Nathan & Webber, 2010). The consequence of this has been a shift toward employing more general mental health practitioners and a shift away from certain professions, such as social work. Thus in the UK, social

workers in adult social services do not have as certain a future as those in the child welfare field (Nathan & Webber, 2010). For example, the Mental Health Act of 2007 has replaced social workers with approved mental health professionals in England and Wales, demonstrating this shift toward integrating more generic mental health workers (Nathan & Webber, 2010).

The emphasis that has been placed on evidence-based practice where social workers are increasingly obliged to show the efficiency and effectiveness of their interventions with clients has raised concern (McCrae et al., 2004). The salience of evidence-based practice aligns well with new managerialist strategies that are focused on “performance culture,” fiscal cost containment, and the ability to measure outcomes, all of which often result in resource scarcity. Evidence-based practice promotes an element of control and rationality, whereby organizations can monitor individual practitioners and implement tools of accountability through measurement and audits (Webb, 2001). The shift toward evidence-based practice as the prominent approach to social work is founded on the idea that behaviour is rational and therefore the response to it can be rationalized and made efficient (Rosen, 2003).

Several researchers have explored the underlying assumption and implications of evidence-based practice for the profession of social work. Webb (2001) revealed the tendency to focus on “facts” and discourage “values” as rational factors in decision-making. This focus can serve to undermine professional judgment and the discretion often needed in social work when working within complex social contexts (Bullen, Deane, Meissel & Bhatnager, 2020; Webb, 2001). Webb (2001) emphasized that rationalized, evidence-based practice negates the fact that social workers are “embedded in highly situated, varied and complex decision-making environments” (p.75) and assumes that social work is largely decontextualized. The presumption of the focus on evidence-based therapeutic practice is that there is a neutral, objective, value-free form of practice. Specifically, it is presumed that the bio-medical model is neutral, objective, and scientific and therefore not politically positioned.

The suitability of applying an approach entrenched within the bio-medical model to the socially complex contexts in which social workers often work has been explored (Bullen et al., 2020). Researchers interviewed 79 professionals working in the education and social service sector in New Zealand and found that practitioners endorsed more inclusive and pluralistic approaches to practice over more traditional positivist approaches. It was noted that the evidence-based movement often promotes a colonial view of evidence that largely excludes the Maori and Pacific Indigenous worldview (Bullen et al., 2020). As a result, “evidence-based” programs often highlight the

privilege of certain knowledge and knowers over others, and often promote the salience of a Eurocentric approach to work in the social service field, thereby isolating marginalized groups (Bullen et al., 2020).

CHALLENGES TO THE DOMINANT MENTAL HEALTH DISCOURSE

Social work draws on long-standing challenges to psychiatry and the medicalization of social life by feminists, medical sociologists, anti-sanism/anti-psychiatry and MAD scholars who reclaim the notion of being “mad”/ insane and use the term MAD as a source of pride and a lever for activism (see Burstow, 1992, 2003; Burstow & Weitz, 1988; Lefrancois, Beresford, & Russo, 2016; Penfold & Walker, 1983; Smith & David, 1975). Within these critiques, psychological suffering is linked to broad social, economic, and political contexts. Within these frameworks and from Burstow’s (2003) perspective, psychiatry is a “regime of ruling.”

Feminist Critiques

For decades now, feminist social workers have critiqued of the psychiatrization of women, as can be seen in Smith and David’s (1975) book, *Women Look at Psychiatry: I’m Not Mad, I’m Angry*, an early call to recognize how responses to experiences of injustice and trauma can be pathologized and quantified as mental illness. The significant history of work by feminist (e.g., Baker-Miller, 1976; Bass & Davis, 1988; L. Brown, 1988; Burstow, 1992; Butler, 1985; Caplan, 1995; Chesler, 1972; Comas-Diaz, 2000; Courtois, 1996; Ehrenreich & English, 1979; Forward & Buck 1988; Herman, 1992; Howard, 1986; Lerner & Porter, 1990; Penfold & Walker, 1983; Shaffer, 1987; Rivera, 1990; Russell, 1986; Ussher, 1991) and mad scholars (Burstow & Weitz, 1988; Capponi, 1992; Lefrancois et al., 2016; Smith & David, 1975; Szasz, 1970) has contributed to social justice and women’s mental health.

Drawing on feminist literature, social workers are aware that mental health and substance issues are often adaptive forms of coping with adverse childhood experiences and other forms of trauma. For example, among girls and women, the links between substance use and sexual victimization are profound (Herman, 2007; Ross, Morrison, Cukier & Smith, 2015).

Importantly, while early feminist critiques of mental health practices were concerned with the general impact of bio-medical diagnosis and pathologization on women, women who live in poverty, and/or are racialized, and/or are living with a (dis)Ability, and/or are queer-identified, they also began to insist that women's voices and experiences must be more central to the conversation. Feminist critiques today now emphasize intersectionality, which stresses overlapping oppressive identities in women's experiences (Marecek, 2016; Morrow & Weisser, 2012). A focus on intersectionality provides an important challenge to the false universalizing of women and recognizes women's diversity. Nevertheless, early feminist writing on working with those who have experienced domestic violence, rape, incest and sexual abuse still forms the foundation of trauma work done today and, importantly, has been extended to address the complexity of difference and diversity among women (see C. Brown, 2020a, L. Brown, 1994; Brown & Root, 1990; Comas-Diaz & Green, 1994).

Anti-Sanism and Anti-Psychiatry

Sanism is the dominant belief that people who are different in any way, who do not conform, who are perhaps eccentric, or who hold opinions at variance with popular beliefs or whose behaviour transgresses commonly approved standards are "insane." Anyone can encounter sanism in their daily life. Sanist ideas are embedded in popular speech and phrases such as "He's a psycho," "It drives me crazy," "You're mental," "You should be in a loony bin," and "She's a nutbar." All of these common expressions communicate the idea that the person concerned should be avoided, discounted, dis-respected, or ignored. So when a person is diagnosed with a mental illness by an expert (psychiatrist), it means that they have been officially designated as a member of this "othered" group of people. To further complicate this issue, we know that psychiatric diagnosis is not "objective" and does not pivot on the hard evidence of other bio-medical diagnoses. There are no biopsy or lab results which confirm the diagnosis, but rather the skill and judgement of the assessing psychiatrist, who is usually guided by the symptomology laid out in the American Psychiatric Association (2013, 5th edition). *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Canadians Bonnie Burstow and Don Weitz (1988) and Susan Penfold and Gillian Walker (1983) were at the forefront of the anti-psychiatry movement, drawing on scholars who questioned the idea of mental illness and insanity (Foucault, 1964 Goffman, 1961; Szasz, 1970). The women's movement in the 1970s also questioned the

medicalization of daily life and the way that women's dissatisfaction and oppression were framed as mental illness (Chesler, 1972; Ehrenreich & English, 1979). More recently, critiques of the bio-medical approach to mental distress have been continued by service users, and anti-psychocentrism and anti-sanism scholars (Leblanc, 2016; LeFrancois, Menzies, & Reaume, 2013; Perlin, 2003; Rimke, 2016; Rimke & Hunt, 2002). Sanism is the pervasive belief system or discourse that drives the oppression of Mad people (Dumbrill & Yee, 2019; Poole, 2014). The term was coined by an activist lawyer called Martin Birnbaum in the 1960s and was later popularized by (dis) Ability rights lawyer Michel Perlin who identified structural stigma, prejudice, and discrimination as embedded in "an irrational prejudice of the same quality and character as other irrational prejudices that caused prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry" (LeBlanc & Kinsella, 2016, p.536). Sanism validates the idea that human and social problems are rooted in broken, deficient individuals rather than social and structural inequities, while psychiatry occupies the expert authority role of establishing who is sane and who is insane. Poole (2013) illustrated the social power of sanism by examining how the common human experience of grief can be constructed psychocentrically into a scale of normal and abnormal grieving. Bereavement leave is prescribed according to this authority and those who are outside the "normal" limits are referred for psychiatric intervention.

Critiques by Medical Sociologists

In his classic works, Thomas Szasz (1961, 1970) argues that the whole idea of mental illness is a myth. He describes the notion as socially constructed and political. Instead, he uses the term problems in living. Similarly, Paula Caplan (1995) asks the following questions: How do we determine what is normal? What is "crazy"? Where do the normative standards of normal/abnormal or health/unhealthy come from? What are they based on? This work is supported by Phil Brown (P. Brown, 1995), who critiques the naming and framing process in diagnosing social life.

As discussed above, the dominant discourse in mental health care is grounded in a bio-medical or disease model. This model has been critiqued since the 1960s by medical sociologists as based in socially constructed notions of normal and abnormal (Goffman, 1961; Szasz, 1961, 1970). This approach narrows acceptable human behaviour and produces/reinforces a social control function for what can be seen as normative. It typically emphasizes the medical expert approach rather than

a collaborative model and is legitimized by the DSM, which creates a classification system based on check lists (Strong et al., 2012). As discussed in detail in the following section, according to LaFrance & McKenzie-Mohr (2013) “the DSM can serve to oppress those on the margins of society, while bolstering professional and corporate interests” (p. 122). The DSM also creates a labelling effect that people can carry with them throughout their lives. The label can result in negative identity conclusions and contribute to social stigma and discrimination. These diagnostic labels illustrate the power of language and focus on deficits and the pathology of individuals, often erasing their strengths (Francis, 2012a, b). Within the dominant bio-medical model, there is little attention to “first voice” and little recognition of cultural and social differences. The dominant assumption is one of a universal “normal” which is also a universal “he”. Examining the prevalence of certain diagnoses is very telling.

Critiques of the DSM

Caplan opposed the masochistic personality disorder diagnosis when the American Psychiatric Association wanted to include it in the DSM in 1985. Caplan argued that the proposed inclusion was predicated on the assumption that women should be considered abnormal when they put others’ needs before their own. In 1987, Caplan fought against inclusion of premenstrual dysphoric syndrome, which pathologized women’s bodies. Robertson (2004) discusses the importance of the depathologization of homosexuality in the DSM and the history of conflating lesbian, gay, bisexual, transgender and/or queer identities with mental illness. Others more recently have critiqued the continued diagnoses of gender dysphoria and the pathologization of gender non-conforming and transgender people (Davy, 2015).

Similarly, Laura Brown (L. Brown, 1992) and Herman, Perry and van der Kolk (1989) note the commonality of complex trauma among women who are diagnosed as having borderline personality disorder (C. Brown, 2020b). For many years, research has shown that this diagnosis is primarily given to women who almost invariably have a trauma and abuse history (Becker & Lamb, 1994; L. Brown, 1992; 2004; Cermele, Daniels & Anderson, 2001; Marecek & Gavey, 2013; Tseris, 2013). Women who live with a “borderline” diagnosis are often seen as angry, noncompliant, resistant, and attention-seeking, often experience ongoing suicidality, and, as such, are too often dismissed by emergency hospital services as unworthy of response as they are troublesome “frequent flyers.” Their behaviour is disapproved of as it does

not conform to dominant gender discourse. Little effort is made to understand why they struggle so hard to be in the world. While they have often been psychiatrized, diagnosed, and prescribed medication, these women typically receive very little psychotherapy or support for their history of trauma (C. Brown, 2020b).

Feminist researchers have also questioned the over-representation and bio-medicalization of women's depression and explored the social contexts related to their experiences of depression (Lafrance & Stoppard, 2006, 2007; Stoppard, 1997; Stoppard & Gammell, 2003). The continuum of eating disorders is significantly more associated with girls and women and within the DSM these diagnoses are separated from the realities and meaning of women's lives (C. Brown, 1993 a, b, 2014).

In 1994, Caplan was involved in a DSM consultation regarding gender and was able to observe how the process works. She concluded that there was a "false aura of scientific precision" (1995, p. 15). Specifically, she observed that despite their common use, very little is known about how psychiatric drugs work and whether or not they are effective. Importantly, she highlighted that research shows that therapeutic relationships are the most significant factor in providing mental health care; this suggests a different therapeutic focus, one that is not rushed by institutional time and fiscal constraints. Caplan asked ethical questions about what a therapist can or cannot do, what they can realistically accomplish, and whether they are honest about these limitations with themselves and their client.

Social justice work is, however, positioned on the side of social critique and transformation (C. Brown, 2012, 2020a). All knowledge is interpretive and there are always alternative competing accounts. Therefore, "knowledge is never point-of-viewless" (J. Bruner, 1991, p. 3). What is presented as non-biased, objective, and evidence-based upholds the power and privilege of bio-medical perspectives (C. Brown, 2020a). Lafrance and McKenzie-Mohr (2013) argue that the master status of the DSM offers a "lure of legitimacy" and that critiques of it are largely ignored. This "medical construction of distress offers the lure, or promise, of validating a persons' pain and legitimizing their identities" (p. 119). Yet, this medical approach often delegitimizes other forms of knowing or interpretations of people's struggles, such as those that situate the problems in the context of people's lives. Strong (2012) and Ussher (1991, 2010) argue that the DSM serves to "medicalize misery." Strong suggests that narrative therapy helps clients recognize, resist, and overcome forms of "discursive capture" and that "discursive capture' occurs when a single prescribed discourse affords linguistic poverty" (p. 60). This creates a "poverty" of possibility for telling one's story.

Postmodernism, or poststructuralism interrogates dominant taken-for-granted truth claims or master narratives such as those of the DSM, arguing that knowledge and power are co-implicated (C. Brown, 2007c; Butler & Scott, 1992; Nicholson, 1990; Scott, 1992). Lafrance (2014) argues that the “hegemony of the medical model can be understood as less a matter of ‘truth’ than of power” (p.141), noting that evidence has yet to provide rigorous support for medical explanation of diagnoses such as depression. Overall, the DSM is descriptive, rather than analytical. It also does not provide treatment strategies, although they are often presumed to be medically based. It does not tend to look at the history, context or life experiences of people. Moreover, diagnostic criteria can be so broad as to include almost everyone at times which can be seen in criteria for “eating disorders” when social weight preoccupation is so ubiquitous (C. Brown, 1993a, 2014). The DSM is socially constructed by the psychiatric profession and reflects the biases of the paradigms of the medical professions. As the DSM and its application are not outside dominant social ideas and values, they are not neutral, and not objective. Diagnoses move in and out of the DSM, reflecting changes in social ideas. For instance, homosexuality and smoking were once considered disorders.

The DSM and the bio-medical model are thus not compatible with an anti-oppressive, social justice, social constructionist, or postmodern analysis of human struggle (Schwartz, & O’Brien, 2010). As the DSM is hegemonic in the mental health domain, other points of view or interpretations are pushed to the margins. Thus the professions allied to the bio-medical model have more power and authority to determine what is true and what is not, and psychiatry and other bio-medical professions are given the social authority to claim their own voices and positions as uncontested truth. The professional paradigms of social work which emphasize the social context and conditions of people’s lives, human strengths, and collaborative approaches have a much less authoritative position than the so called evidence-based or scientific language of the DSM. It is not an even playing field, when it comes to power, authority and knowledge. Social work knowledge remains at the lower end of the helping profession hierarchy. Social workers, especially those working within mainstream institutions such as government-based services and hospitals, are expected to conform to the dominant bio-medical paradigm which relies on the DSM. Their legitimacy to question the medical hegemony is limited, and when social workers present with a different approach it is often interpreted as a lack of skill. This is less true in non-profit community-based organizations.

Despite the power of the DSM, Frances and Widiger (2012) suggest it is a guide to psychiatric diagnosis: nothing more, nothing less. They suggest it is imprecise, uses

non-specific markers, is fallible, limited, elastic, imperfect, but inescapable. They reject its biological reductionism and note it is constantly changing. According to Frances and Widiger (2012), there are only six of the original diagnoses left in what is now over 300 diagnoses. Like Caplan (1987), these authors suggest that the DSM fails to meet its own standards: objective, unbiased, scientific and evidence-based.

The gender and race bias in the DSM has been shown repeatedly (see Becker & Lamb, 1994; Caplan, 1987; Cermele, Daniels & Anderson 2001; Marecek & Gavey, 2013). Cermele, Daniels and Anderson, (2001) illustrate the social construction of notions of mental illness through dominant definitions of what is normal and evidence of stereotypical notions of gender and race (see page 237 for chart). Frances and Widiger (2012) report that the work groups in the development of the DSM-5 sought a new paradigm. In the process there was 'diagnostic inflation' which produces multiple new markets for medication. They state:

Work groups were instructed to think creatively since everything was on the table. Accordingly, they came up with numerous pet suggestions that had in common a wide expansion of the diagnostic system (e.g., hypersexual disorder, binge eating, paraphilic coercive, skin picking, and Internet sex addiction) that together would redefine tens of millions of people previously considered normal and thousands previously considered criminal, delinquent, or irresponsible. Several of the new diagnoses (particularly mixed anxiety, depression, binge eating, and minor neurocognitive) would go from not currently recognized as mental disorders to become among the most common of the psychiatric disorders, potentially creating false epidemics of misidentified pseudopatients. (p.122)

Material-Discursive Approaches

Lafrance and Stoppard (2007) present an argument about depression which can be extended to mental health in general: There are two culturally competing ways to understand mental health issues, those that are located in the body and those that are located in people's lives. The dominant medical model views mental health issues as a medical illness involving a biochemical imbalance in the brain, which narrows the focus to pharmaceutical solutions. Women's experiences of depression, for instance, cannot be explained solely by bio-medical frameworks that emphasize their

reproductive lives such as menstruation, pregnancy, child-birth, and menopause or by their cognitive styles (Lafrance & Stoppard, 2006; Stoppard, 2000; Ussher, 2010, 2011a,b). Corresponding to a biochemical view of depression, dominant approaches to treatment have increasingly involved the prescription of antidepressants, especially to women (World Health Organization, 2001, 2004).

In an effort to avoid the body/mind and individual/society dichotomies which the above approaches often reflect, Lafrance and Stoppard (2007), Stoppard (1997) and Ussher (2005, 2010, 2011a,b) suggest an alternative material-discursive approach to understanding mental health issues. Referring specifically to depression, Stoppard (2000) argues that, like all human experience, it is a complex bio-psycho-social phenomenon that “involves experiences grounded in the materiality of the body which continually, and reciprocally, feed back into people’s experiences in the social context of their everyday lives” (p. 21).

People themselves often understand that their mental health distress or issues have physical, psychological, and social influences. Women, for instance, typically do not view their bodies and their lives as completely separate. Indeed, many do opt to use antidepressants as a way to level out feelings of depression (MacKay & Rutherford, 2012). Yet many report that they do not want to simply be prescribed an antidepressant when they tell their doctor they are feeling depressed (Lafrance, 2014). They may resist what they view as a superficial approach as it fails to make an effort to understand their distress in the context of their lives. Research has shown that women often feel their voices are silenced and their knowledge and accounts are minimized. Importantly, research has found that some women needed to break free of oppressive social expectations in order to find a way to tell counterstories of depression and to “highlight and name those otherwise taken-for-granted aspects of women’s lives that are so often integral to their stories of sadness” (Lafrance, 2014, p. 154).

SOCIAL DETERMINANTS OF HEALTH AND MENTAL HEALTH INEQUITY

In the area of mental health and addiction, we need to highlight the fluidity and complexity of social categories of inequality, exclusion, and oppression (McCall, 2005). Crenshaw (1989) focused our attention on the “crossroads of multiple oppressions.” Marecek (2016) emphasizes that “intersectionality theory focuses on the intersecting categories upon which such systems are built. In short, people are

not intersectional, social categorizations are (p.177). According to Marecek, structural social categories “mark people’s position in hierarchical social structures. People inhabit such social categories, which together constitute the matrix of privilege and oppression that structures social life” (p. 178).

Not all people experience mental health and substance use issues in the same way. We need to be careful not to overgeneralize descriptions. For example, men and women often have quite different experiences in relation to mental health and well-being (Augusta-Scott & Maerz, 2017; Ussher, 2011b). Not all women have the same experiences as each other, as they are influenced by intersectional matrixes of privilege and oppression (Marecek, 2016; Morrow & Weisser, 2012). Moreover, Black women and White women often experience mental health and substance use issues in different ways (Beauboeuf- Lafontant, 2007; Cain, 2009; Nicholaidis et al., 2010). Trans, non-gender conforming, and queer-identified individuals experience significant rates of depression (Davy, 2015; Duong, 2012; Hoffman, 2014; Lehavot & Simmoni, 2011; Singh, 2016), as do Indigenous women living in First Nations communities (Baskin, 2016, p. 194). It is important that we do not totalize people to a diagnosis, where the diagnosis becomes the defining aspect of their identity. For example, instead of seeing individuals as experiencing a problem with alcohol use, they are totalized as an “addict” or “alcoholic” (C. Brown, 2020a, pp.64-65).

Intersectional theory then centres on exploring and challenging overlapping social categories and hierarchical structures that serve to maintain relations of oppression and domination (C. Brown, 2020a, pp.45-46). This is very important in designing mental health and addiction programs as programming cannot be a one size fits all approach. We discuss several examples from the literature below.

In their 2014 report on the social determinants of mental health, the World Health Organization (WHO) states that social, economic, and physical environment in which people live play a key role in shaping both common and severe mental health problems with increased risk related to social inequities. Early life is identified as critical to life-long mental health and so prevention and reducing risk through improving life conditions through environmental, structural and local interventions is emphasized at community and national levels. The WHO report states, “There is considerable need to raise the political, and strategic priority

given to the prevention of mental disorders and the promotion of mental health through action on the social determinants of health” (p.12). In an extensive review of 115 epidemiological studies, they found that 70% reported an association between poverty and common mental health issues. It is further noted that inter-generational experiences of inequity and poverty produce mental health inequities across generations. Policy solutions advanced include reducing poverty, improving work place environment and satisfaction, and addressing loneliness and isolation particularly among older adults, particularly women. In addition, the WHO advocates improving the mental health treatment gaps and access to health care and social resources, promoting human rights and reducing discrimination against people living with mental health and psycho-social (dis)Ability. Improvement is needed in direct mental health services alongside the broader social environment. Importantly, the WHO recommends that every country should prioritize mental health through committing to greater financial, medical, and human resources and through reducing inequities. Further, they advocate avoiding short term thinking and to emphasize a life course perspective. All policies, strategies and practices should be designed to avoid increasing mental health inequities and to work toward reducing them.

Social Determinants of Depression

Depression is a common mental health issue experienced by Canadians and serves as a powerful example of the social determinants of mental health and illustrative of the importance of addressing social inequities and mental health. For instance, women are twice as likely to experience depression and more likely to experience other mood and anxiety disorders than men (C. Brown, 2019a). The World Health Organization states:

Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks....Gender specific risk factors for common mental disorders that disproportionately affect women include gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others (2004).

The social context of women's lives, including age, education, employment and economic inequity, emotional and caring labor, sexual orientation, racialization, and gender-based violence, is relevant in women's rates of depression (Jones, 2008; Lafrance, 2009; Mays & Cochran, 2000). Taken together, these intersected social contexts significant in the development of depression among women, are often associated with psychosocial perceptions of having little life control, few social supports (Hughes & McCormack, 2000; Lafrance, 2009; McGrath, Keita, Strickland, & Russo, 1990; Stoppard, 1997; Ussher, 2010). In addition, the challenges of managing multiple social roles as women juggle paid and unpaid work (Mazure, Keita, & Blehar, 2002), how women cope with depression by "getting on with their lives" despite the stress of managing multiple social roles (Scattolon, 2003; Scattolon & Stoppard, 1999), and their efforts at constructing a nondepressed self (Lafrance, 2007; Lafrance & Stoppard, 2006; Ussher, 2010) all illustrate how women's intersectional and gendered lives play a role in their depression (Brown, 2019a).

Further, poverty has been consistently associated with depression among women, as it creates significant stress, insecurity, and disadvantage (Belle & Doucet, 2003; Brown, 2019; Levy & O'Hara, 2010). Following up on their original influential research, Brown and Moran (1997) found that low-income mothers, especially sole parents, are at very high risk of depression. Women living in poverty and caring for young children are particularly at risk for depression (Levy & O'Hara, 2010).

Racism has had an impact on health and mental health through increased rates of anxiety, depression, and high blood pressure as compared with individuals of European descent (Etowa et al, 2005; James, Este, & Thomas Bernard, 2010). African Nova Scotians experience higher rates of unemployment, are less likely to attain a university education, and have double the prevalence of low income compared to all other Nova Scotians (Office of African Nova Scotian Affairs, 2015).

Continuing the example of depression, research among African Canadian women has found that racism, family burdens, and work-related stress are often associated with midlife depression (Etowa et al., 2005). Women reported that they were expected to assume the role of the "strong Black woman," taking care of others' needs at their own expense. Similarly, research on Black women's experiences of depression suggests that the discourse of strong Black women encourages taking care of others' needs in a selfless manner (Beauboeuf-Lafontant, 2007). Although the cultural construction of being a strong Black woman is a compelling part of many Black women's depression experiences, this mandate can invisibilize their struggles and increase their distress.

According to Beauboeuf-Lafontant, “[m]ental health and wellness, therefore, depend on a woman’s realizing that the discursive sociocultural representation of her womanhood fails to incorporate her reality” (2007, p. 30). Understanding the relationship between normative womanhood and distress would benefit from the inclusion of diversity of gendered experiences (Beauboeuf-Lafontant, 2007).

Women’s experiences of depression are both gendered and raced (Beauboeuf-Lafontant, 2007). While depression among women exists across cultural contexts it is critical to develop informed culturally appropriate understandings of normative and dominant cultural expressions of distress within a culture (Chentsova-Dutton, Ryder, & Tsai, 2014). Both race and gender are socially and politically constructed determinants of health that are reflected in the differential impact of social value and power, and continued discrimination and prejudice experienced by racialized women relative to non-racialized women (Hamilton-Hinch, 2016).

Racism and Access to Services

The impact of historical and current impacts of racism and gender discrimination are evident in the lived experiences of people of African descent and are contributing factors to poor health outcomes among people of African descent (Beagan & Etowa, 2009, 2011, 2012; Bonner & Thomas Bernard, 2018; Collins 2000 a, b; Hamilton, 2016; Hooks, 1990; James et al., 2010; Jones, 2008; Office of the African Nova Scotia Affairs, 2015; West, Donovan, & Daniel, 2016). Sheppard (2016) notes that African Nova Scotians have limited access to and receive substantially less mental health treatment than non- African Nova Scotians. He argues that mental health professionals in Nova Scotia lack culturally appropriate training and observes that there were fewer than 10 African Nova Scotian mental health counsellors, counting himself. Sheppard therefore states that there needs to be an increase in funding for mental health services that would allow for culturally-sensitive programming and services. More African Nova Scotian counsellors would help reduce stigma and suspicion among African Nova Scotians, and would provide more culturally appropriate services. Sheppard argues that it is not surprising that social institutions and structures have historically been racist:

Personally, I suffer from anxiety and the mental health professionals I have visited had no clue or understanding about my culture, heritage, customs, traditions or the impact that racism has had on my mental wellbeing. Likewise, my father and many other seniors in the community suffer high levels of mental distress based on the power and control of racism. (2016)

Currently, many African Nova Scotians “suffer in silence” because they do not identify with existing mental health services. Sheppard (2016) maintains that existing Afrocentric mental health programs and services are often geographically disconnected from African Nova Scotian communities. He therefore advocates for non-profit, community programming that is able to respond to youth and others in crisis in a timely manner, stating that if funding were in place these services “could be the instruments and vehicles for necessary change.” Research supports Sheppard’s experience finding that African Canadians often do not see themselves represented in health care settings which produces barriers to navigating and accessing such systems and contributes to the ongoing perpetuation of historical trauma (Hamilton-Hinch, 2014; McGibbon & Etowa, 2009; WHO, 2001a).

2SLGBTQIA+ Discrimination and Stigma

Queer and transgender women also experience significant depression and suicidality. Transgender women’s experiences of depression and suicidality are much higher than the general population (Hoffman, 2014). The existing research suggests the rates of depression reflect the lack of positive social support, discrimination, violence, stigma, isolation, lower income and education, and higher unemployment often experienced in transgender women’s lives. Among women who identify as lesbian and bisexual, victimization, homophobia, identity concealment, and a lack of social support often play a significant role in their depression experiences (C. Brown, 2019a; Lehavot & Simoni, 2011).

Due to the stigma and discrimination, 2SLGBTQIA+ youth are more likely than non- 2SLGBTQIA+ youth to struggle with their mental health (Human Rights Campaign Foundation, 2017). Transgender youth are almost four times more likely than their non-transgender peers to experience depression. 2SLGBTQIA+ youth are more than twice as likely to feel suicidal, and over four times as likely to attempt suicide, compared to heterosexual youth and these rates may be especially high for bisexual

teens (Human Rights Campaign Foundation, 2017). Research has found that a third of transgender youth have seriously considered suicide, and one in five has made a suicide attempt. Importantly, transgender students denied access to gender-appropriate facilities on their college campuses were 45 percent more likely to try to take their own lives (Human Rights Campaign Foundation, 2017). It is clear that family and community support can make a significant difference and transgender children who have supportive and genderaffirming families appear to be as psychologically healthy as their non-transgender peers. The Human Rights Campaign Foundation reports that transgender adults also experience greater mental health and substance use problems, with 40% of transgender adults attempting suicide during their lifetime.

According to Ross et al. (2018), elevated poverty rates are seen among 2SLGBTQIA+ people. In addition to economic disparities, 2SLGBTQIA+ people face health disparities in particular with mental health (Ross et al., 2018). In their Canadian study, Ross et al. (2018) adopted an intersectionality lens which built upon existing research that has established a clear relationship between poverty, 2SLGBTQI+ identity, and health by exploring whether 2SLGBTQIA+ identity and poverty together may impact upon health. They found that while barriers to service access clearly exist for low-income 2SLGBTQIA+ people, removing barriers (for example by increasing access) alone will not produce an equitable mental health system because mental health services are typically inadequate to meet the specific needs of 2SLGBTQIA+people living in poverty. Ross et al. determined that service providers lacked knowledge and preparedness to address issues relevant to the intersection of 2SLGBTQIA+ people, poverty, and health. They also reported that the dominant bio-medical framework fails to acknowledge the fundamental impact of social discrimination on mental health for poor, marginalized, 2SLGBTQIA+ communities. In addition to poverty and mental health care access, Ross et al. also highlight participants' stories of violence:

This violence was often connected to childhood experiences of living in poverty, and to being part of racialized and transgender communities, and participants described the daily work they needed to do to manage the impact of these experiences. For example, the high rates of violence targeting Indigenous women in Canada, including the multigeneration impact of residential schools...Further, harassment and abuse were sometimes experienced from mental health providers directly." Such cumulative experiences of violence added to the work that participants described having to do as they tried to take care of themselves and their loved ones, and create needed supports outside of formal systems. (pp.19-20)

A position paper by the Canadian Psychiatric Association (CPA) highlights the importance of reducing the stigma and discrimination faced by 2SLGBTQIA+ communities (Veltman & Chaimowitz, 2014). Importantly, they concede that psychiatry has a history of conflating lesbian, gay, bisexual, transgender and/or queer identities with mental illness and has, therefore, historically contributed to the stigma and discrimination people have faced. Veltman and Chaimowitz (2014) acknowledge that this has contributed to negative effects on mental health as well as access to appropriate mental health care. The CPA position paper addresses the need for psychiatrists to increase their understanding of the mental health needs of people who identify as 2SLGBTQIA+. Davy (2015) concurs with the CPA position paper, noting that the change in the DSM-5 diagnosis for trans people of all ages from Gender Identity Disorder (GID) to Gender Dysphoria (GD) does not lessen the stigma experienced by trans people. Davy recommends that psychiatric involvement and diagnosis should not be a requirement for trans people to transition, as is the case in Denmark, France, Argentina, and Malta.

Indigeneity

The colonization of Indigenous people and the intergenerational trauma Indigenous people have experienced have been significant determinants of health. The recent report on missing and murdered women and girls is further evidence of the level of violence that Indigenous people face in Canada (Brennan, 2008). Indigenous people experience major depression at twice the national average (Khan, 2008). Suicide rates are twice the national average and increasing among youth (Khan, 2008). While rates differ from community to community, Khan notes that some communities have had “epidemics” of suicide, while others have had few or no suicides for periods of time. Suicide rates among Inuit are six to eleven times the Canadian average (Khan, 2008). Of significance, in Nunavut 27% of all deaths since 1999 have been suicides; this is one of the highest suicide rates in the world. In the general Canadian population, females attempt suicide more often than males and the same is true for Indigenous females. However, the overall Canadian average is around 4% of females and 2% of males for reported suicide attempts. In Khan’s survey of Indigenous people, the rate was 19% for females and 13% for males (Khan, 2008).

In addition to depression and suicidality, alcohol and drug use is a concern in Indigenous and Inuit communities. Khan (2008) reported that approximately 75% of all community members in the study feel alcohol use is a problem in their community,

33% indicate that alcohol use is a problem in their own family or household, and 25% say that they personally had a problem with alcohol.

Similar to experiences of other marginalized and oppressed groups, such as African Nova Scotians and 2SLGBTQIA+ communities, there are significant barriers for Indigenous people accessing services, which is exacerbated by a lack of cultural appropriateness. Khan (2008) notes for instance that Indigenous people have a holistic view of mental wellness. As such, dominant bio-medical European models tend not be useful frameworks. For Indigenous people, wellness involves a balance with family, community, and the larger environment. According to Khan (2008) effective approaches to treatment involve “identifying the strengths of families and communities and developing programs that build on these strengths” (p.7).

Boksa, Joober, & Kirmayer (2015) acknowledge that while it is clear that there are social, structural, and historical causes of adversity in Indigenous communities, we need to address current mental health issues. Like Khan, these researchers recognize that there is a lack of appropriate mental health services and long-term funding for mental health. Further, smaller and remote communities often have very little if any access to mental health care. As with other marginalized communities, stigma and discrimination are a significant barrier.

Further to intergenerational trauma, research also explores domestic (Brownridge, 2003) and sexualized violence against Indigenous women, including violence by police (Palmater, 2016). The overrepresentation of violence toward Indigenous women speaks to their vulnerability in a racist society (Brennan, 2009). While Indigenous women and girls are only 2 percent of the female Canadian population, they represent 16 percent of the women who are murdered or go missing (Palmater, 2016). Overall, Indigenous women and girls represent 55 percent of all of the women and girls who are murdered or go missing in Saskatchewan and 49 per cent in Manitoba. Indigenous women and girls are three times more likely to suffer violence and are significantly more likely to be killed by an acquaintance than non-Indigenous Canadian women. Racism and failures in policing are significant factors. According to the Native Women’s Association of Canada (Canadian Council on Social Development and Native Women’s Association of Canada, 1991), “It is an exception rather than the rule to know of an Aboriginal woman who has not experienced some form of family violence throughout her life” (p. 25).

Research has further established that Indigenous people are overrepresented among homeless populations and the prevalence of Indigenous homelessness appears to be increasing in Canadian cities. Bingham et al. (2019) explored gender

differences among Indigenous Canadians experiencing homelessness and mental illness and investigated mental health, substance use, and service use among Indigenous people who met criteria for homelessness and mental “illness.” The study explored whether women had significantly higher rates of trauma, suicidality, substance dependence, and experiences of violence compared to men. Findings were consistent with the widely documented violence against Indigenous women in Canada. Of note, the researchers found that Indigenous women who become homeless are seriously impacted by violent victimization, post-traumatic stress, and suicidality. They found that Indigenous women were 6 times more likely than Indigenous men to be victims of forced sexual violence, and were significantly more likely to experience PTSD and suicidality. Bingham et al. conclude that Indigenous women continue to experience multiple forms of violence, social exclusion, and marginalization. The researchers highlight the importance of acknowledging the experiences of Indigenous women when providing housing and support services that are culturally appropriate and reflect trauma informed care.

(dis)Ability

Critical (dis)Ability theory recognizes that people who live with (dis)Abilities are often oppressed. The focus is typically on physical and visible (dis)Ability with little attention to intersectionality. Some argue that mental health issues are often themselves invisible (dis)Abilities. Our social and economic systems have not yet adequately accommodated (dis)Able people’s physical/mental health conditions or integrated their struggles into the cultural concepts of everyday life. Stienstra (2012) states, “People with disabilities [sic] are implicitly and explicitly told that they are not worthy, or of enough value, to receive human rights and related protections because they are, or cause, too much trouble or require too many resources” (p.29). The dominant discourse on (dis)Ability in social work has been that of an individual/medical model, which largely relegates the ‘problem’ of (dis)Ability to a deficit within the individual. The consequence of (dis)Ableism in itself may produce mental health distress. These views play a role in creating a sense of devaluation, stigma, marginalization and oppression among those who experience mental health struggles alongside (dis)Ability and mental health issues as a (dis)Ability itself. The notion of individual inadequacy is socially produced and reproduced. Barriers are socially created which we can see in the stigma and discrimination often associated with to (dis)Ability.

There needs to be a greater focus in social work however to promote (dis)Ability rights. The constructionist perspective asserts that a (dis)Ability-related impairment comes from the relationship of the person with a (dis)Ability to the socio-cultural environment; thereby the environment is seen as the primary target of intervention. A feminist model recognizes that both the female and the (dis)Able body are cast within cultural discourse as deviant and inferior; both are defined in opposition to a valued norm of the male, white, able-bodied, which is assumed to possess natural physical superiority (Garland-Thompson, 2005; Neath, 1997).

MacDonald (2020) describes the difficulties women living with chronic pain often have being heard, noting health professionals too often doubt the physical origins of their pain and the legitimacy of their experiences with pain is questioned. “Chronic pain and (dis)Ability leaves one struggling for ‘normalcy,’ trying to make sense out of the fundamental operations of one’s body, the meaning of suffering, and the social construction of wellness” (MacDonald, 2008, p. 135). MacDonald’s (2006) exploration of women’s experiences of chronic pain reveals that the women studied developed multiple coping and support strategies and resources. Yet, living with chronic pain is emotionally as well as physically difficult. One participant quoted states: “It’s knowing the fear, the doubt, the depression, the sadness, the despair, the pain, the disability[sic], and the emptiness and having no control of a situation. Control, the loss of control was a big issue.” (p. 61).

In this report “(dis)Ability” is referred to as (dis)Ability: “ ‘(dis)’ to respect the person’s social and physical connection with (dis)Ability, and “Ability” to highlight the creative and innovative ways of dealing with societal barriers” (MacDonald & Friars, 2010, p. 140). In recent decades, social work has moved past empowerment, strengths, and resilience perspectives to an anti-oppressive and critical approach identifying the importance of inclusion and accommodation for individuals with (dis)Abilities. Ableism “is a belief that impairment is inherently negative and should the opportunity present itself, should be ameliorated, cured or indeed eliminated” (Carter, Hanes & MacDonald, 2017, p.155). Disableism is “the disadvantage or restriction of activity caused by a contemporary social organization, which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of social activities” (p.155).

Critical social work views (dis)Ability as inextricably linked to social, cultural and political milieu, and challenges the bio-medical or personal tragedy framework as deficit focused and the individual is seen to be in need of bio-medical correction. Under a critical (dis)Ability framework, the extent of (dis)Ability is determined by

transactions between people and their environments rather than within the individual alone. In social work there is an effort to revision (dis)Ability.

The Canadian Survey on Ability (Statistics Canada, 2017) focused on Canadians 15 and older who experienced limitations in their everyday life due to long term conditions or health related problems. Almost half with a mental health related (dis) Ability feel it makes it difficult to change or move ahead in their jobs and that many believed this was due to discrimination and stigma. This survey found that over a million Canadians with a mental health-related (dis)Ability report they need counselling services. Of these, 519,400 received counselling, but 286,400 did not. Among youth aged 15-24, women are twice as likely as men to have a mental health related (dis)Ability. Most commonly reported were anxiety, depression, bi-polar disorder and “severe stress disorders.” Of those with a mental health-related (dis)Ability, 63% also reported a pain related disorders.

Research explores the relationship between (dis)Ability and mental health issues, finding that there is an elevated risk for people living with a (dis)Ability to experience mental health or substance use problems. Turner, Lloyd, and Taylor (2006) found in their epidemiological study that those with a confirmed (dis)Ability were twice as likely as those who were not to meet diagnostic criteria for a mental health or substance use problem at some time in their lives. Schweininger, Forbes, Creamer, McFarlane and Silove (2015) report that PTSD, anxiety and depression are common responses for people who experience a significant injury. Their research explored the relationship between mental health and (dis)Ability caused by recent injury. They did not find a reciprocal relationship between (dis)Ability and “psychopathology,” but found that that depression played a role in early (dis)Ability while PTSD played a role in contributing to long-term delays in recovery. The findings emphasize the importance of screening for symptoms of PTSD and depression following trauma and early intervention programs in injury populations. In an Australian study on gender based violence it was found that violence often resulted in mental health issues and (dis)Ability and recommended that approaches to prevention and clinical intervention needs to integrate this knowledge, noting that trauma is often separated from mental health services (Rees, et al., 2011). They suggested that mental health problems experienced by women with the gender-based violence history often have more extreme and co-occurring mental health issue. A comprehensive approach to care must ensure that women receiving care for experiences of gender-based violence should also be provided mental health care services.

IMPACT OF TRAUMA ON MENTAL HEALTH

Feminist researchers, therapists, and advocates were foundational in bringing gender-based violence forward (Armstrong, 1978; Bass & Davis, 1994; Brownmiller, 1975; Butler, 1978; Courtois, 1988; Forward & Buck, 1988; Herman, 1981, 1992; Pizzey, 1974; Russell, 1986, Terr, 1990). Since 1974, feminist scholars have identified that sexual assault, domestic violence, incest, and sexual abuse are associated with significant mental health sequelae, including depression, anxiety, eating disorders, “borderline” personality disorders, post-traumatic stress, and a range of substance use problems (Burstow, 2003; Courtois, 1988; Herman et al., 1989; Herman 1992).

Co-occurring struggles with trauma, depression, anxiety and substance use are intricately linked, not as an individual deficit or pathology, but as ways of coping and responding to sexual, physical, and emotional childhood abuse (L. Brown, 1992, 2004; Burstow, 1992, 2003; Courtois, 2004; Haskell, 2012; Herman, 1992, 2015; Kaplan, 1991; Lafrance & McKenzie-Mohr, 2013; Marecek, 2006; Ross & Morrison, 2020; Stewart & Israeli, 2003; Ussher, 2010; Webster & Dunn, 2005). For example, the vast majority of women seeking substance use treatment have prior experiences of childhood sexual abuse and/or trauma (Ross, Morrison, Cukier & Smith, 2015). According to Valerie Taylor Psychiatrist-in-Chief at Toronto’s Women’s College Hospital, “While trauma is not the only factor for women who experience mental illness, it is far more widespread than many people recognize.” She further states, “We need to look at how we can come together to provide better care for women and appreciate that we are more than the sum of our parts.” (CAMH, 2014).

The link between depression and violence against women cannot be overstated (Brown, 2019a; Herman 1992, 2015; Stewart & Israeli, 2003). Feminist approaches have also drawn our attention to the high risk that women living with (dis)Abilities have of experiencing physical and sexualized violence and the impact on reproductive and sexual choice (Garland-Thompson, 2005). Abuse, trauma, and disrespect in women’s social relationships are often associated in women’s accounts with depression highlighting feelings of betrayal, hopelessness, and demoralization (Hurst, 2003). Explorations of violence, race, and depression have found that the “strong Black woman” discourse is a barrier to both acknowledging and seeking support for depression and that there is significant mistrust among Black women of the normative white healthcare system due to systemic and cultural barriers. Nicholaidis et al., emphasize the strong association between use of drugs and alcohol to self-medicate for depression and the effects of multiple and complex violence and trauma histories

among Black women (2010). A combined history of colonization, ongoing racism, violence, and poverty among First Nations women in Canada and the United States impacts on their well-being and puts them at risk of depression (Culhane, 2003).

Research on trauma and violence points to the need for intergenerational healing within families and communities and recommends engaging with communities to learn what is most relevant in generating new cultural norms that mirror the values and aspirations community members have for their children (Porter, Martin & Anda, 2017; Ross & Bookchin, 2020). Intergenerational trauma among Indigenous and African Canadian communities in particular must be addressed. While we know trauma can be caused by war, witnessing violence, childhood neglect, sickness, illness, and death, we also need to ask why some people are violent toward others through rape, domestic violence, and incest and what social conditions produce this violence and abuse of others (C. Brown 2019c,). For instance, men with experiences of childhood trauma may be more inclined to use violence themselves, and be incarcerated (Augusta-Scott & Leland 2017; Augusta-Scott 2017, 2007).

The effects of adverse childhood experiences produce many related health and mental health outcomes with substantial public costs (Bellis et al 2019; Kagi & Regala, 2012).The world's largest longitudinal health study of adverse childhood experiences began in 1995 as a joint initiative of Kaiser Permanente and the Centers for Disease Control and Prevention in the United States and found that experiencing adversity in childhood is common (Felitti et al., 1998). The study looked at ten categories of childhood adversity that included physical, sexual, and emotional abuse; physical and emotional neglect; and five measures of household dysfunction that included domestic violence, parental mental illness and/or substance abuse, an incarcerated relative, and separation/divorce. Key findings of this study indicated that 61.7% of adults reported experiencing at least one adverse childhood experience and one in six or 16.7% had experienced four or more.

In Canada, one study conducted in Alberta found that almost 70% of the sample reported at least one type of adverse childhood experience and almost one in five (18.1%) reported four or more (Poole, Dobson & Pusch, 2018). A study conducted in rural Nova Scotia found 73% of survey respondents reported one adverse childhood experience and 31% reported four or more (Ross et al. 2020a).

Today, more than 2,000 peer reviewed journal articles comprise a body of research that helps to explain the links between childhood adversity and negative impacts on physical health and psycho-social well-being across the lifespan. Specifically, research has demonstrated that the more adverse childhood experiences a person experiences,

the higher their risk of developing physical health challenges (e.g., chronic stress, increased rates of heart disease, chronic pain, and difficulty sleeping), unhealthy lifestyle behaviours (e.g., interpersonal difficulties), mental health challenges (e.g., depressed mood, anxiety, suicide attempts, substance use), and social underachievement (e.g., lower educational achievement and economic productivity) (McDonald, Kingston, Bayrampour & Tough Mail, 2015; Felitti et al., 1998; Anda et al., 2006; Douglas et al., 2010; Dube et al., 2003; Edwards et al., 2001; Logan-Green, Green, Nurius & Longhi, 2014). There is a clear relationship between the number of adverse childhood experiences and health challenges in adulthood.

Hughes et al. (2017) conducted a global systematic review and meta-analysis of the effect of multiple adverse childhood experiences on health and found that individuals who have experienced at least four adverse childhood experiences were more than twice as likely to be current smokers or heavy drinkers, almost six times as likely to drink problematically, about four times more likely to experience anxiety and depression, about eight times more likely to be a victim and/or perpetrator of violence, and thirty times more likely to attempt suicide than those who had no adverse childhood experiences.

Social work has a lengthy history of responding to adverse childhood experiences and this supports the need to look beyond the bio-medical model and narrow individualized responses to address interpersonal and social causes of health challenges. The bio-psycho-social perspective embraced by social workers to resolve adversity compels a simultaneous perception of the individual and recognition that development and behaviors across the lifespan occur within a lived social context shaped by cultural and structural factors (Houston 2016; Larkin, Felitti & Anda, 2014). In Nova Scotia these factors are influenced by a colonial history that has resulted in systemic racism that has been experienced intergenerationally. For example, Bombay, Matheson & Anisman (2014) demonstrated the intergenerational effects of residential schools on children who experienced adversity in these schools and in their communities. Similarly, the final report of the Restorative Inquiry on the Nova Scotia Home for Colored Children (Council of Parties, 2019) described the impact of intergenerational harms resulting from the experiences of former residents of the Home. This report, like others documenting systemic racism, points to different ways social workers and other allied professionals can respond to trauma and adverse childhood experiences that move from individual responses to more relationally focused approaches that are integrated and holistic. Social workers recognize the profound ways in which structural and cultural inequities contribute to experiences of child-

hood adversity, oppression, and poor health throughout the lifespan. The critical social theory and analysis that characterizes critically based social work interventions position the profession to lead responses to adverse childhood experience science in the development of holistic responses and trauma-informed and trauma specific services, and in defining social policy measures and prevention strategies.

SUBSTANCE USE

The World Health Organization (2005) declared that harmful drinking was among the foremost underlying causes of disease, domestic violence against women and children, (dis)Ability, social problems, and premature death. The Nova Scotia Alcohol Indicators Report estimated that 237,270 Nova Scotians 18 years and older had been harmed by another person's use of alcohol (Graham, 2005). This situation also results in financial costs to Canadians. For example, the economic burden of substance misuse, excluding tobacco in Canada, was estimated to be \$22.8 billion annually, of which alcohol-related health care costs alone total \$3.3 billion (Etches, 2013).

In terms of other substance misuse, Ashbridge et al. (2011) concluded that addiction to prescription drugs is more common in Nova Scotia than addiction to illicit drugs. Ashbridge et al. (2011) note that while many youth use medications such as Ritalin, amphetamines, and tranquilizers as a result of a prescription, recreational use of prescription medication is also high, particularly pain medications, which are used at a rate of 19.5%. Canada as a whole is experiencing a public health crisis of opioid use, including synthetic opioids such as fentanyl. While acquiring statistics on rates of misuse is difficult, there has been an average of 60 overdose deaths per year in Nova Scotia from 2011 to 2015 (Nova Scotia Opioid Use and Overdose Framework, 2017).

Canada's serious rates of substance use and addiction have led to significant debate about what factors contribute to a predisposition to substance use problems. An extensive amount of Canadian and international literature links substance use problems with violence (Adlaf, Begin & Sawka, 2005; Guise & Gill, 2007; Alexander, 2008; Brown & Stewart, 2008; Covington, 2008; Jenkins, 2003; Mate, 2008; Najavits, 2002; 2007; Parker & McCaffree, 2013; Plant, 2008; Poole & Greaves, 2012). These authors write about the links between being a prior victim of violence, including sexual assault and adverse childhood experiences such as childhood sexual abuse and other traumatic experiences, with a subsequent vulner-

ability to substance use problems. Alcohol dependency is up to 15 times higher for women impacted by violence and women who experience violence at the hands of their partners are six times more likely to be depressed, and four times more likely to use psychoactive drugs. As discussed further in the following section, these connections between experiences of previous trauma and violence and subsequent substance use and/or mental health issues are especially pronounced among girls and women (Brown & Stewart, , 2008; Minerson, Carolo, Dinner & Jones, 2011; Najavits, 2002; Poole & Greaves, 2012). Violence against women, referred to as the number one human rights violation in the world today, impacts the majority of women who access mental health and addiction settings.

RELATIONSHIP BETWEEN MENTAL HEALTH ISSUES AND SUBSTANCE USE

In Canada, at least 20 percent of people with mental health problems have a co-occurring substance use problem (Bell, 2015). Research estimates a 7 to 45 percent overlap between alcohol dependence and depression and anxiety, a link which is generally higher among women (Rush et al., 2008). In general, the research literature has established strong links among substance use, eating disorders, depression, anxiety and posttraumatic stress, and histories of trauma and violence among women (C. Brown, 2011, 2014; Brown & Stewart, 2008; Canadian Women's Health Network, 2006; Herman, 2015; Najavits, 2007; Stewart & Brown, 2007; Stewart & Isreali, 2003). Kessler, Crum, Warner & Nelson's (1997) large epidemiological study on mental health and substance use also demonstrated the commonality of co-existing mental health issues. For instance, they found that depression and anxiety often co-exist and that trauma and substance use often co-exist. As discussed above, the growth of adverse childhood experience research since the 1990s also clearly demonstrates the likelihood of people developing a variety of mental health and substance use problems when they have experienced trauma in childhood. A growing body of research has shown the value of addressing a history of trauma experiences for interventions with women living with co-occurring mental health and substance use problems (Cusack, Morrissey & Ellis, 2008; Huntington, Mores and Veysey, 2005; Morrissey, Jackson, Ellis, Amaro, Brown, & Najavits, 2005). In addition, as there is now a clearly established relationship between multiple mental health issues and substance use problems there has been a significant focus both

on continuing to understand the pathways between concurrent issues as well as to attend to these clinically (Bartha & Parker, 2004; Rush, Urbanoski, Bassani, Castel, S, et al. 2008; Skinner, 2011; Skinner & O’Grady, Stewart, 2010; Stewart, Brown, Devoulyte, Theakston, & Larsen, 2006; Stewart, Karp, Pihl, & Peterson, (1997). From a clinical standpoint the burden associated with living with coexisting issues of trauma, mental health and substance use needs to be addressed (Brown, Huba, & Melchior 1995; Cusack, Morrissey & Ellis, 2008).

Although, the link between mental health, substance use, and trauma has been well established in the research literature, less attention has been directed to understanding the pathways among these connections. Stewart and Brown (2008) argue that trauma often precedes the development of anxiety and/or depression, which is addressed through substance use. Substance use becomes a way of coping and providing relief from the effects trauma, such as feeling poorly about oneself, anxiety, and depression. Herman’s well known text, *Trauma and Recovery*, also argued this as early as 1992.

Feminist writers have explored these co-occurring struggles as ways of coping and responding to sexual, physical, and emotional childhood abuse, not as individual deficit or pathology (L. Brown, 1992, 2004; Burstow, 1992, 2003; Courtois, 2004; Haskell, 2012; Herman, 1992, 2015; Lafrance & McKenzie-Mohr, 2013; Marecek, 2006; Ussher, 2010; Webster & Dunn, 2005). Women in treatment for an alcohol use problem have been found to have very high rates of both depression and complex and often life-long experiences of abuse and trauma which had often not been clinically recognized as a significant (Brown & Stewart, 2005, 2008). The pathologized disorder post-traumatic response has often been diagnosed as “borderline personality disorder” and overwhelmingly given to women who have a trauma and abuse history (Becker & Lamb, 1994; L. Brown, 1992; 2004; Cermele et al., 2001; Herman, 1992; Herman et al., 1989; Marecek & Gavey, 2013; Tseris, 2013).

These studies highlight the need for social workers who work in mental health and addiction settings to put links between prior adverse childhood experiences and trauma at the forefront of their work. This work is relational, sometimes time-consuming, and requires a broad lens to examine the influence of our social context on mental health. In particular, given that women often experience co-occurring mental health challenges, it is important that clinical and policy work employ a gendered perspective. If addiction and mental health services are to respond effectively to the gender-specific needs of girls and women, women specific services positions are necessary.

FRAMEWORKS OF PRACTICE

We have critiqued the dominant bio-medical model of mental health service provision throughout this report. In this section we concentrate on other frameworks and approaches to providing mental health services. As already noted in the sections on neoliberalism, attempts to introduce new approaches are frequently confounded by the hegemony of the medical model and the prevalence of neoliberal economic and managerial constraints.

Critical Clinical Social Work Practice

A recent collection focusing on critical clinical practice authored by faculty at the Dalhousie School of Social Work tackles various substantive issues including co-existing mental health and addiction issues among women, working with complex trauma, men's use of violence, women's and girls' experiences of violence, unpacking pain through living with (dis)Ability, and the value of animal/human bonds in social work practice (Brown & MacDonald, 2020). The emphasis and ethical stance in critical clinical practice involves equalizing power in the therapeutic context by stressing safety, client power and control over their own choices, and transparency throughout the work. The collection analyzes the overall implications of a critical clinical approach in substantive areas of practice across dimensions of social work that may include social advocacy and activism, political change, community-based practice, enhancing clinical practice, policy development, and teaching. Within a critical clinical approach, a positioned counterviewing of problem-saturated stories makes possible a contextualized exploration of how these stories developed (C. Brown, 2014; 2017, 2018, 2019a,b, 2020; Madigan, 2003). Through this counterviewing, counter-discourses and resistance can emerge that challenge hegemonic structures of meaning and power (Brown, 2007c; Butler, 1993; 1997; Foucault, 1984,1991, 1995; Smith, 1990). Critical clinical conversations can purposively disrupt the discursive mechanisms of power that often shape people's stories and negative identity conclusions. Central to this work is an emphasis on collaborative practice and therapeutic alliance.

Both the practitioner and client bring *partial* knowledge to the therapeutic conversation in collaborative practice with individuals, couple, families, and communities (C. Brown, 2007c, 2012; Brown & Augusta-Scott, 2018; Haraway, 1988; Scott, 1992).

This approach avoids binary notions of the “expert,” of seeing either the client or therapist as an expert knower. Each brings partial knowledge and is an active subject who contributes to the conversation.

The therapist is understood to have more power by way of their institutional and professional roles and because the client is the one who is vulnerable in this context. However, the emphasis and ethical stance in critical clinical practice involves increasing shared power in the therapeutic context by stressing safety, client power, and control over their own choices, and transparency throughout the work. Within this collaborative approach, clients’ stories are contextualized and their strengths and agency, alongside their vulnerability, marginalization, and pain, are emphasized. Taken together, this encourages rather than shuts down possibilities for living a preferred life and identity (C. Brown, 2020a p.58).

Within critical clinical social work, feminist and narrative approaches emphasize the unpacking of gendered, racialized, and classed stories. These stories are understood to emerge from the culturally available meanings and discourses that make them possible. This approach enables a contextualized analysis of mental health struggles and challenges limiting cultural meanings and descriptions of mental health. The multiplicity, complexity, and diversity of stories are emphasized, whereby gender, race, class, and sexual orientation often intersect. Identities are not “essentialized”, but rather seen as socially constructed and differently situated within social relations of power (Brown, 2012; 2020a). A critical clinical approach recognizes that people often internalize dominant stories about mental distress and its treatment and that these stories often do not work well for them (Hare-Mustin, 1994; Madigan, 2003; White, 2001, 2007). Critical clinical social work is therefore committed to unpacking and challenging dominant discourses and the ways they impact upon our lives (Lafrance, 2009). This critical clinical approach provides a framework to explore the ways that dominant stories of mental health issues such as depression, anxiety, eating disorders, substance use, and post-trauma may injure people when the focus is on individual deficits (Brown, 2020a).

Social group work is part of direct social work practice but uses a different methodology from dyadic clinical social work with individuals and families. Consistent with critical clinical practice, social work with groups often mobilize anti-oppressive, non-hierarchical, strengths based approaches in a collective setting that facil-

itates mutual aid and collective resistance to identified socially oppressive policies, practices and traditions. A central ethical consideration, according to *The Standards of Social Work with Groups* is that “no one person should be more privileged in a group than another, not a worker, a group member or the agency director.” A second core value of social work with groups is “the creation of a socially just society.” The profession needs to re-examine standards-based group work practice, with its democratic formulation, for all social workers practising in groups. This is not only to ensure effective practice skills, but also to recover the genesis and continuity of social work’s ethical and value base. Social group work is a powerful practice modality and joins the profession’s one-on-one practice approach. It can adopt a structural social justice approach, often seen in feminist groups for women dealing with violence and in non-profit organizations.

Critical clinical practice with individuals, couples, families or groups adopts the ethical, social justice, social foundations of the profession that are based on collaboration, respect, dialogue, democratic process, mutual aid, and community. These principles are central to critical clinical practice for instance through feminist and narrative practice approaches. Within critical clinical practice, whether individual, couples, families or groups, the understanding is that individual experiences and struggles emerge within a social context and relationships and thus the focus is always an integration of the individual, social discourse, and social systems and structures of power.

In 2003, Australian social worker Christine Morley completed a comprehensive review of the literature and established a strong pattern of social workers not extending their critical practice into the mental health field (Morley, 2003). Morley noted that even though there had been numerous social work publications on how to practice with a critical perspective, these ideas had not been taken up. She therefore issued a challenge to social workers to “deconstruct how bio-medical discourses operate to maintain the social order and obscure inequitable power relationships” (p.79). A review of current texts on mental health social work suggests that this trend continues, with social workers working in partnership with mental health teams structured around the bio-medical model using evidence-based approaches (Bentley, 2001; Bland, Renouf & Tellgren, 2014; Gibbs, 2003; Golightley, 2020; Raines, 2019; Regehr & Glancey, 2014). In a new publication, Morley and her colleagues (2020) have assembled a handbook of critical pedagogies for social work which take up relevant ideas and approaches from multiple disciplines outside of psychiatry and psychology, which have relevance to social work. Michael White (1995) a social worker central to the creation of narrative therapy rooted his therapeutic conceptualisations in philosophy, anthropology and narrative theories.

Johnstone (2020) uses the philosophical ideas of Fricker (2010) to reconceptualise assessment strategies in child welfare work. Brown (1993,a,b,c,d; 2007 b,d; 2014; 2020b) integrates feminist and narrative nonpathologizing clinical approaches to counterview and counterstory women's body talk and weight preoccupation stories as well as with the effects of trauma and violence on women's lives.

Critical clinical social work practice is grounded in anti-oppressive, intersectionality and social justice-based theories. This critical clinical lens seeks to integrate theories of social and structural inequities into intentional, consistent ways of practicing social work. Often missing from anti-oppressive practice and intersectional frameworks is an explicit recognition of sanism as a form of oppression, that is, the valuing of rational thinking and socially acceptable forms of behavior, and the subsequent ostracization and/or punishment of people who do not or cannot conform (Dumbrill & Yee, 2013). In addition, an integrated critique of dominant psychiatric bio-medical discourse is often missing (C. Brown, 2019a). The dominance of the bio-medical model has produced conflicts for social work mental health practitioners whose professional identity and training is often rendered invisible within mental health care settings. European and British social workers have stressed the need for a collective voice to address these constraints to social work practice (Ferguson & Lavalette, 2013). The School of Social Work at Dalhousie University has emphasized the importance of critical clinical social work for social justice approaches to mental health (Brown & MacDonald, 2020). It is important to recognize however, that critical clinical approaches will be constrained by the very structure of mental health and health services unless those services are restructured. In San Francisco, for instance, a study was conducted attempting to put into place a critical model of mental health care delivery that had been developed in Italy in the 1970's with some success and considered by the World Health Organization to be one of the most progressive in the world (Portacolone, Mezzina, Scheper- Segal, & Hughes (2015). However, facing the inequities and multiple limitations of the American health care system, the Trieste public psychiatry model was simply not possible in San Francisco.

Person-centred Practice Models (Individual, Family, Community)

The origins of client or person-centred clinical work began with Carl Rogers who focused on the relationship between the client and the therapist, emphasizing the client's knowledge, values, preferences and experiences (Rogers, 1951). The Rogerian approach has significantly shaped social work practice.

Instead of focusing on psychodynamic motivations or mechanistic behavioural approaches, person-centred work was largely defined by the person seeking support. His was a humanist approach, not structural or social change focused. Yet, as an alternative to expert-driven bio-medical or pathologizing practice theory, this approach has been central to empowerment, social justice and feminist based social work. Person-centred work emphasizes clients' voices and this is particularly important for those whose voices have not been valued or heard. Following person-centred models, feminist and post-modern perspectives have emphasized the overall social and relational context of people's lives, alongside a collaborative relationship between clients and therapists.

Clinical work involves not just individuals, but couples and families. Family based mental health and addiction services need to be available in particular for children and youth. Family and systems/ecological approaches to therapy have a long and influential history in social work moving from Bateman, Minuchin, Bowen, Bowlby to the Milan approach (Flaskas & Humphrey, 1993).

Family-centred work draws its history from the general systems theory of the influential American sociologist Talcott Parsons. Many critics rejected its structural functionalist foundation which minimized the idea of social conflict, maintaining that society achieved homeostasis and equilibrium. The organization of society was seen to work equally well for all. Goodness of fit was a concept that emerged implying problems reflected a lack of fit between the individual and society, which harkened back to the Darwinian evolutionary theory of the "survival of the fittest notion". He was seen by some as deterministic and mechanistic with a view of the individual and society based on a model of the body and the idea that all parts influence the whole. There was no discussion about how the "whole" impacted people differently or who contributed what or how much to the whole. A type of circular relativism exists here that provides little distinction about who benefits and who suffers everything is the same for everyone. Critics of structural functionalism often moved on to more politicized structural and ideological analysis that addressed power and oppression.

Murray Bowen (1978) was an important contributor to family systems therapy emphasizing common patterns found in all human emotional systems and encouraging individuals to acknowledge and disrupt intergenerational patterns in their families of origin rather than engaging in individual therapy (Brown, 1999). Family systems work has understood that mental health and substance use issues impact all family members, not just the individual with the mental health or substance use issue. Further to the impact on all members, is the family systems view that mental health and sub-

stance use issues may reflect a person's attempts to cope with emotional wounds within the family. This idea was popularized in Claudia Black's work on adult children of alcoholics which underscored the idea that the individual struggling with alcohol often affected the whole family and frequently resulted in psychological injuries. Adults found themselves addressing their painful childhood experiences in a family system where addiction and trauma were often experienced intergenerationally (Black, 2018).

Family systems theory recognized relationships and interactions with extended families, workplaces, and communities members in addition to multiple generations of shared lived experience (Kerr, 2019). This knowledge informs the work of social workers in mental health and addiction settings and has implications for assessment, service plans, interventions and evaluations of the process. Social work attends to the points where people interact with their social environment including the multiple social systems that people are embedded in (International Federation of Social Work, 2020).

Feminist relational theory in the 1980's and 1990's acknowledged the importance of social relationships in the formation of self with a particular interest in gender, arguing that girls and women had a heightened emphasis on being relational which they saw as a strength as well as a limitation when women put others needs before them own (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). While this relational theory contributed to gender analysis, it was critiqued by other feminists for failing to adequately address the social construction of gender by treating women's relationality as natural and for universalizing women's experiences rather than acknowledging the influence of social intersectionality and differences in experiences among women.

Feminist critiques have often centred on family systems' lack of attention to power, gender, and heteronormative assumptions about what constitutes the family (Flaskas & Humphreys, 1993; Marchant, 1986). Flaskas & Humphreys (1993) note, "Not surprisingly, feminists writing and working in the field of child abuse and domestic violence were particularly struck by the grave difficulties of working in fields where the abusive effects of power were all too obvious, and yet finding in family therapy no real acknowledgment of power, and a therapeutic framework that gave little help in working with its abusive effects" (p.2). These authors explore intersections between Foucault's (1980) analysis of power, and the way in which systemic family therapy has engaged with the task of theorizing about power.

While family systems theory has made significant contributions, it has been critiqued for failing to contextualize maternal behavior, or recognize patriarchal assumptions, leaving women vulnerable to mother blaming and having their social-

ly prescribed roles pathologized (Brown, 1999). Social workers practicing from a person and family-centred approach need to be aware of these significant critiques while appreciating the relational nature of human experience. Nonetheless, as social work attends to the social histories and social context of people's lives it needs to address their relationship with others and this will often include the family. Influenced by feminism, and postmodernism, ecological models of systems theory and the family have emerged which seek to provide an approach which situates individual and family struggles in the larger social context (Ungar, 2002). All told, feminist and social justice based social work has often shifted toward narrative approaches in relational and family work, which contextualizes people's struggles both within and beyond the family.

Recovery Model

The recovery model of mental health care emerged in the 1980s as counterstory to the bio-medical model prognosis of hopelessness, chronicity, and no cure. Psychiatric survivors such as Patricia Deegan, Pat Capponi, Don Weitz, and scholars such as William Anthony were at the forefront of the movement in the early days (Anthony, 2000; Burstow & Weitz, 1988; Capponi, 1992; Deegan, 1996; Penfold & Walker, 1984). They shifted the focus to a personal journey of recovery grounded in survivor rights and peer support.

In contrast to the way the recovery model has been taken up in Canada, in Australia the recovery oriented approach to mental health treatment and services was widely adopted as a more transformative model of service delivery (Australian Health Ministry's Advisory Council, 2013; Le Boutilier et al., 2011; Andresen, Oades & Caputi, 2002; Victorian Department of Health, 2011). Le Boutilier et al. (2011) recognized this model as transformational to how those living with mental illness are perceived and understood in society. As the recovery approach questions the dominance of professional "power" and "expertise," challenging the often paternalistic divide between service users and providers (Australian Health Ministry's Advisory Council, 2013; Le Boutilier et al., 2011), it began by moving away from the focus on pathologizing mental illness and taking a more holistic approach to the treatment of mental "illness," emphasizing the service user's own personal strengths and autonomy (Victorian Government, 2011). Breaking down traditional notions of service provider/user is often done in recovery approaches through the provision and development of peer support programs led by peers with lived

experience. England has developed extensive peer-support models as a response to the implementation of recovery focused mental health services (Basset, Faulkner, Repper & Stamou, 2010). Other components have also been integrated into this approach, including evidence-informed treatment, psychosocial support, and therapy (Le Boutilier et al., 2011).

The recovery approach emphasizes the social determinants of health, stigma, discrimination, and other barriers that may negatively impact recovery from mental health concerns (Australian Health Ministry's Advisory Council, 2013). Recovery approaches adapt to the needs of those that access services, recognizing the complexities of individuals' lives and how their social location impacts both their mental health and recovery from it (Australian Health Ministry's Advisory Council, 2013).

In Canada, the report *Towards Recovery and Well-Being: A Framework for a Mental Health Strategy in Canada* (2009) endorsed the recovery approach to mental health which they framed as "hope, empowerment, self-determination and responsibility" (p.122). The Mental Health Commission of Canada (2012) established a recovery-oriented mental health system as the cornerstone of its strategy. A challenge of this approach has been the ambiguous understandings of what "recovery" from mental "illness" means (Victorian Government Department of Health, 2011). Recovery in the bio-medical field may refer to an absence of or recovery from symptomatology associated with an illness. However, it is noted that the recovery approach itself views recovery more as a holistic non-linear process that is self-defined (Australian Health Ministry's Advisory Council, 2013). In their research, Le Boutilier et al. (2011) identify the key characteristics of a recovery-oriented approach as promoting citizenship of those with mental illness, an organizational commitment by mental health providers, supporting recovery as defined by the service user, and strong working relationships.

Part of Australia's mental health strategy, which aligns with a recovery approach, is to focus on what work can be done across sectors to address some of the structural and systemic barriers faced by those with mental health concerns. For example, the housing sector increasingly acknowledges the importance of considering the needs of those with mental "illness" when planning social housing initiatives (Australian Government Department of Health, 2009; Australian Institute of Health and Welfare, 2019). Specialist Homelessness Services (SHS) agencies provide support specific to those with mental health concerns through accommodation services (Australian Institute of Health and Welfare, 2019). Furthermore, developments in the justice sector have included diversion programs for people with mental "illness" or substance

dependence (Australian Government Department of Health, 2009). States and territories in Australia also provide Psychiatric (dis)Ability Support Services which are outlined under the *National Disability Agreement*. Those eligible for (dis)Ability supports can access a range of services from residential support services to community support, community access, respite services, and employment services (Australian Institute of Health and Welfare, 2019). Medicare subsidized mental health specific services include general practitioners, psychiatric services, psychologists, and other allied health professionals. Allied health professionals which qualify for subsidy under Medicare include mental health nurses, social workers, and occupational therapists (Australian Institute of Health and Welfare, 2019). However, in Canada today the concept of recovery in mental health and wellbeing has often been reframed. A rhetoric of recovery has emerged which is being used to legitimate neoliberal and bio-medical strategies and approaches (Poole, 2011). Morrow and Weisser (2012) argue that we must honour the original principles of the recovery movement and address power and the social and structural impediments to recovery.

Integrated Models

Integrated care as a model of mental health service delivery is well-represented in the literature, although there are different understandings of what “integrated care” entails. In most cases, it refers to multi-provider, co-ordinated service delivery. Integrated care can involve one care plan that is initiated and supported by a multidisciplinary team of professionals (Collins, Hewson, Munger & Wade, 2010). Specialists, support providers, and various allied health professionals work collaboratively as a team to improve the determinants of health of those they are working with (British Columbia Minister of Health, 2012). In some cases, these health professionals may be housed in the same building for ease of access by service users (Kilbourne et al., 2012).

Integrated care can also involve collaborative care models where service providers and specialists each have their own care plan and independent services, but acknowledge the importance of communication, partnership, and the provision of services that help support the goals of each other’s care plans (British Columbia Minister of Health, 2012). Collaborative care is characterized by providers maintaining their own independent service but who have agreed to work collaboratively with the goal of attaining a more comprehensive continuum of care (British Columbia Minister of Health, 2012; Collins et al. 2010).

There is a strong case made in the literature for models that include this type of care coordination, partly due to the recognition that fragmented care systems where services are siloed often result in poor quality of service, services that are insensitive to the needs of service users, and services that are inconsistent health outcomes (Daniels et al., 2009). Internationally, mental health services that are characterized by separate teams for acute mental health services and longer-term care coordination are strongly favoured (Flannery, Adams & O’Conner, 2011). Furthermore, services are often fragmented into specialized areas of treatment rather than centred around a mental health team. Despite this, there is strong evidence supporting the benefits of a continuity of care model where the same team is able to work with a client throughout all phases of their illness (Daniels et al., 2009; Flannery, Adams & O’Conner, 2011). Enhanced care coordination for individuals in the mental health system can better support recovery and positive health outcomes (Daniels, Adams, Carroll & Beinecke, 2009; Hollander & Prince, 2008).

Some literature refers to integrated care as the integration of specific mental health services and capacity to frontline primary health care providers, such as general practitioners, nurses, pediatric medicine, and internal medicine (Delaney, Robinson & Chafetz, 2013). This means that a person would have both their behavioural and medical needs addressed within one healthcare system (Delaney et al., 2013). An argument for this model of care is that practitioners may be more aware of how what are described as co-morbidities can impact a person’s mental health, whereas in other models these practitioners may be only working on one issue at a time. Recognizing interconnectedness can be helpful to clinicians in devising a plan of care that considers all aspects of a person (Collins et al., 2010; Delaney et al., 2013). Some of the challenges of integrating mental health care into the primary care include the capacity of health care providers, such as physicians, to have the funding and time available to more thoroughly work with clients experiencing mental health challenges (Carey et al., 2013).

Tiered Approaches/Stepped Care Approaches

Stepped care approaches to mental health service delivery are prevalent in the literature, specifically in the treatment of depression and general anxiety “disorder” (Bower & Gilbody, 2005; Scogin, Hanson & Welsh, 2003; Seekles, van Straten, Beekman, van Marijk & Cuijpers, 2009). Stepped care has been a widely proposed

solution to the gap between supply and demand of mental health services as it is focused on providing the least intrusive and most minimal intervention required to address treatment goals (Bower & Gilbody, 2005). The premise of stepped care is that intervention is delivered at the most appropriate time and targeted at the level needed to achieve positive health outcomes. The goal of the stepped care model, according to the literature, is to not provide intensive services to a service user but to instead bolster self-management capacities so as to make efficient use of the mental health resources available (Mutingh et al., 2014; Seekles et al., 2009; York & Kingsbury, 2013). Stepped care models often start with interventions that are efficient and least resource intensive, such as brief therapies, group work, self-help approaches, bibliotherapy, and treatments offered via technology (Bower & Gilbody, 2005). More intensive, specialist, and resource-intensive services are reserved under this model for those who are less likely to benefit from these “minimal interventions” (Bower & Gilbody, 2005; Scogin et al., 2003). This approach is consistent with the principles of neoliberalism.

There are 5 tiers in the model that is used by the Nova Scotia Health Authority.

1. Tier 1 services are based on population health promotion and initiatives targeted at the general population using strategies focused on health improvement.
2. Tier 2 services include primary care, self-management, and community care. Services under Tier 2 are targeted to service users at risk or who have mild to moderate mental “disorders” including addictions. Early interventions that are brief, centering on self-management support, are provided at this level of care.
3. Tier 3 is formal mental health and addictions care. Services at this level are targeted at those with moderate to severe mental health “disorders” and addictions. Those receiving treatment at Tier 3 are considered to have mental health “disorders” that impact their daily functioning and services are delivered in the community through outpatient clinics.
4. Tier 4 is highly intensive mental health and addictions care targeted at those in need of more intensive or specialized care. Treatment at this level may be in the form of acute inpatient services.

5. Finally, Tier 5 is specialized mental health and addictions care, which is targeted at those with high risk and complex needs, including severe concurrent mental health and substance use “disorders” that require specialist intervention and a high level of care coordination. Treatment at the Tier 5 level may be delivered in the form of specialty inpatient care (IWK Health Center, 2020).

In 2012, Nova Scotia adopted the choice and partnerships approach (CAPA) model for mental health service delivery at the IWK and in mental health and addiction services. In Canada, Ontario also adopted this model, as have the UK, Belgium, Australia, and New Zealand. Community Mental Health in Nova Scotia is now following a tiered/stepped approach to service delivery, and is also using CAPA within the tiered approach. The CAPA model is premised on the concept of “having the right service, in the right place, at the right time, delivered by the right person” (IWK Health Centre, 2020; York & Kingsbury, 2013). This service model aims to provide a range of options for service users that meet the goals of the individuals and family seeking treatment. The model is based on a choice and partnership approach, with service users first completing a “choice” appointment where they discuss with a clinician what their needs may be. Through this appointment, the clinician works with the client to determine what kind of service best suits their needs.

In their book on the CAPA model, York & Kingsbury (2013) declared their allegiance to the Maori-inspired CAPA framework, which is based on the Maori canoe (Waka), a salient part of the Maori sacred heritage: “you do not paddle the waka, alone: it takes many paddlers to make the water shift” (p. iii). From these noble intentions—a model of collectivity that is client-centred and mobilizes the appropriate supports and the best specialized interventions available for each and every referred person—the CAPA model has devolved to its present application in Nova Scotia. It is currently dominated by the bio-medical model of healthcare and implemented under the fiscal constraints of a neoliberal economy. As a result, the initial “choice” appointment, which is intended to facilitate individualised care and autonomy, is dominated by a medical assessment where mental distress is evaluated in the light of symptoms and a DSM diagnosis.

The subsequent intervention appointment flows from this medical appraisal of the person. While the original intent of the CAPA model was to shorten wait times, the result has been to move wait times from waiting for the first appointment to waiting inside the system for the intervention appointment. Those who are referred who

do not “fit” into the DSM are turned away. Those who continue to the intervention part of the model are provided with time-limited, one-size-fits-all responses in accordance with the “specialized” responses available in the community. In locations that are under resourced, such as rural locations, the options available are very limited and the wait lists are long. Social workers providing service within this model are very constrained as they do not have the autonomy to respond to a referral and begin an immediate response based on their clinical social work assessment and expertise.

Assertive Community Outreach

One of the more prominently researched and most widely used treatment programs for mental health is assertive community outreach, also referred to as assertive community treatment or ACT (Bond, Drake, Mueser & Latimer, 2001; Killaspy et al., 2006). ACT originated in the United States, but has also been implemented in the Netherlands, Great Britain, Australia, and in some provinces in Canada (Bond et al., 2001; Killaspy et al., 2006; van Vugt et al., 2011). ACT is a model of care typically used for those diagnosed with more severe mental illness and is largely delivered in the community setting (Bond et al., 2001; van Vugt et al., 2011). ACT is an intensive mental health treatment program that involves a multidisciplinary team of professionals who work with clients who may be at a higher risk for psychiatric hospitalization (Bond et al., 2001). ACT is typically targeted at those with severe mental illness who are not utilizing clinical-based programs and aims to keep people in the community and out of the hospital.

While the stated purpose of ACT is to provide community treatment, the teams are located in hospital settings and are most commonly led by bio-medical model practitioners. In some cases, this is a social worker, but the expectation is that the social worker will conform to the medical model. Compliance with pharmaceutical treatment prescribed by treating psychiatrists is a central part of the program. Community treatment orders (CTO) are used to enforce medication compliance and case management revolves around medical-model expectations of incurability, chronicity, and symptom-dominated functioning. The goal is to prevent hospital re-admission (a fiscal goal). Therefore, the community part of the program revolves around medication compliance as it is believed that this is the key to successful functioning (a medical-model perspective). As such, holistic and strength-based approach to wellness is not the leading paradigm for ACT (Lee et al., 2019; Lee, Herschman & Johnstone, 2018).

Professionals that are a part of the multidisciplinary ACT team may include social workers, nurses, psychiatrists, substance use counsellors, and rehabilitation specialists (Bond et al., 2001). When following ACT principles, these multidisciplinary teams claim to take a holistic approach to service delivery, and to be focused not only on the diagnosis and treatment of mental “illness” itself, but also on housing, finances, medications, and any other barriers or challenges a client might be experiencing (Bond et al., 2001). Key principles of the approach include a low patient-to-staff ratio, contact in the community, a focus on medication management, the integration of all relevant services, assertive outreach, time-unlimited interventions, and a focus on other issues or systemic barriers a client may be facing (Bond et al., 2001; van Vugt et al., 2011). Research shows that outcomes for ACT approaches to mental health treatment are positive. When model fidelity is consistent, these outcomes include greater stability in housing, the reduction of admission days in hospital or acute care, more sustained contact with clients, and greater satisfaction by service users (Bond et al., 2001; van Vugt et al., 2011).

Other Initiatives

Denmark piloted the program Arts on Prescription (AoP) between 2016 and 2019. “Culture Vitamins,” an AoP program, is a 10-week program that includes a range of cultural activities done in a group setting. The cultural activities are offered through 2.5 workshops per week and are offered to those experiencing moderate depression, stress, or anxiety. AoP programs are largely defined as “non-clinical” activities with social and creative opportunities. Participants are referred to these programs through their general practitioner or other health or social care providers. Community group-based arts programs are offered in a range of time lengths and number of participants, and offer different activities. These programs aim to supplement traditional treatment of mental health by promoting social engagement to those who may be socially isolated. Activities can include visiting museums, art galleries, orchestras, concerts, and walking by the sea, for example. (Jensen, 2017). A qualitative study evaluated participants enrolled in the program and found that reported mental health benefits included “increased energy levels, increased self-esteem, more joy in life, less panic attacks, increased motivation, a better understanding of own needs, an increased level of selfcare” (Jensen, 2017 p.131).

In the leading discussion of this section on critical clinical social work we discussed an approach that we believe offers a social justice centred approach to mental health

services which best meets the needs of persons in mental distress. If this approach were incorporated into mainstream services, it could be provided across a range of substantive issues and modes of delivery.

SOCIAL POLICY ON MENTAL HEALTH AND ADDICTION

In response to growing recognition of the prevalence and impact of mental illness, both the federal and provincial governments in Canada have released strategies out-lining commitments to providing better mental health prevention, intervention, and treatment.

Canada's first mental health strategy, *Changing Directions, Changing Lives*, was released by the Mental Health Commission of Canada (MHCC) in 2012. The strategy outlines six strategic priorities and a number of calls to action with the goal of overhauling the Canadian mental health system. The strategy includes a greater focus on promotion and prevention, recovery-focused interventions, increased access to services, addressing disparities, and the creation of a continuum of mental wellness services specifically for First Nation, Inuit, and Metis populations. The final priority outlined in the strategy is a call for leadership and collaboration in coordinating mental health policy across governments and sectors, as well as increasing the role that those with lived experience play in policy making related to mental health. The strategy concludes with calls to action that include a need for increased investment in mental health, as well as measuring progress on the implementation of the strategy (MHCC, 2012). In 2016, the MHCC released a follow-up to the strategy titled *Advancing the Mental Health Strategy for Canada* that outlines a five-year framework to expedite specific actions to fulfil the priorities outlined in the original strategy. This is to be completed by 2022 (MHCC, 2016).

Nova Scotia also released its first-ever mental health strategy, *Together We Can*, in 2012. The strategy was set to be completed within five years and outlines a number of action items within five different priority areas. These priority areas include early intervention and treatment, better care and shorter wait time for accessing services (i.e. implementation of the CAPA model), addressing disparities experienced by Aboriginal and racialized communities, better collaboration between government agencies to address barriers to living well, and reducing the stigma of mental illness (Nova Scotia Department of Health and Wellness, 2012).

A progress update on *Together We Can* was released in 2016. The update stated that 28 of the original 33 action items have been either started or completed, leaving only 5 items in the strategy not yet started (Nova Scotia Department of Health and aWellness, 2016). In 2017, the Office of the Auditor General of Nova Scotia (OAGNS) completed an audit of mental health services provided by the Nova Scotia Health Authority, the IWK, and the Department of Health and Wellness. The Auditor General concluded that, at that time, the health authority lacked a province-wide plan for mental health services and policies, that the 2012 mental health strategy was poorly managed, and that there remained 10 strategy items not completed. The Auditor General also found that there was no plan by the province to evaluate the 2012-2017 mental health strategy to assess whether mental health services have improved (Office of the Auditor General of Nova Scotia, 2017).

In 2019 in Nova Scotia, building on *Together We Can* (2012), the government identified three key areas for improvement in mental health and addictions planning over the next three years (2019-2021) that focus on access to services, integration and continuum of care. In this report it was noted that the CAPA at the IWK and NSHA had resulted in shorter wait times for child and mental health services while also acknowledging continued challenges in access to care.

Both the federal and provincial strategies outline the need for services to address concurrent substance use and mental health disorders to provide better access to quality and effective care. The federal strategy, *Changing Directions, Changing Lives*, speaks specifically to the importance of integrating mental health and addiction services both at the administrative as well as the direct service level. The strategy recognizes that coordination of services for those with concurrent “disorders” is lacking and that there is a need for better collaboration by service providers (MHCC, 2012). One of the guiding principles of *Together We Can* is being accessible and responsive to the needs of Nova Scotians experiencing mental health, substance use, and gambling disorders (Nova Scotia Department of Health and Wellness, 2012). Actions within the provincial strategy that specifically target substance use include implementing school policies related to mental health, substance use, and gambling, as well as expanded opioid replacement treatments, locating mental health and addiction beds, and promoting the gambling awareness hotline and other provincial gambling services. The strategy also includes concurrent “disorder” training for service providers, improving information systems, the implementation of diversity groups for policy-making, supporting municipalities to reduce the harms of alcohol, and collecting data related to drinking, drugs, and gambling. Lastly, the strategy

includes improving mental health and addiction care for seniors and incarcerated adults (Nova Scotia Department of Health and Wellness, 2012).

These recent MHCC reports *Advancing the Mental Health Strategy for Canada*, (2017-2022) the subsequent *Frameworks for Action* (2017-2022) and the earlier *Changing Directions, Changing Lives* (2012) are meant to work together to meet their overlapping goals. Along with the Nova Scotian provincial report *Together We Can* (2012) these reports emphasize reducing stigma and discrimination, enhancing recovery, and the significance of social context in the development of mental health. These reports express an interest in the voices of service users and providers and acknowledge the importance of recognizing diversity and inequality. Despite these reports there continues to be significant need to address the impact of mental health inequality. There is no evidence in 2020 that the determinants of mental health have actually been addressed. Under neoliberalism and the dominance of the bio-medical model the oppressive and marginalizing social context for instance of poverty, racism, intergenerational trauma, and gender based violence often associated with mental health and substance use problems have not improved. There is an ongoing gap between these reports and the implementation of them in policy and programming development. Mental health and addiction issues will only be adequately addressed alongside addressing social inequality. Associated budgets and resources needs to be allocated in order to realistically addresses the social determinant of mental health outlined by WHO (2014).

And while we can see for instance, in the Bell Let's Talk private campaign (2015) an effort to tackle stigma associated with mental health, this campaign arguably props up individual responsibility for recovery, not government mental health services and resources. In addition, despite the seeming focus on social context and destigmatization of mental health issues in the most recent federal and Nova Scotian mental health reports, one can question how this can be reconciled with the language and power of the DSM-5. The government documents do not directly raise the issue of the efficacy of the DSM and bio-medical model and their predominance remains firmly intact. Finally, treatment strategies need to be reconfigured to reflect ideological shifts which do recognize social context and diversity in mental health. The existing CAPA management model in Nova Scotia, put in place initially to address wait times and increase efficiency, has not demonstrated success regarding accessibility, the provision of appropriate cultural services or attention to issues of diversity. It has not demonstrated an integrated approach for co-occurring mental health, trauma and addiction issues. Despite government policy, CAPA is restrained by a neoliberal

agenda of economic rationalization. A commitment to quality mental health care and social equity will only be demonstrated when sufficient prioritization is given to mental health and to addressing the social determinants of mental health and addiction through the funding of programs and resources and through reducing social inequities.

Recognition, Collaboration and Support may represent a positive direction in recognizing the significant impact of a wide range of traumatic experiences on people's mental health and wellbeing and help reduce mental health inequity through for instances a focus on at risk and vulnerable populations including those experiencing homelessness, 2SLGBTQIA+ people, Indigenous communities, refugees, armed forces and veterans, as well as those who have experienced gender based violence and adverse childhood experiences.

Across Canada, government reports emphasize improved access, population health, social determinants of health, reducing stigma and discrimination, mental health promotion, early interventions, community capacity, culturally responsive services, and addressing the needs of Indigenous communities. Notably all recognize that they do not have the funding to be able to fulfill these goals. Unless a commitment to prioritize mental health and addiction services can be made to provide the funding and resources needed these important goals will not be met. Alongside the federal government, Manitoba, Saskatchewan, and British Columbia specifically refer to the need to address intergenerational trauma. However, philosophically and socially valuable these policy goals may be, clear and specific strategies need to be developed to meet each goal.

PROVINCIAL MENTAL HEALTH AND ADDICTION POLICY ACROSS CANADA

Throughout Canada government policy reports on mental health and addictions emphasize the need for services that are culturally responsive, timely, and effective. All provinces and territorial reports are clear that they will need further funding to accomplish their goals. In the provincial and territorial reports the CAPA model is noted only in Nova Scotia and Ontario.

The CAPA model has been implemented in Ottawa, Ontario as a means to enhance effectiveness, efficiency, and reduction of wait times (The Child and Youth Mental Health Lead Agency Consortium, 2019). *Open Minds, Healthy Minds; Ontario's Comprehensive Mental Health and Addiction Strategy* (2011), a ten year plan, identified four goals: improve mental health and well-being for all Ontarians, create healthy,

resilient, inclusive communities, identify mental health and addictions problems early and intervene and provide timely, high quality, integrated, person-directed health and other human services. Quebec, as in other provinces, is emphasizing a population mental health framework for public health that is informed by a social determinants of health perspective (Montoura, Roberge & Fournier, 2017).

New Brunswick's (2011) action plan for mental health (2011-18) includes seven goals to transform Addictions and Mental Health Services, and focuses on collaboration, recovery-based approaches, cultural competence and cultural safety, increasing a sense of belonging, increased training, reducing stigma, and building community capacity to support youth in mental health. The government of New Brunswick's Addictions and Mental Health branch emphasize a recovery oriented approach where people living with substance use problems and mental illness are supported through their journey of well-being (New Brunswick Health, n.d.). Prince Edward Island developed a ten year (2016-2026) mental health and addiction strategy noting five priorities: mental health promotion; recovery and well-being; invest early by a focus on children, young people and families; an innovative and collaborative workforce; and access to the right service, treatment and support. In their efforts to transform mental health addiction services, PEI will continue to embrace tiered care and a recovery- oriented system as they view these approaches as offering best practices while also investing more in the five priority areas.

In 2017, the All-Party Committee on Mental Health and Addictions released *Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador* that identified recommendations to be implemented within a five-year period (2017-2022). This five-year plan plans to be built on a conceptual model that intends to consider and fully integrate recovery and well-being. This plan is built on the work of Mulvale and Bartram (2015), *No More "Us" and "Them": Integrating Recovery and Well-Being into a Conceptual Model for Mental Health Policy* and the approach taken in Canada's mental health strategy, *Changing Directions, Changing Lives*. It included four pillars: promotion, prevention and early intervention, focusing on the person, improving service access, collaboration and continuity of care and including all people everywhere.

A recent report about mental health and addiction services in Manitoba, informed by extensive consultation with the general public and key stakeholders, noted the urgent need for reform to meet the needs of the province. Recommendations in this report focused on a population health perspective including the need to take steps to become culturally responsive, particularly regarding the Indigenous population (Rush et al. 2018).

The province of Saskatchewan has *Working Together for Change: A 10-year Mental Health and Addictions Action Plan for Saskatchewan* which outlines 16 recommendations that fall into seven categories: enhance access and capacity and support recovery in the community; focus on prevention and early intervention; create person and family-centred and co-ordinated services; respond to diversities; partner with First Nations and Métis Peoples; reduce stigma and increase awareness; and transform the system and sustain the change.

A Mental Health and Addictions Advisory Council has been created in Alberta to help improve access to mental health and addiction prevention, treatment and recovery services with a final report expected in 2020. This council will develop a strategy outlining recommended actions to increase quality and access to a recovery-oriented mental health and addiction system, with a particular focus on treatment, recovery and justice programs. Home care and primary care will also be addressed.

In 2017 British Columbia created the first Ministry of Mental Health and Addictions in Canada as a starting point to address mental health issues described as nearly the lowest in the country due to personal to global concerns – from childhood and intergenerational trauma to the impacts of climate change. The 10-year goals (2019-2029) of this ministry include a shift in funding priorities to focus more on promotion and prevention efforts, the provision of equitable, seamless, integrated and culturally safe care, and on Indigenous health and wellness.

The Forward Together Yukon Mental Wellness Strategy 2016-2026 report describes mental wellness as a balance of the mental, physical, spiritual and emotional aspects to frame their “whole person” approach. Given the Yukon’s population and current capacity they will continue to rely on out-of-territory resources and supports as well as from Whitehorse back to the community for some complex and high-risk individuals. However, the primary objective of their Mental Wellness Strategy is to increase seamless mental health, trauma and substance use services with equitable access; a full continuum approach that spans the lifetime; cascading and need-appropriate service delivery and matching; to be accessible through any entry point or provider in the Yukon system in a culturally competent manner. Four strategic priorities include: promotion and prevention; service delivery; system performance and access; and innovation and research.

Mind and Spirit: Promoting Mental Health and Addictions Recovery in the Northwest Territories – Strategic Framework 2016-2021 is committed to providing culturally appropriate services that build on connectedness of culture and community grounded in a population-health framework. This framework has four key directions:

a focus on prevention and early intervention, a recovery-oriented system, personal experience (learn from individual experiences through ongoing research) and outcomes and a whole (better integration) government approach. Nunavut Territory with a population of approximately 35,000 has historically relied heavily on out of territory services for addiction and mental health services.

Published in 2002, the *Nunavut Addictions and Mental Health Strategy* has not been followed with supplementary policy documents until recently. According to a news article this strategy noted the importance of increased funding commitments, accountability and governance, policy and standard development and evaluation while recognizing escalating crime rates, domestic violence and substance abuse (Murphy, 2002). In 2018 the Government of Nunavut contracted NVision Insight Group to undertake a needs assessment, development of options and feasibility study for in-territory addictions and trauma treatment programs and services noting that since 1999 they had addressed the needs of individuals requiring treatment for addictions and mental health issues by offering access to residential facilities and programs outside the territory and that these were often not culturally sensitive. However, within Nunavut there are communitybased programs and organizations that offer opportunities for Nunavummiut to seek and receive counselling and support in non-residential settings.

In March of 2020 the Nova Scotia College of Social Workers and the Canadian Centre for Policy Alternatives-Nova Scotia released a social policy framework for Nova Scotia. The need for progressive organizations to add to the political dialogue with thoughtful progressive social policy solutions is now greater than ever if we are to capture the hope and aspirations for a society in which all Nova Scotians flourish. The social policy framework provides 10 principles to drive the creation of clear and specific strategies in order to create greater well-being and address inequality and inequity. The guiding principles for social policy include a focus on interconnectedness, decolonization, social inclusion, universality, climate justice, decent work and well-being, public provision, fiscal fairness, shared governance and democratization. Any social policy being created needs to be embedded in these principles in order to shift our society to be more caring, compassionate, and equitable (NSCSW and Canadian Centre for Policy Alternatives Social Policy Framework, 2020).

CANADA'S NATIONAL DRUG STRATEGY

As discussed in detail above, substance use is often a reflection of mental health struggles and vice versa. Yet dominant addiction discourse, and beliefs about alcohol use problems in particular, are deeply entrenched in our society. Dominant addiction discourse maintains that substance use is a disease, that one has no control over their use, and that abstinence is the only viable treatment option (Brochu, 1990; Fingarrette, 1988; Heather, 2006; Marlatt & Witkiewitz 2002, 2010; Sanders, 2007; Tatarsky, 1998). These beliefs shape how options for dealing with substance use problems are viewed. These beliefs are part of social policy and the development of treatment protocols and practices. Yet, the belief in dominant addiction discourse is so pervasive many don't consider alternatives at all. By not doing so we fail to offer "real" choices in dealing with alcohol use problems and create more limited policy frameworks (see Brown & Stewart, 2020).

Debates about whether problems with alcohol use are a disease, about what constitutes an "addiction," and about whether abstinence is the only realistic solution produce powerful emotional responses among both service users and service providers (Brown & Stewart, 2007). These tensions are also present in drug and alcohol policies, within social service organizations, and provincial and federal government. Addiction ideas are often powerfully and fervently defended by service users and providers. These ideas are political; it is contested terrain linked to people's overall world view. As with dominant mental health discourse, addiction discourse is rooted in biomedical disease discourse and other approaches remain marginalized and have greater difficulty being considered legitimate among service users and providers.

In Canada, the recognition of substance use as a primary health concern began in 1987 with the launch of the National Drug Strategy. While this strategy addressed illegal substance use through control and enforcement, a new and important focus on harm reduction emerged. By 2003, Canada's National Drug Strategy had evolved to include problem use of legal substances such as alcohol. Its four pillars were designed to enhance substance abuse programs, knowledge, and partnerships in the areas of prevention, treatment, harm reduction, and enforcement (Collin, 2006). Revisions in 2007 under the Harper government produced the National Anti-Drug Strategy (NADS; emphasis added) and the "four pillars" were scaled back to "three action plans": prevention, treatment, and enforcement (Dupuis & MacKay, 2008). In other words, the 2007 strategy signaled a deliberate retreat from promoting harm reduction as central to Canadian discourse on policies and strategies to address sub-

stance use. The new action plan was a return to the enforcement-based focus on illicit substance use of pre-1987 (Davies, 2007; DeBeck, Wood, Montaner, & Kerr, 2009). With the neoliberal political and economic climate, this policy approach emphasized deterrence through punishment and criminalization. Sidelining harm reduction not only contradicts research literature on how to address drug use and misuse, it also contradicts Canada's federal commitment in 2005 to "knowledge-based" action on drug policy (Debeck et al., 2009). While Canadian provinces and territories have moved forward to develop their own alcohol strategies, the absence of a national strategy endorsed by the government which guides the tone and approach around alcohol- and drug-related issues suggests a political ambivalence towards the social costs of alcohol use (Babor, 2010). NADS does not focus on alcohol related issues and does not include a separate alcohol policy. While the CCSA continues to advocate the need for a national alcohol policy, alcohol use is not a priority for the federal government (Department of Justice, 2010).

The 2016, Canadian Drugs and Substances Strategy (CDSS) replaced the NADS. The CDSS, led by the Minister of Health, aims to restore harm reduction as a key pillar of Canada's drug strategy alongside the existing pillars of prevention, treatment, and enforcement. The inclusion of harm reduction as a pillar of Canada's drug policy supports the federal government's focus on the current "opioid crisis." Harm reduction-focused policies, including support for properly established and maintained supervised consumption sites and increased access to naloxone, are now part of the government's strategy. The federal government is committed to ensuring that its policies under the CDSS are based on a strong foundation of evidence, including data related to harm education policies, programs and intervention.

CONSULTATION RESEARCH DESIGN

Data Collection

Data collection entailed an online survey, interviews, and focus groups, all of which explored experiences of social work in mental health care among service users, providers, and supervisors in Nova Scotia. We chose participants from each of these groups because they occupy a different location within the mental health service delivery system and, as such, are likely to offer a different perspective on mental health care in Nova Scotia. We are interested in all of these points of view in order to present a fulsome picture of mental health in the province. The three methods of data collection, alongside a literature review, provided consistent data and data saturation.

To ensure a large sample pool in this consultation we conducted an online survey that explored experiences around mental health care, using the Opinio software platform through Dalhousie University. Participants were recruited largely through the NSCSW newsletter, which is emailed to over 2000 members of the College. We expected to get an initial sense of social workers' perspectives on mental health care which we followed up with more in-depth interviews and focus groups. Recruitment criteria was membership in the NSCSW which is a requirement for practicing social work in Nova Scotia. To maintain anonymity, participants were asked to not provide their contact information. In total, 115 participants completed the survey online (166 contributed but did not fully complete the survey).

Data collection began with a separate author-compiled socio-demographic questionnaire with all participants in the study. The aim of the socio-demographic questionnaire was to provide insight on the social determinants that impact participants' realities, such as income, employment, ethnicity, sexual orientation, gender expression, and education.

We conducted in-depth, semi-structured narrative interviews with 50 English-speaking adults in rural and urban Nova Scotia. All participants were 18 years

or older. Of these 50 participants, 30 were mental health service providers, 10 were supervisors, and 10 were service users. In addition to the NSCSW newsletter and word of mouth (snow ball sampling), interviewees were recruited through posters that were distributed in communities as well as on a service user Facebook site. Individual interviews took place in person or by telephone to allow for greater representation across the province. One-on-one interviews were approximately 90 minutes in length. We offered a \$50 honorarium to service users who were interviewed to compensate for childcare and/or transportation costs incurred.

Service providers who were interviewed were given the option of participating in a future focus group which would follow up on some of the major themes that emerged in the interviews within this group. Focus groups took approximately 90 minutes each. We conducted three focus groups among service providers: one in Halifax (n=5); one rural focus group 1 (n=6); and one rural focus group 2 (n=4). The focus groups were conducted in person by the research team, except for the last rural focus group which was conducted through Zoom due to provincial requirements of social distancing due to COVID-19. The focus group in Halifax was held at the Dalhousie School of Social Work. One rural focus group was held at a community mental health centre.

Individual and focus group interviews were audio recorded and later transcribed verbatim with identifiers removed as part of the data collection and research findings. We received formal consent from participants at all steps of the research process. The results of this study were shared with participants for member-check upon the completion of the project.

Data Analysis

In order to produce this report on mental health care advocacy, we adopted a narrative methodological approach which emphasizes gathering in-depth information on participants' accounts of mental health and mental health services and begins from the assumption that these stories emerge within a social context. Participants' accounts of mental health (including addiction) offer understandings of and insights toward the development of more meaningful and effective approaches and interventions for mental health care and advocacy. The transcribed interviews and focus groups were thematically coded and integrated with the survey data. Survey data involved primarily closed ended questions and Opinio calculated the results. The

open ended questions in the survey were thematically analyzed. Thematic analysis is a flexible method that involves identifying, analyzing, and reporting patterns within data and can be used with a variety of epistemologies (Braun & Clarke, 2006, 2013; Clandinin, & Connelly, 2000; Wells, 2011).

In-depth, semi-structured interviews allowed for a life story approach which provided a narrative structure across time. Participants were asked about the time sequence or history of events in their lives (thematic content) and what these events have meant to them over time (discursive) (White, 2007). Moving beyond a content analysis, a latent thematic analysis is interpretive, concerned with thick description that moves past the surface story to the rich meaning that holds a story together (Braun & Clarke, 2006; 2013). We explored what these narratives say, what they mean to participants, how they are organized, what cultural practices and discourse are evident, how the story is constructed, and what it accomplishes. These strategies allowed us to unpack, contextualize, and interpret the narratives produced in this study. Data analysis situates participants' stories about mental health and mental health care by social workers within dominant social discourses and the context of their lives (Brown & Augusta-Scott, 2007a, b; Brown, 2007a; White, 2007).

In accordance with Braun and Clarke (2006), a six-phase process of thematic analysis was used to describe both the story and the emerging themes: Phase 1, familiarizing oneself with the data by reviewing transcripts several times; Phase 2, generating initial codes; Phase 3, searching for themes; Phase 4, reviewing themes across entire data set (i.e. eliminate, collapse, and separate themes); Phase 5, defining and naming themes; and Phase 6, producing the report. Continuous attention was paid to the gaps and contradictions that exist within accounts. After the initial generation of themes describing in-depth narrative accounts, a discursive analysis began that enabled participants' narratives to be contextualized into the broader social constructs and dominant discourse of mental health.

Using both thematic and discursive approaches to analysis allows for the construction of descriptive narratives of events as well as what those events have meant to the participants. This allowed for the formation of potential counter-narratives in participants' accounts which may be more helpful in formulating mental health care advocacy and reform strategies (e.g., challenging bio-medicalization, criminalization, bio-determinism, de-contextualized approaches, fiscal restraint).

CONSULTATION REPORT FINDINGS

Participants' Socio-Demographic Information

This section of the report will present the findings of this consultation from the Opinio survey, interviews, and three focus groups. We begin with the participant demographics and follow this with quotations from those who participated in the study (See Appendix A for detailed information on socio-demographics). The findings represent the views of the service users, providers and supervisors in this consultation.

All told, we were able to consult with a sizable number of people, across multiple methods of data collection. Taken together with the literature on social work and mental health a clear and consistent picture emerged of experiences across social work mental health service users, providers and their supervisors. We reached out and sought to ensure that we maximized diversity in our consultation. Among those who did respond there was some level of diversity, particularly among those who identify as 2SLGBTQIA+.

Social Demographic Information 1.1

Summary	Opinio Demographics Summary Supervisors/ Service Providers	Participant Focus Group n=14 Service Providers	Service Provider/Supervisor Interviews n= 40	Service User n= 16
Age Category	20 (18-29), 51 (30-44), 47 (45-59), 21 (06-65), 7 (65+)	1 (18,29), 5 (30-44), 5 (45-59), 1 (60-65), 2 (65+)	5 (18-29), 13 (30-44), 13 (45-59), 6 (60-64), 2 (65+)	4 (18-29), 8 (30-44), 1 (45-59), 2 (60-65), 1 (65+)
Gender Identity	119 Female, 22 Male, 1 (Cis-male Two-Spirited), 1 (Gender Diverse)	9 Female, 5 Male, 1 Trans-gender	26 Female, 10 Male, 1 Non Binary, 1 Transgender Male, 1 (Male (cis) Two Spirit)	11 Female, 2 Male, 1 (Male/gender fluid), 1 (Non binary), 1 (Gender fluid femme)
Sexual Orientation	121 Heterosexual, 21 2SLGBTQIA+	12 Heterosexual, 3 2SLGBTQIA+	27 Heterosexual, 11 2SLGBTQIA+	10 Heterosexual, 5 2SLGBTQIA+
Employment Status	135 Employed, 2 Unemployed, 2 Retired	13 Employed, 1 Retired	37 Employed, 2 Retired	10 Employed, 4 Unemployed, 1 Retired
Place of Employment	107 Public Sector, 15 Private Practice, 6 Public/Private Sector, 2 Academia	10 Public Sector	18 Public Sector, 1 Academia, 1 Public/Private Sector, 2 Private Practice	2 Public Sector, 1 Private Sector, 1 University, 1 Service Industry
Social Assistance	No 136, Yes 9	13 No	37 No, 1 Pension	9 No, 7 Yes
Level of Education	42 BSW, 93 MSW, 3 PhD	10 MSW, 3 BSW	7 BSW, 30 MSW, 1 PhD	13 Post-Secondary, 2 Some Post-Secondary, 1 Secondary
Individual Income		1 Lower Middle, 6 Middle, 5 Upper Middle	4 Lower Middle, 26 Middle, 8 Upper Middle	8 Low, 5 Lower Middle, 2 Middle
Household Income	1 Low, 14 Lower Middle, 80 Middle, 49 Upper Middle		5 Lower Middle, 16 Middle, 13 Upper Middle, 2 No response, 4 NA	2 Middle
Racial Ethnic Identity	113 White, 4 (African Nova Scotian), 1 (Sri Lankan), 1 (Canadian, mixed family ethnic histories), 1 (Indigenous), 1 (White /potential Indigenous link), 1 (Indigenous (Mikmaq/European), 1 (Acadian with Mi'kmaq ancestry), 1 (Half European/half Lebanese), 1 (African Canadian/Biracial), 1 (Biracial), 1 (Indigenous/ European)	12 White, 1 Sri Lankan	32 White, 1 (Sri Lankan), 1 (African Nova Scotian), 1 (African Descent), 1 (Lebanese/Scottish), 1 (Indigenous/Biracial)	14 White, 1 (White/ Acadian), 1 (African Canadian/ Indigenous First Nations)

Social Demographic Information 1.2

Summary	Opinio Demographics Summary Supervisors/ Service Providers	Participant Focus Group n=14 Service Providers	Service Provider/Supervisor Interviews n= 40	Service User n= 16
Identify With a Marginalized Group		5 Women, 3 2SLGBTQIA+, 1 Other Racialized	18 (Women), 10 (2SLGBTQIA+ various intersecting identities: women, gender diverse, (dis)Ability and Indigenous), 2 (Other Racialized), 1 (Woman/African Nova Scotian), 1 (Woman/African Descent)	
Children	83 Yes, 61 No	7 Yes, 6 No	18 Yes, 18 No	8 yes, 8 No
Relationship Status	99 Relationship, 29 Single, 1 Complicated	10 Relationship, 3 Single	28 Relationship, No Relationship	9 Relationship, 7 Single
Social Status Growing Up	1 Extreme Poverty, 2 Poor, 16 Low Income, 31 Lower Middle, 14(Working Class, 69 Middle, 9 Upper Middle	1 Working Class, 3 Lower Middle, 7 Middle, 2 Upper Middle	1 Poor, 1 Working Poor, 2 Low, 6 Working Class, 11 Lower Middle, 15 Middle, 3 Upper Middle	1 Poor, 3 Low, 3 Lower Middle, 1 Working Class, 1 Peasant, 5 Middle
Chronic Illness or (dis)Ability	110 No, Yes 31	11 No, 2 Yes	27 No, 9 Yes	5 No, 11 yes
Language	140 English, 1 Sri Lankan	11 English, 1 (English/Sinhalese), 1 French	36 English, 1 French, 1 No, 1 (English/Sinhalese)	15 English, 1 French
Refugee	141 No	11 No	27 No, 1 Yes	16 No
Residential Area	71 Rural, 71 Urban	3 Urban, 9 Rural, 2 Suburban	13 Rural, 18 Urban, 8 Suburban	11 Urban, 2 Suburban, 3 Rural

IDEOLOGICAL TENSIONS BETWEEN SOCIAL WORK AND BIO-MEDICAL MODEL

Views of the Bio-Medical Model

The majority of participants in this study viewed the bio-medical model to be limiting to their practice as social workers. Both supervisors and service providers were aware of a divide between dominant mental health discourse and social work values, and paradigms of practice.

Yeah, I mean I think the dominant mental health discourse has been adopted from the bio-medical model. And that we treat symptoms. You are successful when those symptoms alleviate or disappear. – Annie, supervisor

Participants were asked to speak to their views of the bio-medical model and its approaches to mental health. They describe the bio-medical approach as grounded in the belief that wellness is the absence of illness and therefore the bio-medical approach is to diagnose and treat symptoms often through medication. Many found this approach insufficient because the bio-medical approach fails to consider the complex and intersecting realities of people's lives and experiences and their connection to mental health. Most participants noted that the bio-medical approach is pathologizing and individualistic:

But in terms of mental health, I think it's mostly the same – individualize it, pathologize it. – Barker, supervisor

Among service providers there was a strong sense that “too much importance is placed on the bio-medical model and not enough on other modalities...” (Opinio, provider). Some service providers were critical of the emphasis on medication:

Medicate them and get them out of our office. – Mark, provider

CONFLICTING PARADIGMS: INDIVIDUALIZATION, PATHOLOGIZATION AND DECONTEXTUALIZATION

Some social work supervisors believed that there is a conflict or tension between their professional training and the dominance of the use of the DSM and the bio-medical model. Participants often referred to the focus on the use of the DSM and diagnosis as an example of this.

DSM driven mental health interventions overshadow broader, more holistic interventions. NSHA is moving more toward a DSM dominated program - focusing on moderate to severe mental health issues based on DSM diagnosis.
– **Opinio, supervisor**

The vast majority, 82% of social work service providers surveyed said they believed that social workers' training and perspectives do not have enough recognition in the current service delivery system (n= 92/112). In the consultation survey, 71% of social worker mental health providers also reported they generally do not have an opportunity to employ an anti-oppressive approach to practice within their work environment (n=80/113). In the survey, 97% of social work mental health providers reported that they experience barriers in offering mental health services (i.e., lack of resources, lack of control, lack of opportunity to implement change) (Opinio n=107/112).

Work within a predominantly medical model environment brings challenges as social workers are often not recognized in the medical community as competent. Also, I would argue that some aspects of the use of DSM within the medical model conflicts with some social work values. – **Opinio, provider**

The majority of service providers who completed the online survey, 62%, believed there is a conflict or tension between their professional training and the dominance of the use of the DSM and the bio-medical model.

I do not like to diagnose individuals. I do not feel that labelling people is helpful. Each person is unique. Understanding their situation, their lived experiences, their early life and present situation is what is important. Labelling individuals puts people in a box. No one wants to be boxed in. People need to be understood. – **Opinio, provider**

The Nova Scotia Health Authority is driven, not by a people first model, but by fiscal constraints and workers within the system suffer moral distress as a result. – Opinio, provider

The bio-medical model presents barriers to exploring the person in the environment, root causes of problems and/or the context of people's experiences. It typically does not address social determinants of health. This creates challenges for social workers in mental health as the foundation of social work training is rooted in exploring the person in the environment and on understanding the interconnectedness of the social determinants of health. Participants explain that social work values and training dictate that practitioners take the time to understand the person's environment and help that person learn how to navigate all the intersecting realities that impact their mental wellness. Often this involves taking the time to understand the social determinants of health that impact upon the person's current situation, be it socio-economic status, housing, food security or violence in relationships. Miller noted the importance of looking at the person in the environment:

I think our ability to really situate people in their broader context is huge. Because if you don't do that, you miss a lot. And it really does affect your ability to be able to establish rapport and meaningful relationships and get to a place where you can actually be an effective helper. – Miller, provider

Social work is built on the foundation of understanding people's lives through their relationship with the environment. This approach is often not considered with other disciplines working in a healthcare environment which causes tensions for social workers. A social work provider explained, "...the more meetings I go to that are multidisciplinary, the more I realize that social workers have a very sensitive awareness of the impact of a person's experience and environment on their capabilities," -Lurleen, service provider. Many social workers note the limitation of certain therapeutic techniques such as CBT and DBT which were seen as less effective for people who are presenting with mental health issues directly related to circumstances of poverty, food insecurity, trauma, domestic violence or other situational stressors. Annie, a social work supervisor, explains that "...the system doesn't allow us to practice in a way that's necessarily helpful for people across the lifespan." Another supervisor explains that without taking people's experiences into consideration short term therapies are essentially ineffective.

If people don't have basic needs, Cognitive Behavioural Therapy (CBT) isn't going to help them. But also I am very clear that if your client is not getting enough food or is moving house to house, there's absolutely no point talking about doing cognitive behavioural therapy if they're starving... You know, if you have no employment, and people are poorly educated, and, guess what's going to happen? And sending them to me for treatment around depression, that may help some but it's not going to fix it.
– Elaine, supervisor

Further, many participants noted that the bio-medical model has ignored the social justice issues that impact people's lives and realities. The system has individualized and pathologized people's experiences of discrimination, oppression and marginalization as psychological distress which invisibilizes social justice issues and contributes to a narrative of individual failure and deficit. This feeds into a neoliberal ideology where individuals are responsible for their own circumstances and there is no collective analysis that seeks to understand the impact of problematic systems that perpetuate patriarchal, colonial, racist and transphobic norms.

Cause we're all often looking at things and if this person is having a bad time or not going well, we tend to look for depression, anxiety so on and if that isn't working well they must have a personality problem. It can be true, but we don't ask if society has a personality problem and the changes that would be involved in this, because it's huge changes. – Stephen, provider

Social Work Contribution

While working within a dominant medical model, where social workers are often devalued and experience themselves at the bottom of a service hierarchy they are also aware they have important contributions to offer.

The place for us to be is clearly that place on the team that understands that human life is about connections, that it's at the intersection of the individual and the wider world that the difficulties in our ability to cope emerge and that understanding those things in a lot of detail is, and with a lot of specificity is really important. I don't think that negates...the value of something like

cognitive CBT, there's a place for that. It doesn't negate the need to make an application for income assistance, but I don't think that's the place for us. We need to be able to be in a team meeting where a client is being discussed or a patient is being discussed, whatever language is being used, and be the voice on that team that says well who else is a part of this person's world and how does that work for them and what might be the advantages of knowing more about that or what might we learn if we examine that? I think that's the place we need to be and I think it's been forgotten in lots of ways.
– **Rural Valley Focus Group 2, R2**

I find I really bring more of that social justice perspective and look more at things like how class or race or colonialism intersect with all of the stuff that we're doing, whereas I don't see other professionals necessarily bring that in the same way or where it's just not as considered as much.... So I think social work actually does lend an important element to mental health work that is often missing when it's psychologists or just other professionals.
– **Leaf, provider**

Generally, the participants in this consultation understood that the contribution of social workers to mental health settings is linked to their social work education.

I think that the biggest thing that social workers bring to their training and into the clinical field is what I call a situational awareness or the capacity to see how systems interfere or support someone's psychosocial development across their lifespan. Because we have that higher analysis from a social justice lens, from a race and trauma, well a race informed lens, from an anti-oppressive lens, we're able to give more variations in what's happening in people's lives. – **Harriet, provider**

A number of participants expanded upon the relational theme of collaborative work with clients.

I think we have to kind of go back to the roots of who we are and our skillset. Which is to understand that we can invite people's expertise into the room. That we have skills in collaborating with our clients. That we really do believe that the work starts where our clients find themselves. That we in a foun-

dational way understand that people aren't individually to be blamed for their situations. That you know, oppression and structural injustice historically and systemically has created a situation whereby some people have had harder times than others. – Patty, provider

The words of the following supervisor reiterated the value placed on building relationships noted above.

I like having social workers because I really see social work as an art...So it's about creating a supportive community, being an advocate, making referrals to the right places, being knowledgeable, certainly building on strengths and those kinds of things but it's got more to do with relationship building. – Blanket, supervisor

A social work provider addressed the importance of critical thinking.

so you're going to be able to go off and you're going to be able to really critically examine the work you do and the systems you work in and so to me that's, like that's been hugely valuable. – James, provider

SOCIAL WORK VALUES AND TENSIONS WITH THE BIO-MEDICAL MODEL

Many social workers, especially those working in the public mental health system, expressed a disconnect between the values and ethics of social work practice and the bio-medical model. These tensions were exacerbated by the hierarchies in the healthcare system and the devaluing of the social work profession which often contributes to social workers internalizing bio-medical discourse and being co-opted into bio-medical dominance. In general, participants responded that there is too much emphasis on the bio-medical model when there may be other contingent factors that are impacting mental health that cannot be treated by a biochemical bio-medical approach.

Primarily those participants who work for the public mental health system reported not having the ability to practice within the scope of their social work training. Jill explains:

...I feel like I was trained very clearly to develop rapport, develop a relationship. That's our platform to help people. And to look at the bigger picture and help them make connections with resources and try to be flexible. And now all of that is almost the opposite of my work. – Jill, provider

Participants explained that decisions about the role and scope of social work practice were topdown, that leadership made decisions with no input from front line social work staff. This lack of collaboration and transparency perpetuates a distrust for the bio-medical model because decisions are imposed on social workers about how they need to do their clinical work. Jess, a social work provider, explains that the Nova Scotia Health Authority doesn't use anti-oppressive approaches and that this causes considerable tension between social workers and the organization. Jane, another social work provider, expresses her desire to push back against the bio-medical model so they could do mental health work that was less pathologizing and more client-centred and community-based. Jane responded to these dilemmas by leaving the public system and opening a private practice.

Other study participants expressed feeling ethically challenged by not being able to use social work techniques and skills that they knew could improve treatment outcomes for their patients.

My acceptance of the unique qualities in a person is often at odds with the trend towards diagnosis and medical intervention. This creates tension between my belief in a person centered, non-judgmental approach that would, in an improved system support maximizing potential in the person, ahead of seeking to induce conformity/control. – Opinio, provider

Tena, a social work supervisor, noted that the hospital environment is not conducive to mental wellness and that it's important to differentiate between mental health and mental wellness. Mental health interventions are best suited to the bio-medical model as this system is set up for diagnosis and treatment whereas a mental wellness approach is holistic and takes into consideration all the various factors that impact mental wellness which is not possible in a bio-medical model. Another participant explains that the public has greater expectations around how mental health services can be delivered in the healthcare environment than is actually possible as it is currently structured.

So I think people have really...the general public has like a really different idea than the healthcare system about what the mental health care system should do and does do. And so anybody that's struggling...You know, these people are significantly distressed and struggling, and like having some mental health symptoms. But we've sort of been taught that the hospital or the healthcare system is where we should fix that. And I think as, society, there needs to be more societal interventions. Because what the medical system is offering is actually very limited. A mental wellness approach is holistic and this approach will not be adequately addressed in a hospital environment which causes tension with social work which focuses on the person in environment. – Alexandra, provider

The bio-medical model approach is problematic to the extent that it removes people's ability to be resilient and have agency over their health. Lori, a private practice social worker explains,

I think that it robs people of their agency. I think that it also robs them of their humanity, it makes them look at themselves through eyes of being flawed but then also feeling powerless. It starts becoming their identity. – Lori, provider

One service provider differentiated between treatment and counselling. Patty explained that:

I just don't think that treatment and counselling are the same things. In treatment, you're prescribing something to somebody, and they're going to buy into it because they don't know what else. Or maybe they start it and they don't finish it because, I don't know, who goes anywhere for 20 sessions? But counselling is a negotiation...like an ongoing negotiation and collaboration of where you're going based on client desires, preferences, goals. The treatment has to do with somebody else's goals. – Patty, service provider

EXCLUDING THE SOCIAL DETERMINANTS OF HEALTH

Some participants noted that social work practice in the bio-medical system is a balance between individual and contextual approaches. Anti-oppressive approaches to

social work which have long argued that the individual must always be seen in their social context often refers to social determinants of health. From this view, a bio-psycho-social model is most effective. It is able to recognize the body, the mind and society. Social workers are concerned about the taken-for-granted dominance of the bio-medical model, and its exclusion and minimization of other approaches.

So I think, and having an awareness of the medical model to work with people who are medically ill or have a mental illness, schizophrenia, bipolar disorder, those significant mental health issues that would benefit from a certain application of psychiatric care, then I think that's perfectly fine. But when we start, as I said earlier, when we start labelling people so early in their lives and attaching labels because the medicalization of it is the way that we then don't have any social accountability, familiar accountability, then that leans and lessens the resiliency of the individual.”
– Harriet, provider

Professional Education and the Dissonance of Approaches

The education and training of social workers appears to be at odds with the expectations of the efficiency-based neoliberal mental health service provision. Social workers often report that their work is undervalued and that they must conform to dominant medical model expectations. Thus, while social workers are trained to address the social determinants of health and establish strong collaborative relationships with their clients, they are expected to practice in a significantly different way – a short term, standardized one size fits all, pathologized, and decontextualized model. This approach is often a difficult fit for social workers, which may be interpreted within the dominant bio-medical model as a lack of clinical skills within the profession. Overall, the participants in this consultation value the anti-oppressive model, while also critiquing a lack of therapeutic skills among social workers. Some social workers report that they have critical clinical therapeutic skills and that there is no room for these within the existing system. We need to explore then where the problem lies - in the bio-medical model expectations of social workers or social workers lack of training or, perhaps, an unresolvable dissonance of beliefs.

Social work supervisors frequently commented that the social work practitioners were strong in theory and critical analysis but lacked therapeutic or clinical skills.

Education provided critical thinking skills less specific clinical skills especially for new social workers. I think the younger ones are missing... What they are missing is they've done very good work in their degrees around anti-oppression, etc. But they're actually lacking what I would call therapeutic skills. Like they don't know even basic cognitive behavioural therapy ideas...inadequate training around therapeutic techniques. So again, things like do you understand cognitive behavioural therapy and how to apply it? Do you understand dialectical behavioural therapy and how to apply it? So they're lacking that. The ones I would say are 30 and over tended to have a more blended education. So they had like probably like I did, they got some of what I would call social work paradigms and norms, and then some basic therapeutic training. And so they tend to have that balance.
– Elaine, supervisor

The social work staff we get who come on board are really strong on theory, not so much in practice. The youth workers we get really good in practice, not so good in theory...We often times see social workers in that particular program often just got a degree, they're getting experience, they don't want to necessarily go to Community Services or the government, they want to be more involved in community work. – Del, supervisor

Social work providers tended to agree that they had a solid anti-oppressive background which they could incorporate into their clinical work.

So you know, my undergraduate and my graduate training was, like I said, not clinical in nature. But provided me with a wonderful social work foundation, you know, with that critical analysis. And so those years of kind of social work training in the university context were very much about those structural and societal issues, and how to work within larger systems with that anti-oppressive approach and that critical lens. And then so later as I expanded my practice to include a clinical lens, all that other stuff that came before was just automatically incorporated. Because again, for me I think, you know, as a social worker, you just start to embody that and it just is part of who you are, and it comes out in your work.
– Jane, provider

While some emphasize university education needs to offer more training in clinical skills and less on critiquing systems, some also note that the mental health system should also provide training.

The mental health system also should be providing better training to their clinical staff to build skills and competence for working in mental health and addictions. Finally, I also think that the Dalhousie school of social work has not adequately prepared new social workers for direct practice in mental health. It's easy to blame a flawed system, as we all know the mental health system is flawed, but much more difficult to look at one's own responsibility for preparing social workers for practice in a flawed system. – Opinio, provider

A number of participants added that social workers should be trained to get the jobs that they are going to do.

There are plenty of evidence based interventions and modalities that fit within a social work lens, some schools and colleges seem to be trying too hard to rock the boat rather than look at how to work within existing systems, I wouldn't recommend doing social work school at present if this is a career of interest based on how poorly prepared I felt and the length of time and cost of training I have had to dedicate on my own to build up a skill set for this work, as well as the stress put on recent grads I am involved in mentoring based on them also not feeling prepared to do the work. – Opinio, provider

One supervisor also indicated concern related to the ways in which social work students are prepared for the workforce.

I sometimes think, depending on what university social workers go to, they can sometimes have a very tunnel vision lens on either working with a personal, interpersonal or societal. So, I think that's a struggle sometimes. That at the university level, we have to be looking at the jobs that people are going into. – Annie, supervisor

CO-OPTATION OF SOCIAL WORK INTO THE BIO-MEDICAL MODEL

Participants report not only the devaluing of their skills and lack of autonomy but that they become co-opted into the dominant medical model expectations of them in their work. When asked about social work practice and the bio-medical model, participants describe the mental health system as becoming more medicalized with less space for other disciplines like social work that don't ascribe to this approach. This has led to the belief that social work has a responsibility to understand the medical model; to have an awareness of the bio-medical approach and when its application is necessary; and to push back against the bio-medical approach to ensure that contextual and situational factors are equally considered when exploring people's experiences of mental health.

*The dominant use of the DSM and medical model continues to perpetuate the myth that mental health issues are internally based within the biology and mind of the individual. As social workers we understand that the family system and other social determinants of health impact peoples overall well-being including their mental health. I personally see “clinical social workers” use the term “therapist” or “psychotherapist” as a way to fit into the medical model. Many times we have become co-opted within this dominant model. – **Opinio, provider***

In the medical model, there is limited space for holistic approaches that focus on mental wellness and as such, any approach that doesn't fit within this model is not valued. Leaf explains “Yeah we're not really encouraged to take that social lens. It does kind of end up co-opting us a lot of the time” (Leaf, provider). As such, social workers begin internalizing bio-medical dominance and become co-opted into a bio-medical approach to mental healthcare. This means that social workers start to use medicalized language and diagnostic terms when referring to patients.

*Yes. Yes. Yes. Because I'm forced...Like in my role especially with the brief mental health assessments, I'm forced to use certain language and to make decisions based on risk that are very medical based....if you're working for the health authority, you don't really have a lot of freedom on how you run your sessions. So yeah, it's very much about like labelling someone with a disorder, and recommending treatment based on medications, psychiatry. – **Samantha, provider***

Further, people have come to internalize these illness discourses which only further co-opts people into the diagnosis and treatment approach. Some participants highlight that without consideration of the various factors that impact people's mental health realities, there is a huge disconnect and false hope about what the bio-medical system can provide versus what people need. Peter, a mental health provider, explains:

I knew how ineffective the medical model was. And the fact that it's so restrictive is just not helpful for kids and youth and families. So it just kind of helps to keep them in that hamster wheel, and not really help to build their strengths or their own skills. – Peter, provider

Social workers also try and mimic other disciplines that are more respected, such as psychologists. One supervisor, Elaine, explains: “And I think what has happened to social work within my lifetime is that we've become more like psychologists.” Since there is no appreciation for a social work approach to mental health and social workers are seen as just other, yet less qualified or capable, clinical therapists treating mental health issues, many social workers have adapted within this system, and are often co-opted within that system. One provider states:

I think you have to conform to the system to a certain degree in order to survive working here. So there is some freedom, although it's getting...it seems like it's getting more and more...the autonomy of each clinic is getting more and more miniscule. So yeah, I guess co-opted into a medical system. – Al, provider

In general, the majority of the social workers interviewed for this study believe the medical model, when applied to mental health, uses a singular and simplistic approach that doesn't recognize the complexities of people's lives and experiences. Most social workers recognize the necessity of a medical approach in certain circumstances, but most agreed there is a growing need for different approaches to mental health that encompass mental wellness with an emphasis on prevention and the social determinants of health. One supervisor explains,

So I find it's just gotten more cookie cutter. We don't have as much individuality or sense of client-centeredness, uniqueness of our community, that has all been watered down in my opinion. – Gladeau, supervisor

Many social workers describe that in particular, mental health rarely fits into “these perfect little boxes that the medical model wants it to fit into.”
– **Jess, provider**

There’s no focus on what is wellness and what do you need to create wellness? So people don’t come into the primary health system unless something’s up. Do you know what I mean? So I know the schools have all kinds of educational programs, and they’re expanding their programs all the time. But thinking about the equity piece, I feel that there is not enough happening for prevention. – **Peter, provider**

I was saying you know where’s the work to make sure that we’re doing the work around truth and reconciliation work or where’s this work around language around issues for LGBTQ folks or you know addressing issues around poverty. – **Rural Focus Group 2, R3**

Lack of Social Context in Service Provision

The need for systems to work more collaboratively and in ways that are culturally responsive was made by the social work supervisor below who said:

I feel that social work and service delivery of programming should be more holistic and client-focused. I think there is a lot of work to be done to ensure that service is more anti-oppressive and works with clients of marginalized identities as experts on their own experiences...I would generally state the NSHA lacks culturally responsive programming and clinical training to meet the needs of ANS and other racialized communities . – **Opinio, supervisor**

One social work provider noted that racialized staff may experience a form of marginalization in workplace settings.

...there is the marginalization of racialized staff that you’re maybe one of and then you know people then impact on your mental wellness and status as your colleagues because then you’re getting racialized and engaging in micro-racial aggressions that are unintentional but are still harmful by your colleagues . – **Harriet, provider**

These comments strongly support the need for an increase in culturally sensitive training, programming and services. As the social work provider below explains, a legacy of racism contributes to mistrust.

I mean years and years of systemic racism and looking at limited accessibility for folks and other groups and it's like we're expecting them to reach out and access these services when they haven't been.....and unfortunately we see a lot of these instances where people from marginalized groups are presenting in crisis because they've put off for so long and you know haven't felt the ability to, haven't had the reach outs that others may have been checked on at their doctor's office or across the board.
– Susan, provider

Another practitioner explains that even though social work can be co-opted in the public system, private practice is an option chosen sometimes because they can exercise their professional autonomy and adhere to their social work values. Private practice for some becomes a way to resist co-optation and to practice consistently within a social work paradigm.

Because ethically it didn't feel right to me to possess clinical skills that the evidence shows are beneficial to trauma survivors and to actually have a formal directive – You're not allowed to practice those in this workplace. And so for me, the internal conflict became an ethical conflict. And ultimately, you know, it was a major factor in me deciding to go into private practice where I have the ability to practice kind of an integrated approach to clinical practice where you can bring in multiple therapeutic modalities and not be restricted. – Jane, provider

Finally, some social workers are concerned that if social work fails to conform to the bio-medical approach they will be replaced or even “phased” out by other professions such as nursing which has a stronger voice in the bio-medical system and a strong union to protect them.

One of my fears and maybe one of the trends that I see is slowly social work positions being replaced. So they're either cut or they're going to nursing. Nursing is...they've got a lot of power. And they've got a lot of power because

they've got one union...Like my union's great. But because social workers are spread across, that one united voice is lost....In rural NS, there's a heck of a lot of MEDs coming in. So if we want to continue to hold these positions, which they come with power, right, so the social work voice is on these teams, what are we doing as a field to say we need to stand our ground, we deserve to be here, our clients need us? – Kelly, supervisor

Well, I think that having CAPA introduced has been a huge barrier. A big change. There's some positive changes but there's...I think there's a lot of not so great changes. And what we've noticed, we actually just had a disciplinary meeting this week of social workers, and the issue is the same issue we talk about at every one, is that job descriptions are for psychologists. We're losing our social worker window. And those of us that are there, there is not many social workers within mental health. Most of the hirers are going to this new school of mental health. – Halifax Focus Group, R2

The co-optation of the profession of social work into the dominant or hegemonic medical model is not just ideological. The system and structure of power within the health care system often situates social work at the bottom of the hierarchy, with little power or autonomy to determine or shape their practices. The ideological and structural system of mental health care is in itself a barrier to provision of strong and effective mental health services. When individual struggles are seen outside their overall contexts of their lives and reduced to a medical problem and forced to fit within models of delivery designed primarily to achieve efficiency and be cost effective it is unlikely the results will be positive.

TEAM WORK IS NOT COLLABORATIVE: THE HIERARCHICAL BIO-MEDICAL MODEL

Most research participants identified hierarchies in the bio-medical model as a point of tension. The bio-medical model privileges and gives power to the voice and perspectives of physicians/psychiatry, as these professions are deeply committed to a bio-medical approach. A number of participants note that social work is seen as less valuable than other disciplines within mental health because they are not authorized to provide mental health diagnosis. James explains:

I think there's a tension between just working within this medical model and well a social worker can't diagnose so they can't do what necessarily a psychologist or a psychiatrist might be able to do so there's, so I think there's a feeling of, are we limited within that model. – James, provider

I'm not critiquing doctors but I'm saying we've given it to them, we've made them gods and then we need to take back the power, but you know it's, oh that's just a bleeding heart social worker... – Tena, supervisor

Now there is one director over the whole zone. But I mean the problem is that the communication is completely one-way. And so every resource that has ever been identified as something that's going to be helpful has been something that's been shoved down our throats without any consultation or any listening. – Jane, provider

The recognition of social inequity and injustice is forefront in the valuing of anti-oppressive and strengths-based perspectives. As described below by service provider Jane this analysis is inseparable from the practice of social work.

Well, I guess it goes back to...What I kind of said before about coming in with that critical and analytical lens and being aware of the power structures that exist within systems, within societies. And being...I think for the most part my experience with other social workers has been we're fairly comfortable in identifying what those power structures are and kind of outing them, and trying to strive to reduce the power imbalance. I think it comes quite natural to us because that's been the foundation of a lot of our training. And so right down to the code of ethics, you know, in terms of advocacy and just that strong supportive stance for the integrity of the person. – Jane, provider

It was noted that the medical approach is patriarchal which is an explanation as to why social work, traditionally a women's profession, is undervalued within this approach. Most social workers feel as though they're at the bottom of the hierarchy within the medical system which contributes to their skills being questioned, services devalued and having limited influence around decisions that inform the mental health system.

...there was always a hierarchy. Psychology was much more valued than social work. And so that created a lot of...problems. For example, they would choose psychologists to be trained in what might have been considered the more difficult skill. – Rural Focus Group 1, R5

...our director now is a nurse. Everything became “nursified”. And that became a problem. So now she’s talking to a co-worker...Well, I have friends in the community here who are doctors and GPs and emergency room doctors, and one’s a neurologist. For him to transfer a patient, he has to go through a charge nurse first and fill out paperwork with this charge nurse before he can transfer a patient back to their family doctor. He said “Why do I have to do that now?” – Al, provider

Social workers regularly note that there is much that needs to be changed within the current mental health system, particularly with regard to the role of social work. As they experience little power or opportunity to voice their thoughts they often feel frustrated about what to do.

How do we do that work to reposition social work within mental health care when it’s still working within a patriarchal system and not recognizing the value that the feminine brings to the work and seeing it as equivalent and paying it as equivalent too right? It’s not. – Lori, provider

Management Approach

The comments of several social work service providers below indicated a top down approach within management that included hyper-policing of their work and little ability to engage in advocacy.

The limitations are to do with the neo-liberal models that are operating, and the managerialism. I mean it’s deadly. It is deadly. Everything is controlled from the top down. And the voices, the experiences of social workers with the actual clients and what the real clients are facing, as well as the lived experience of social workers, they’re never taken into account... So everything has risk assessments and all of those neo-liberal devices

that actually curtail the work that you do with people...I mean the boxes that we're put in, the calendars that we used to have more control over but now we have lesser control over our own calendars. It's all part of the managerialism, right. People can just insert something in your calendar. So those sorts of things that come from the top, those are always tensions.
– Heidi, provider

Although increased visits with children can support mental well-being of families, these efforts are assessed as outside the scope of practice by management who relay this information in a top down manner. A service provider noted that when she attempted to organize supervised visits to children she would be reprimanded and not supported legally because this was outside her mandate.

So I'm a social worker, and we get lots of cases that may include custody issues...One social worker before me was organizing supervised visits and custody and access. And the legal department told me if you touch that within a mental health facility, we will not support you legally. We will not advocate for your review within these actions because that's not your mandate as a mental health clinician. – Heidi, provider

A sense of being curtailed and limited to address health issues in the community was also expressed by other service providers.

Social work remains one of the few professional disciplines that are able to address the issues of health and wellness in the community. Unfortunately, we continue to be absent from policy and development issues. – Opinio, provider

The following comment made by a social work provider also indicated frustration and disappointment in being limited in advocacy and political work.

We're not always a strong voice advocating for the big picture meaningful policy and legislative kinds of changes that we need to see. We're actually actively discouraged from contacting politicians on our own as clinicians. We will get our hands slapped very quickly for doing that kind of advocacy.
–Miller, provider

The tension of working in a system that was increasingly demanding more while decreasing access to resources is described by other service providers.

But they need so much more. And you almost feel like you're having an ethical dilemma because to stay involved and offer so much less than they need. But then to not. So I've just learned to just do it – do the best I have with what I have, and know my role, literally. Because I only have so much power.... Like we're being asked to manage the unmanageable. In mental health and addictions, in child protection, income assistance as well... it's too much.
– Lurlee, provider

This feeling of being overwhelmed was expressed as moral distress.

The NSHA is driven, not by a people first model, but by fiscal constraints and workers within the system suffer moral distress as a result. My role does not provide opportunity for peer supervision and this too is distressing...
– Opinio, provider

Working within the mental health care system was also described as similar to being in an abusive relationship.

It's like being in an emotionally abusive relationship, we really like your ideas or we really like social work, but we don't want to hear all that stuff... –
Opinio, supervisor

Feelings of exclusion, moral distress, and emotional abuse characterize the experiences of social workers in mental health and addiction settings and yet the following supervisor acknowledges that while the organization does not value their critical lens it does value their contribution.

So when somebody doesn't know what to do with a case or a situation, they want to call social work in because of that flexibility to work with multiple people and multiple backgrounds. So in some ways they know if there's serious issues, well, I want the social worker there or the social work team. But then they don't really value that lens when it's turned on the organization. So social workers are one of a few professions that are actually trained to

critically reflect on their systems. And that's not welcomed in systems. So I think some struggles for social work that I have seen is role clarity and role identity, struggles with the system on that and what they can do and what's within their scope of practice. – Annie, supervisor

Several social work providers described a belief that management was disconnected from them and the work they did with people accessing the service.

There's people in the room in our staff meeting saying, "Yeah, who are they?" They didn't even know who they were or what they looked like. So that's a big concern. I think they need to come here and do something like this, and listen, and take our word for things, and stop blaming us. – Rural Focus Group 1, R1

Another social work provider reasoned that feedback was not sought because perhaps the system and management itself was overwhelmed.

Maybe our feedback isn't asked for or welcomed because there's nothing they can do with it in reality. Like maybe it's all too far up and everybody's just waiting to be told what to do, right. And professionals don't want to just sit here and wait and be told what to do. That seems like a lower level of skill is required to just do what you're told. And social workers aren't putting up with that. – Rural Focus Group 1, R1

Social workers also expressed frustration about the limitations placed on them to provide support to people in the community.

Because we are very specific in that we don't do any follow-up. So we don't do any referrals that are outside of mental health. Like we wouldn't help someone with their housing situation or food insecurity. Like we're very limited in what we can offer. So if I'm talking to someone and it's obvious that they have a lot of struggles like with poverty or something that is influencing their mental health then I can't talk about those things with them. – Samantha, provider

The following comment made by a social worker indicates the value placed on establishing relationships within the community and the constraints on doing so within the mental health system.

So I think social work practice honours the power of relationships and community. Like I got really tired of explaining to my team leader and my manager that we need to have a presence in the community, we need to have collaborative treatment planning meetings with schools, with justice. And yes, there's driving time, and yes, it can be resource heavy. But if you put the work in from the outset and help build the capacity of treatment teams then you can sit back a little bit, you know. But yeah, that didn't fly so good.
– Lurleen, provider

This consultation clearly indicated that workers in rural communities were challenged by a lack of resources.

In rural NS, we just don't have that stuff. It's there and it's beautiful but it's more family based, right. So this is the person that I go to. Well, how do I draw that person in if I don't have resources to support that? What works in urban doesn't often work in rural. – Kelly, supervisor

DISEMPOWERING AND UNDERVALUING SOCIAL WORK: THE NEED FOR A STRONGER SOCIAL WORK VOICE

Most research participants describe that social work as a profession was not valued, respected or seen for the richness that it can offer in a medical mental health environment. Some social workers interviewed who work in child welfare and other publicly funded organizations describe feeling undervalued and that their skills and insight are unrecognized.

I don't think social workers are respected and thought of in the way that we should be and I'm not patting myself on the back, I'm just saying that social workers, like you've all said, bring different ways of looking at things, different ways of presenting things, different, I don't know different questions, different, and so without that you aren't considering a really big piece in someone's life and so I really do think that you know I'm a little resentful that they didn't call us an essential service, I just have to say. Cause I think we are.
– Rural Focus Group 2, R1

Is that social workers were used as a specific tool to get access to things. So you said that you were asked to do taxes. And reflecting back on my experience with social workers, a lot of social workers were approached to get bus tickets, to access funding from federal programs, housing. So mom needs a home, so on and so forth. Versus being seen as somebody who can also provide care in a clinical sense. So I felt like the professional is pigeon-holed into this is what you're going to do on the team versus recognizing that social workers can do many things. – Halifax Focus Group R4

Many participants believed that like society at large, workplaces do not fully understand what social work does.

Social workers are in the minority in my work environment and their expertise is not recognized or valued. We are frequently overruled by other disciplines. We are also overburdened so that we can't do the work to adequately address this. – Opinio, provider

The NSHA is driven, not by a people first model, but by fiscal constraints and workers within the system suffer moral distress as a result. My role does not provide opportunity for peer supervision and this too is distressing, as I work exclusively with medically trained professionals. It has led to isolation and necessitated more work, as I must seek out supervisory support outside my service with people who may not understand what I do. – Opinio, provider

I don't know if there's a defined understanding of our profession. And we're not good at that. And we have so many different roles and responsibilities in general, and so many levels of care that we're involved in – micro, meso, macro – that it's very confusing to the general public, to the healthcare system that I work in. – Halifax Focus Group, R1

This was attributed to various factors such as the absence of a singular professional focus and the lack of a strong united voice which other professions like nursing have done well. This position is supported by service providers.

We're not a strong...Well, I should say we are so confused and discombobulated ourselves in what we do because there's so many of us doing so many

different things that we can't stand together and say this is what we do and we're proud of what we do. – Heidi provider

One participant explains that social workers do a poor job of selling their skills which include bringing a “micro, mezzo and macro” approach to their work. This participant notes that rarely are social workers represented in leadership and management positions. This may be in part to social work being perceived as disruptive or non-team players for bringing a critical lens on the organization. For those social workers in leadership positions, it's often an ongoing struggle to maintain a strong social work voice and perspective. Annie, a supervisor, explains:

Within social work leadership, you're always...you have to have a strong foundation of what social work is and be constantly repeating that. That's the defence of that. So I have openly seen people say that to social workers who respond and do time inappropriate ways. Or I've had to respond and kind of go in and say this is the competency of social work, this is what social work does around a lot of tables. So because again that role clarity issue comes up between the organization wanting social work to do one thing, social work being trained and having that lens on a different thing, sometimes that respect is not there at the level I'd like to see it there. So I think there's the bio-medical model. I think there's the advocacy piece that we're always putting things on the table and seen as resistors. So sometimes counsel is not taken as seriously as it needs to be at different times. A lot of questioning. – Annie, supervisor

Other participants explain that the profile of the profession needs to be strengthened, particularly with respect to clinical skills that social workers can provide. Some note that the Nova Scotia College of Social Workers should play a part in supporting and promoting the role of social workers in mental health. Private practice social workers explain they are often trying to convince organizations that social work clinical skills are worth covering through benefits and private insurance. A social worker in the NSHA reports that they feel unsupported doing clinical work outside the formal mental health system and undermined by the formal mental health system in their role as a mental health clinician. Miller explains:

If I've been seeing someone in my practice who I've determined needs a higher level of help from the formal mental health system, my work and my

experience and my assessment means nothing. So I have to refer them. It's treated the same as a self-referral would be...They'd start from ground zero, doing an intake assessment just like they would for any other referral. So my professional expertise and opinion counts for nothing. And that's incredibly frustrating. – Miller, provider

Not valued, respected I would say because I think it's still really, it's a role that still continues to be devalued, it's a role that's not you know not looked at in terms of all it might offer in terms of the richness I think in terms of just that, you know if you're, so if your focus is on that sort of diagnostic piece or formulation piece or whatever it might be, then what would not be more richer than to have that sort of lens to be able to kind of look at like again on that intersectionality and all those systemic issues and things. So I think it is really kind of disrespected and disregarded. – James, provider

One social work supervisor below expressed frustration in not having an influence in determining policy.

I think that the lack of participation by workers and clients/citizens in determining policy and programming should be exposed and the White middle-class neoliberal orientation of mental health and addictions revealed for all Nova Scotians. – Opinio, supervisor

Another social work supervisor shared their thoughts about the creation of ineffective policy developed by individuals who were not familiar with their work.

There are also people who are making policies who know nothing about front line work and what is needed, and managers...who are leaders who do not know what they are doing...the system is broken and people are suffering. – Opinio, supervisor

A description of voicelessness was noted by Jane, a social work provider who shared experiences of exclusion.

And you know, where social workers are completely excluded from the management table in that district and there is no voice... – Jane, provider

This description of having no voice was also made by a social work supervisor.

But there's been a very significant shift in the last few years that our feedback is not wanted. So, things are being done without us being consulted. – Rural Focus Group 1, R3

BIO-MEDICAL MODEL IN COMMUNITY MENTAL HEALTH

While one might assume that community mental health is community based and more accessible, participants describe public services available for mental health in Nova Scotia as largely based on a medical approach. As such, the emphasis is on diagnosing and treating symptoms. This has an impact not only on people seeking mental health services, but also on social workers who provide mental health care. In order to be eligible for services through Community Mental Health, people need to have a DSM diagnosis.

Like the kind of policy that they don't really qualify for service unless they have a major mental illness...But basically unless you're tier 3, unless you have like a major mental illness diagnosis, you basically don't even qualify for services. – Alexandra, provider

This contributes to what another participant explains as, “a general approach of getting people medicated, then getting them out of the system rather than focusing on creating resiliency, building relationships and exploring people's life circumstances”. – Kelly, supervisor

Many social workers employed within Community Mental Health note the discomfort they feel working in a system where the focus is on diagnosis versus the person and their experiences. One service provider explains:

It's definitely illness-based. So it's focused on what your symptoms are of your illness, and how to treat those symptoms, rather than what is going to help you like live a more...I don't know, like less of a holistic approach. So what is it that your goals are in life in general, not just around your mental illness, and what are things that you enjoy, and what do you want to be doing, and

relationships that you want to be having, and things that are going to like create more resilience, I guess. – Samantha, provider

As there is a requirement for a diagnosis in service provision in Nova Scotia, there are a lot of people who have mental health distress or struggles that fall through the cracks. Unless they have insurance or can afford to pay for private services their options are limited.

INCOME BARRIERS TO ACCESS MENTAL HEALTH SERVICES: PRIVATE PRACTICE

Participants comment that outside the Nova Scotia Health Authority (NSHA) and the Department of Community Services (DCS) there are little to no free mental health services. Thus, for those who are not eligible for public services, or don't fit into "perfect little boxes" for treatment, they have no access to mental health services. Bob, a social work provider who runs a private practice, notes that private practitioners need to offer free trauma work with clients because trauma is inadequately addressed within the public mental health system and many people aren't able to pay for private services.

Many participants point out that people lack benefits or access to private insurance that would enable them to see a mental health practitioner in private practice, and identify this as a further barrier to accessing mental health services.

Income is a huge one. Because if you don't have money to pay for private services then you have to wait quite a long time. So upwards of 3 months or more maybe just to see someone for an initial appointment. And the same with addictions. Like that's a huge issue. For people that do call us with addictions, and we end up having to refer them to the addiction services intake. And they know that it's going to take a while, especially for withdrawal management, like the detox programs. People will call themselves or they'll call about someone who is using and wants help now. And then they're told they have to wait. – Samantha, provider

But I think something that does set it up as in we are the public system, sometimes we are dealing with the demographic of...or population of homelessness and things that there's no other way for them to get support. Where if

you are dealing with people that maybe have the financial means, they will go elsewhere and get private. And we don't maybe hear from them as much. Sometimes they call and ask for information, and we direct them to private if they have that as an option because it's faster, right. – Josie, provider

A number of providers in this consultation work in private practice. Some acknowledge the difficulties of access this can cause for people who have no or inadequate insurance or a lack of income.

think predominantly still the people who access private counselling are people who can afford it. And not only can afford it but that would mean that they would have a health plan. So you know, in NS, that would mean predominantly dominant culture folk... So I also then see folks who work for the provincial government with Blue Cross plans. And again, you know, largely they're people who have \$1,000 or \$1,500 a year. It's not quite as lucrative as Veterans Affairs but certainly not bad. So I like to keep my rates in keeping with \$130. Although I certainly have quite a few folks who I see at \$120. I'm aware that that's lower than what the college is recommending. And I'm also aware that it gets people more sessions. – Patty, provider, private practice

I think that it's really hard to access good mental health care that sufficiently meets people's needs. Even if you decide to go the private route and if you're so lucky to have medical insurance, you know there's inequity there, there's inequity in what your policy and plan allow for you, if it's \$500 or it's \$1500 a year. – Lori, provider

And our at-risk populations don't tend to have access to insurance. And they don't tend to have access to services as they need it. – Bob, supervisor

Some of the providers in this study who were in private practice emphasized that they were better able to provide ethical and continuous care

Very impossible choices. And the flip side also being in private practice, you can very much provide ethical care and see people bi-weekly. And then you're also seeing those that can afford it or have the insurance. So the other piece of the social worker in you is like ahhh! [laughs] Like it's the public system that needs help. – Rural Focus Group 1, R3

...it's expensive is the only negative side of it really but I think more people should be using them if it was cheaper and more accessible.
– George, service user

I would have that opportunity and lots of people don't and lots of people don't have the financial means because when I was working I had the financial means to see social workers cause social workers aren't covered under SunLife medical and so on, which is ridiculous. And so if I'm somebody who doesn't have the financial means to do that then I'm sunk... And at this point because I worked in clinical research for so long, I don't have a nursing pension which really has come back to bite me so right now I really have to, I sought out the woman from NSHA because it was free, with a doctor's referral I could see her for nothing. – Haze, service user

“EVIDENCE-BASED” APPROACHES: SYSTEMIC BARRIERS TO ANTI-OPPRESSIVE PRACTICE

The emphasis on “evidence-based” therapeutic strategies, is in itself not a problem, but the question of what constitutes evidence-based and how this is determined is. The notion of evidence based appears to be used as a way to legitimize certain strategic choices made within the CAPA service delivery model, central to Nova Scotia mental health care services. When the model deployed is one that emphasizes efficiency and cost effectiveness above all else, it is not surprising that the short term and fairly uncomplicated, one size fits all strategies which do not consider the social determinants of health are considered evidence based and that social workers have some concerns about these strategies.

The comments of Annie and Stephane below focus on evidence-based practice and the ways in which it can limit approaches used by mental health providers.

I would say the main approaches that I've seen in recent years are cognitive behavioural therapy, solution-focused therapy, motivational interviewing, assessment... But cognitive behavioural therapy has really entrenched itself within healthcare as kind of the premier model... I think working within a medical model that there's a lot of other disciplines within psychology and psychiatry that support that model. I think it's evidence-based. So there's been

a lot of research about the value of working with CBT and now trauma focused CBT. Which is great because at least there's a trauma kind of lens and an attachment lens on that coming in. So I think it's just that because it's research-based. I think the hospitals are attached to a lot of research innovations.
– Annie, supervisor

...we get very focused on we've got to do this cognitive thing, we need to focus on these processes, these individual in the mind processes and we don't think of the context. – Stephane, provider

There's no analysis of where the evidenced based approaches come from? Who's funding the research, who's what demographic is being studied. CBT is not a helpful approach for trauma. – Leaf, provider

Lack of Choice and Autonomy

The following comments further the theme noted above by critiquing a preference for Cognitive Behavioral Therapy within their workplaces as it has been defined as evidence-based, which leaves them feeling like they have a lack of choice and autonomy.

CBT. Oh my goodness, how many letters have I gotten from doctors telling me I have to use CBT. No, I'm going to take that back. Not doctors, insurance companies. Because when I'm working with folks that are on short term illness, the (dis)Ability case managers want to dictate the treatment plan. – Jane, provider

We often hear back from management and the higher ups of, you know, making sure that it's evidence-based...I feel certain types of evidence are often valued over others. So for example, quantitative research, numbers is often valued more than maybe more qualitative research. – Jess, provider

That's what this work is about, the present and you have to have a way of thinking about the present which I'm not sure most social workers adequately have unless they have training in CBT or something else which allow them to do something, which I think is insufficient in the overall problems that people face. – Rural Focus Group 2, R3

BARRIERS TO MENTAL HEALTH EQUITY AND SOCIAL JUSTICE IN MENTAL HEALTH SERVICE DELIVERY

Resources

A supervisor shared her perspective about a need for more resources to promote mental wellness within communities, suggesting that if individuals were more supported within communities it would reduce the burden placed on mental health systems.

We just don't cope as well if we have multiple stressors and few resources. That doesn't mean we have a mental illness right....What we need is more resources in the community to support individuals who don't need, don't have a mental health illness diagnosis, who don't necessarily need the intensive services that a hospital would offer, but there isn't that level of support in the community. – Tena, supervisor

Participants reported the need for more resources within communities and a reduction of working in silos.

We're working in silos now. It's really not a good trend at all. So that's a big problem at the political level, at the funding level. They say, okay, we're going to close down the service, we're going to...people should be served in the community, but they don't fund the community to serve the people. – Rural Focus Group 1, R5

There was a widely shared opinion that there is a lack of equity in mental health services. This was identified as evident economically in underfunding and under-resourcing as well as in policies which standardize and homogenize and in policy implementation which ignores the needs of marginalized and oppressed groups in our midst. A supervisor, Annie, noted that not everyone feels welcomed at mainstream mental health services as they are largely staffed by non-diverse people and operate with policies and practices which exclude many people.

I think because of our standardized processes and practices, that sometimes we're excluding, not meaning to exclude purposefully, but in some ways

because of the things we've chosen and the policies we've chosen and the practices, that does cut out a lot of populations that may need us. So when you don't have a diverse staff, and you don't have different ways of looking at the world, and you don't have different interventions you can offer people, you are making decisions that exclude other people. – Annie, supervisor

Underfunding for mental health and addiction services, the lack of accessible resources and an uneven distribution of limited resources were described as characteristic of services throughout the province. A service provider, Heidi, observed that generally in Nova Scotia:

We know Mental Health is what I call the underarm of the medical care system because we're not given the finances or the supports that our residents of NS or Canada even need to be successful in their recovery or in their life as a well person. – Heidi, provider

A rural focus group reported significant underfunding and under-resourcing which was in excess of that experienced in the rest of Nova Scotia. These social workers expressed frustration and powerlessness as they confronted gross inequity in the distribution of mental health resources.

Poverty, homelessness, and unemployment leading to despair and hopelessness was noted as characteristic of the folks they see daily. One service provider, Miller summed it up succinctly. Poverty is huge. And along with that comes inadequate housing, inadequate drug coverage, inadequate access to medications, food insecurity, you know, compromised physical health, mental health issues. Like it's tied into everything. So poverty I think would be the biggest. – Miller, provider

Another service provider noted there were five Indigenous reserves in Cape Breton and longstanding social problems of intergenerational poverty which take a heavy toll on mental well-being, both individually and on the collective community.

How many years ago was it that Cape Breton had one of the highest rates of child poverty in Canada? That wasn't that long ago. And so for that... Just the intergenerational poverty, and the intergenerational trauma that has come

along with all of the stresses, I think...I kind of see Cape Breton as being unique because of its postindustrial history. And it's isolated. There's lots of pieces that play into that. – Rural Focus Group 1, R3

Lack of transportation and lack of childcare was identified as a significant barrier for persons living in poverty, as well as for persons living in rural locations. A service provider, Blake, described this vividly.

And so the population out there is desperate for services. Yet the closest mental health office for people who live in that area is in Cole Harbour. So if you live in Sheet Harbour, which is at least a 90 minute drive from Cole Harbour, and you rely on...You're employed. You can't take time off work. You might not have a car to travel to Cole Harbour. There's no telehealth services offered in that respect. And people are left with no options, really. So I think that's a huge population of Nova Scotians. Those who live in poverty, I think are affected the most. – Blake, provider

You know, the lack of transportation in the rural areas; childcare, women talk about that in terms of coming to groups. If people work in the daytime, when are they going to access services, you know, because they need to work? Even if someone's in a bad state of anxiety and can't walk from one end of Yarmouth to the next, or it's too cold on a winter day to walk. – Karen, provider

One supervisor, Annie, reported the application of a quota system which restricts the number of clients that can be registered in a particular service. She observed this policy is a serious systemic barrier and impediment to equity.

No sense. And I don't know, I don't understand this whole quota system. Like it's like if you went to the emergency department--I always use this example—with like chest pain, they would never ever say to you like, "Oh, I'm sorry, we've reached our quota for heart attacks today. Like you're going to have to go on a list, and we'll see you next week." Like they would never say that to you. And so the fact that we're treating mental health issues differently and not treating things concurrently is just highly problematic...Yeah, because again I think we do bring like a much broader perspective. And we're not always given the credibility. – Annie, supervisor

Some service providers identified the standard practice of weekly counselling appointments as inappropriate for non-middle class folks who are struggling with daily issues related to poverty and marginalization and suggested that the delivery of services should be made more user friendly and accessible.

Service providers also identified the presence of discriminatory attitudes held by mental health workers towards certain types of mental distress which has created distinctive stigmas within the mental health professions. There were the observations that the understanding and construction of mental illness acted to impose moral judgement and exclusion on certain types of mental distress. This was noted as particularly apparent with what are diagnosed in the medical nosology as personality disorders. Alexandra, a mental health service provider, noted,

So like in my work, like people are always saying, “Oh, it’s personality, it’s personality. It’s just personality.” Like oh my god, the number of times a day I hear someone say it’s personality! And like that doesn’t mean that a person...1) A personality disorder is still a major mental illness in the DSM. 2) It doesn’t mean that that person like doesn’t need help. Like doesn’t deserve or doesn’t need help...But yeah, it’s just like anything that doesn’t fit like this perfect little box of like major depressive disorder, like clear cut major depressive disorder, or like clear cut bipolar, or like...it just gets like labelled as personality and not taken seriously. – Alexandra, provider

This dismissal and exclusion of certain profiles is systemically operationalised through the CAPA program with the “choices” appointment where so called evidence-based interventions are sought by the service provider facilitating the “choice.”

And the person who did the Choice appointment said, “I can’t help you. There’s no help for you here.” It was before they started the DBT programs. And the woman was like, “What do you mean there’s no help for me?” They’re like, “There’s no help for you.” And I was like what the heck? So she came back and we did work individually. But it’s very frustrating to see, you know, when someone has borderline on their file, their medical file, they get treated very differently by doctors. People with schizophrenia, everything is blamed on their schizophrenia. Like if they go in with a medical condition, they chalk it up to mental illness first. – Grace, provider

This stigma attached to persons who are deemed to be untreatable according to the “evidence” means that certain types of mental distress are sidelined and excluded. A service provider, Blake, identified this as an area where social workers can advocate and educate non-social work mental health workers.

So I think there's a big role that social work plays in my experiences, is trying to normalize a lot of this stuff and to reduce stigma, and to take opportunities when they present themselves to educate other staff about different types of behaviours and disorders so that they are in a better position to understand and relate with some circumstances and things that people are experiencing. – Blake, provider

Service users identified experiencing social stigma attached to receiving mental health supports, which was experienced in a variety of contexts. In some cases it was described as within their own families and social circles.

Just I guess related to this there's definitely a stigma, like when I told my parents I was going to see a therapist they were very not in favour of it, they didn't see the need of it and stuff but they're from, it feels like most of that generation is very not coping with mental health but it seems like a lot of younger people are more, like most of my friends they don't have much of a reaction, it's just oh that's good. But it seems a lot of older people when you tell them they look at you like this is like you're unstable or something and it's just like well I've become more stable than you are hopefully so. – George, service user

In other cases stigma influences membership in communities and can impede employment and housing opportunities. A service user, Moon Baby, reported that,

So I felt the stigma of seeming unemployable because I was on a pill that people don't have enough information about so the stigma of being mentally unwell was bearing heavily on my mind and on my reality. – Moon Baby, service user

DIVERSITY AND THE ABSENCE OF ANTI-OPPRESSIVE APPROACHES TO SERVICE DELIVERY

It was identified that many persons seeking mental health services are members of non-dominant groups such as persons who are transgender or have a non-heterosexual orientation, are racialized or Indigenous, or are aged, poor, or differently abled. For these people, there are many barriers and inadequacies in the current mental health system. James, a service provider, identified that there are systemic shortcomings in the training and resulting understanding and awareness of many practicing social workers working with the 2SLGBTQIA+ population.

I know it's made a big difference to a lot of the queer and trans youth I work with that I am queer and trans, and that they feel like I get it in a way that other people don't, and even providers who claim that they're like safe and competent are like not a lot of the time and they are not like realizing for themselves that they've got these kind of like underlying pieces that are showing up in the work that they do with people and making people feel unsafe or not understood or not validated. – Leaf, provider

Miller, a service supervisor, noted that there are many significant mental health challenges for trans people who are confronted with widespread stigma and lack of understanding, and that this insensitivity and poor awareness is sometimes also present in health service providers.

And then of course in the context of my trans health work...So the hormone assessment for people who are diagnosed with gender dysphoria. Not all of them identify as trans. We see a huge prevalence of suicidality, depression, anxiety, sometimes more serious mental health issues as well because of the stigma and problems folks have bumped into living in a world that still hasn't been super welcoming to folks who are gender nonconforming. – Miller, supervisor

One supervisor, Elaine, identified that maintaining equity in small communities was very challenging as not only do people in the community know one another, but social workers also know particular families and persons, and so stereotyping and prejudice become barriers to good service delivery.

I would say being First Nations. I mean there are terrible stereotypes that First Nations hear...I've certainly seen with First Nations. I think women generally get it harder than men, still. I think particularly...largely women who get diagnosed with personality disorders get poo-pooed when they come to emergency rooms or others with health concerns. I think in small communities like this, your family name can be a form of how you get marginalized...So I think in small communities, there's like a...it's not just socioeconomic, it's a historical bias that comes up because everyone knows each other. – Elaine, supervisor

A service supervisor, Kelly, identified that there are tensions between different services such as the police and mental health services regarding their respective roles and approaches to mental distress. She noted that when some social workers are unable to manage certain mental health presentations they call the problem “behaviours” and involve the police.

Because if you can't deal with mental health then they're dubbed behaviours. And then if they're dubbed behaviours then the police are called. I think transition between systems and inter-system collaboration, that's a major problem. I think intergenerational trauma. I think marginalized and systemic racism. These are all major issues in my practice that not everybody gets. – Kelly, supervisor

RESPONDING TO TRAUMA: INTERGENERATIONAL TRAUMA, CHILDHOOD TRAUMA, POST-TRAUMATIC STRESS

It was widely reported that issues relating to trauma, anxiety, depression and addictions are commonplace in social work practice and that these issues are often inter-related and are diagnostically described as concurrent. Intergenerational trauma faced by Indigenous communities who are residential school survivors and African Nova Scotian people who have also experienced intergenerational marginalization and discrimination was identified as prevalent in certain areas of Nova Scotia. A number of service providers expressed concern that mental health professionals, including some practicing social workers, don't always recognize the particular needs of this group of service users and are ill equipped to respond effectively. Kelly, a service supervisor commented:

I think intergenerational trauma. I think marginalized and systemic racism. These are all major issues in my practice that not everybody gets.
– Kelly, supervisor

Some of the service providers we consulted certainly did get it and described how the insidious effects of the trauma impacted the delivery of services. In a rural focus group discussion it was noted by one service provider that intergenerational trauma underpinned the challenges in establishing a working relationship with Indigenous communities where distrust and suspicion were high. This provider noted that there were,

difficult relationships with the Indigenous population that do reach out for services on reserve. A lot that don't. So we get I guess a lot of intergenerational trauma and presenting trauma. But intergenerational trauma. That it's a population of the whole area of Cape Breton that don't really go out and reach out for services in their own communities for security...for trauma reasons, right. Sometimes we relate it to their trauma and reaching out to services within their community. It's sad situations. But I guess higher proportions, yeah.
– Rural Focus Group 1, R6

Another service provider in private practice, described the mental distress resulting from intergenerational trauma and the impact of this on parenting and family functioning.

Attachment wounds is a huge one that I see over and over again with almost every mom I see through Child Protective Services, definitely there's so much intergenerational trauma, definitely see in I would say almost, a huge percentage of my clients I see definitely intergenerational, I'm just going to use the word complexities right now being passed down... Definitely those clients that grew up in poverty and how that's affected them, the opportunities that they had or didn't have, most of them didn't have and how that, and then also the communities that they grew up in and what they weren't exposed to and what they were exposed to, that then further marginalize them and set them on a course that made it really difficult for them to thrive. – Lori, provider

A supervisor in youth services commented that mental health concerns were foremost in the reasons for referral. Many teenagers and pre-teens reported high levels of

anxiety and debilitating depression as well as concentration and attentional difficulties which impeded school performance.

There is an increasing intensity in terms of some of the youth that we see around acuity and around complex needs... And not surprisingly of the 200 kids in the past three months that came to our door, mental health was by far the biggest issue that was, what we determined to be a precipitating factor or an area which was driving them to walk into our front door to seek services. When I say mental health it's going to be everything from lack of a better word, more of those issues around anxiety, depression, right down through to psychosis and all points in between. It can also include if we want to more cognitive and those issues as well. But without a doubt, the issue that is the number one issue for our staff members in terms of issues or factors that lead a young person to our front door is mental health. And addictions would be a close second but not entirely. – Del, supervisor

There was an identification that often the reasons identified for intervention initially, were later recognized by social workers as surface issues and that there were other issues, often connected to trauma that had not been identified. This presents a variety of problems as the intervention models such as CAPA do not anticipate this and in addition some social workers do not feel that they are equipped to respond therapeutically to these issues. Service provider Jess identified the prevalence of an underlying history of trauma and the absence of training in that area.

So the reality is that most people that come through my door have experienced some type of trauma in their lives that absolutely has an impact on how they're functioning currently with regards to their mental health. So I don't have any training in any trauma specific therapies. So you know, I don't do like prolonged exposure or anything like that to directly address the impacts of trauma on an individual's life. But I work with people who have experienced trauma every day. And that's always a part of the conversation. – Jess, provider

A service provider from the Opinio survey identified the shortcomings of the DSM and the medical model in identifying trauma related issues, and described how this has resulted in additional advocacy for recognition of the needs of the service user.

Medical models and the DSM do not appropriately cover, to my experiences, aspects of trauma both within marginalized populations or those who are viewed as marginalized. While there is a usefulness of the DSM and its ongoing changes, complete reliance on this has found clients needing mental health services coming into my counselling space due to rejection only to have referrals done over again by myself or in collaboration with their medical doctors (if they have one) due to our concerns which are then finally recognized as client-based needs and they are accepted for assistance.
– **Opinio, provider**

Service providers reported the constraints of working in a system such as CAPA where mental distress is funnelled into a DSM nosology and so social workers are forced to comply with this construction of presenting issues in order to access services for their clients. Jill, a service provider, observes that she looks for DSM categories to put people into.

Anxiety, concurrent sometimes with alcohol use disorder. Depression. Post-traumatic stress. Adjustment stuff. Bereavement – which I just categorize under adjustment stuff because we're not supposed to see people just for bereavement. What else? Who else?, I mean that's the typical. There's other outliers that are different. But that's the "bread and butter" of the problems, I'd say.
– **Jill, provider**

An additional complication that was reported is that recovery from mental distress is a process and changes occur along the way. Once again, the rigidity of a system which positions assessment as the starting point of a linear process which is followed by an evidence based decision as to an appropriate treatment limits this journey. Moon Baby, a service user, describes how their successful recovery from the grip of addiction opened up a new kind of mental distress.

Yah I think that I got sober and then started to experience mood changes more like intensely which is why I ended up seeking care...I think so, I think that because I was partying a lot in university and that extended into the year following me graduating, I wasn't having, my understanding of having like a lower or altered mood was like based around feeling maybe I was hungover or needed to do drugs and I think that there's definitely a

correlation between the two. I think that addiction and mental health definitely go hand-in-hand and that's it's like realistically a coping mechanism.
– Moon Baby, service user

It was reported by service providers that there was often insufficient time to respond to the mental distress such as that reported by Moon Baby. Traumatic experiences often emerged while working with someone and for some service providers, they expressed feeling ill equipped to respond and others reported not having the time as the number of occasions they see a person was often decided before the intervention even began. It was noted that there was an initiative in the NSHA to integrate trauma work and to have a trauma-informed approach woven into assessment and interventions employed. However, service provider Annie noted that trauma work doesn't fit well with the medical model and so implementing this “new” approach is difficult.

In order to do really effective trauma-informed care work, we'd have to deconstruct a lot of practices and policies that are going on, and personal values and team values, and organizational values. And that's going to take a long time....I think social work is well aligned to shift because trauma-informed care aligns very well with social work. – Annie, supervisor

CHOICE AND PARTNERSHIP APPROACH: CAPA SERVICE DELIVERY MODEL MANAGERIALISM

The name of this model is ironic for social workers as the lack of choice, autonomy and actual collaboration or partnership Nova Scotian social workers experience working in a CAPA mental health system has been repeatedly critiqued by the participants in this consultation. Much of the discontent that was expressed by service providers focuses on the NSHA and IWK's transition to a CAPA “efficiency” based model for delivering mental health services. Many participants feel as though the CAPA model was simply imposed and there is a disconnect between how the CAPA model functions and the type of social work mental health services they want to provide. Further, it was noted that the CAPA model was implemented without consideration of the needs of diverse communities. Another participant explains:

So I have an ethical problem with how the organization has moved to this CAPA-based model which when it was first introduced in this province or within the IWK or within the Nova Scotia Health Authority, I saw all the cracks in it if you thought about it critically and some of the ethical considerations that weren't taken into, and cultural considerations that were negated when you raised them. – Harriet, provider

And actually this brought a desire from our [health] authority to want to operationalize mental health as...I don't know how to describe it. Like as physical services, as goods that need to be provided, that need to be accounted for. – Rural Focus Group 1, R1

Because I remember the determinants of health, we used to talk about it on a regular basis. And that seems to have gone to the wayside...Since CAPA's come, I've noticed that. And that's slipped away. – Halifax Focus Group, R3

So I get concerned as a social worker about how things are shaping up to deal with increased capacity. Who are we narrowing out? Whose voice doesn't get heard? . – Rural Focus Group 1, R2

Efficiency Versus Clinical Model

Participants are clear that the primary impetus of this managerial approach is achieving efficiency through setting up a particular structure and it is most often their view that it does not emphasize an effective clinical approach in the process.

It's a really nice program...or a model. But personally, my opinion is that right now it's being used as an efficiency model versus a clinical model. – Halifax Focus Group, R2

I feel for myself in the past and for people who may be involved with the services presently that to set a certain number of times that they can see the social worker or a certain timeframe may not really be helpful. To say well we have six sessions together and you know and then you're kind of on your own that may not necessarily be helpful for some people. People may need

a longer-term support, people who don't have any personal coverage, any, that are only, their only option is to go through Capital Health to access these services, and then to know that they can only see somebody for a couple of months could really impact somebody. – Lori, service user

Right now we're becoming a factory. And I don't like it. And I don't want to push people through. I want to do quality care, best practice. I want to make sure people are healed sufficiently. And using the analogy of if someone's going for surgery, are you going to do a partial surgery? Is that person going to be...are they going to heal? So I struggle with these 8 sessions and 16 sessions, and being boxed in because I don't think it's real. And sometimes people, you know, you're working with their basic needs for the first so many sessions. – Halifax Focus Group, R3

Participants frequently commented that one of the limitations within the implementation of CAPA is those clients who “relapse and return.” As clients are seen for short periods of time, regardless of whether that is adequate, it makes sense that a good number of people either return for more support or simply do not and try to cope on their own.

What's it called? The ROTs, I guess they're called. Like the 3 months that they come back to folks. Which I think is excellent. But if somebody called me at 4 months, I certainly would not say sorry, I don't know you anymore, I've forgotten you. I mean once you build a relationship with somebody then you're going to say okay, let's navigate. Because why would you make... Like for me in the system, why would I make somebody go through all of that with all the barriers that are already there for just coming in? Plus, you make a relapse prevention plan, which is a provincial. So, you have your relapse prevention plan. You're part of that relapse prevention plan. So that makes sense. So, I don't know if anybody's telling you that you can't do that. I think that some people want to have it all boxed. – Halifax Focus Group, R3

One supervisor explained that the Nova Scotia Health Authority valued social workers as master problem solvers, but didn't actually allow for social work approaches to practice or application of the critical thinking skills that are so important to the profession. Generally, other healthcare providers do not understand the role and scope of social work practice. Annie explains:

They want you to be those master problem-solvers but they don't want you turning that spotlight and lens on the system you're working in. So a lot of tensions can come up when you say, well, okay, there's this but what about these bigger pieces that we're not addressing, or what about these... So the system itself, because of the busyness doesn't have time, they don't want to take the time to really unpack some of those kind of different issues kind of coming up. And they don't necessarily understand that that's the role of social work. – Annie, supervisor

Lack of Accessibility and Wait Times

It was noted that the CAPA service delivery model was implemented as a response to pressure from the community to reduce waitlists for mental health services. One participant explains that the CAPA service delivery model met the needs of the directors of NSHA and IWK, but not the needs of the community. They went on to explain, in order to reduce the waitlist there needed to be an overall reduction in the length and duration of mental health services for individuals. As a result, service providers feel pressured to move people through the queue quickly and off the waiting lists, which impacted the way that social workers were able to take the time to meaningfully engage with those accessing services. Participants explain the serious ethical dilemmas that social workers encounter with the how the CAPA service delivery model has been implemented:

Social justice, right, yeah. Yeah, that's not driving this - real people. Efficiency is driving this. The factory model. – Elaine supervisor

The CAPA model framework provides for URGENT assessments, i.e., someone who has been seen at emerg; however, the following New Partnership may be months away - this is not satisfactory...Input from the clinicians appears to not be heard, and clients suffer from bureaucratic decision making (with respect to job planning, number of clients etc.). – Opinio, provider

So we have a CAPA model that is supposed to be effective. But it's only effective when we're fully staffed. And so right now we have...I don't know the exact rate but I think we have like 40% of our social work positions are actually

unfilled right now... So when you can intake right now, you're given a Choice appointment. So currently due to this new expectation that our intake is live, meaning you call in and then you're supposed to talk to someone right away and get an appointment before you hang up the phone... So because of this expectation, let's say you called today (January, 2020), you're going to get an appointment in October of 2020. – Sara, provider

The impact of excessive wait times is felt in the lives of people coping with unresolved challenges and can cause feelings of frustration and anger as noted by the comments of the social work provider below.

I don't enjoy meeting people the first time anymore because I know the follow-up isn't... in my mind, it isn't even ethical. The wait, it's too far away even after they've seen me. – Rural Focus Group 1, R4

Another social work provider noting the impact of the wait lists described how it was compounded by having not control over their schedule to better prioritize who should be seen.

There's a wait list and that's how it goes because there's no other resources. And no control over what's actually, "Oh, I feel that this person is priority, should be seen more intensively, more..." If there's room within amazing long wait lists, it might happen. So it's really distressing to be working in this context actually. – Rural Focus Group, 1, R4

Despite claims that the current CAPA service delivery model will reduce waiting times, participants in this consultation report that the actual waiting time can be very lengthy before you could start to work with a therapist.

So from the time you called, it's a year and a half before you're starting the work. Well, arguable. You can do work... Intake does some stuff. You know, that initial Choice clinician will give them stuff to work on in between. – Rural Focus Group 1, R2

While appearing to reduce wait times, it is also observed that those considered Tier 3 will be assessed quickly, but not others. Further, that once people are assessed they are likely to wait months to actually be in a treatment program of some sort.

You brought up the kind of political lens in terms of the government at the time. So that was a huge win because as far as society is concerned, the taxpayer is concerned, the wait times are low. So whatever government is in power, people think okay, so it's fixed. – Halifax Focus Group, R5

Lengthy wait times could increase vulnerability.

I think you know we have some wait times that are just unacceptable. I'm particularly thinking of our trans health folks and the wait times and their heart drops when I'm having to tell sometimes you know you are on the waitlist, you'll be contacted sometimes in all honesty could be a year and a half, two years. – Susan, provider

The negative impact of excessive wait times on people who are gender diverse and gender nonconforming was also shared by the social work provider below.

One of my major concerns about the mental health system the way it's operating right now, especially when it comes to people who are gender diverse, gender non-conforming, dealing with gender dysphoria, is that they're put onto a separate wait list. So if I present to Mental Health as having gender dysphoria and depression, they will put me on two separate lists to get care. So they deal with my depression fairly quickly but they're not going to deal with my gender dysphoria, which is probably responsible for my depression, until my name comes up on that list. – Miller, provider

Intake Limiting Clients; Access and Number of Sessions

Social workers described the limitations of the manner that NSHA and IWK have implemented the CAPA service delivery model that determined the number of sessions for which a client could be seen.

When the CAPA came in, it was supposed to be around 8 to 10 sessions. And then, well, there is the push to limit the sessions because you always have clients coming in. So what it actually does is it downloads the responsibility

of the system onto the backs of individual workers. Because if you don't move people in and out, you'll be swamped. – Karen, provider

Participants regularly note that clients are limited in how many sessions they are able to see the counsellor.

It also, gave them a formula or a process where that a family was in this system or in this treatment cycle for whatever six sessions, eight sessions, twelve sessions, and then you know discharged versus, they were coming in and staying in treatment for a lot longer then maybe wait times were a lot longer as a result. I think it's given them a mechanism to control the wait time and then the public perception is that this is working because I called like three years ago and I had to wait a year and a half and now I'm working six weeks, but you know the level of service. I think even the menu of services is much more confined in terms of a brief solution focused therapy model that most are using or following or expected to follow. So they're really seen for shorter times, discharging them, they're often referred back again or coming back again, so it's a very false perception I think that people hear. – James, provider

And actually we had at a recent staff meeting, the discussion came up about urgent assessments, right. So when a person's deemed urgent, they have to be seen within 7 days. Which we are doing. And that's always been...that's a juggling act but we do it. However, the huge problem right now is the follow-up. And we also talked about the liability issue....And then of course the trouble with that though is then we're interfering with our regularly scheduled appointments. So if we ethically feel that I need to see so and so every two weeks, well, when I start adding this extra that I don't have the time to do, who else suffers. – Rural Focus Group 1, R5

One supervisor notes that the current intake system was meant to restrict access to mental health and addiction services.

The current intake processes are designed to weed out many people seeking help since mental health and addictions now only deals with Tier 3 clients. There aren't adequate community resources or provincial programs available to address people's needs which are structural, not individual. – Opinio, supervisor

The first appointment under the CAPA service delivery model is the choice appointment. People then move on to a limited number of partnership appointments.

I find the interesting lead there, I don't know where it could take the system that adopted it the idea that we do run into the funding thing, how many positions you can have, how many hours then you get the CAPA response of you know it's almost like a war room we have so many Choice appointments available, we have so many, I can deploy so many choice appointments, I can deploy so many seven session units you know to meet this oncoming attack by ill people who are just overwhelming our defenses. And we can get driven down into this thing, we have to triage, we have to see the people who are the most severe and we have to make sure we don't see someone too many times, or we don't see people that we can't help. – Rural Focus Group 2, R4

Limited Hours of Operations

A social work supervisor suggested that limited hours of operation posed barriers to accessing mental health services.

I haven't seen things like adjusting our clinic times. Which I think is something that could be helpful to the general population. Like Monday to Friday, 9 to 5. Well, that's when everybody's in school or everybody else is at work. So sometimes people just can't make it to appointments, and can't show up... And also our ability to connect with the community. So we know certain populations don't show up well within our systems. But then we're not given the time to make relationships and relationship building with those connections. – Annie, supervisor

The suggestion that services could be more accessible and effective if offered in the community was supported by the following comments made by a service user who believed mental health services could be more community-based.

I think you should have like mental health people working a little bit like MOSH [Mobile Outreach Street Health] and Mainline [harm reduction community based program] you know. – Opinio, service user

Increased Paperwork and Reporting

Increasing paperwork demands were described as an additional challenge facing front-line social workers.

There's no time built into the daily schedule for paperwork. Although if you said that to a manager, they would say you're not managing your schedule appropriately. – Jane, provider

It makes me very upset because a lot of it is redundant, not necessary. It makes me feel like we really aren't client-centred, we're just sort of numbers and funding and safety and legal-centred. The things sometimes I have to complete with clients are pretty ridiculous feeling and insensitive. – Jill, provider

The demands to complete paperwork were described as curtailing limited opportunities to collaborate with other service providers or to advocate on behalf of particular clients.

Yeah, like I found when I first started, I was doing everything. Like that eager social worker – going to the school meetings, calling Schools Plus people, like really rallying for each individual client. But what I started to notice is, hmm, I'm months behind in paperwork. I'm getting nothing done. So now...my practice has a lot of limits and boundaries in it. I'm extremely stringent with people. I don't go to school meetings. I don't reach out to the school anymore. Is that good? No. – Rural Focus Group 1, R4

Lack of Clarity of the CAPA service delivery model

I was told a couple of months ago that I couldn't refer myself anymore. Like it used to be that you could just call and self-refer and that kind of has been, over the last several years, like that goes back and forth. Like sometimes you can refer yourself and other times you can't refer yourself, so this time I was told I couldn't refer myself that I would have to have my family doctor refer me. – Lori, service user

I do think that definitely having more clarity for people coming in in terms of the process of how care within that space actually works. Because I think that there's a lot of questions that go unanswered and also because of the lack of health professionals in Nova Scotia there's such large gaps in between when you're seeing like your next person, so I think that it makes it really challenging for people who are like, I'm very fortunate to not be engaging in drug use right now or I'm also I guess very fortunate to have a job and a job that's understanding of when I'm kind of a little bit in and out and I have an apartment and my family is here. – Kit, service user

Nova Scotia Context

While some critique the CAPA service delivery model as being developed in the UK and thus not fitting in Nova Scotia, this is a limited view. One might ask: does it fit anywhere? It is the neoliberal managerial ideology that is of concern. The emphasis is on efficiency, management and reducing costs, not clients well-being from a holistic perspective. Social workers in Britain are raising the same concerns as those in Canada and elsewhere in the world for the tendency to adopt these kinds of service delivery models.

I have a little bit of doubt about that because I have a feeling, like a lot of things, when you talk about the environment, I'd say the environment that the CAPA model was designed in is very different than ours. It was out of the UK. As part of the CAPA model, the idea is that there are...you're not the only resource. You're not the only place to go get help. So I think clients there would have a lot more options that would be appropriate. That doesn't exist here, right. – Rural Focus Group 1, R4

Given the many restrictions and limitations of the CAPA service delivery model, particularly for accessibility, participants raised the failure to address diversity as a significant concern.

A concerning factor for me with sometimes models within organizations is where did these models come from? Like instead of having something that meets the context of the province we're in, of our Indigenous popu-

lations, African-Nova Scotians, Acadian population, immigrant population, LGBTQ+ population, like sort of looking at the 1 million people in this province and what's kind of needed or whatever, sometimes we're taking models from other countries or other provinces, if I can say that, that don't necessarily look at the person in the context of their environment, don't necessarily look at the population in the context of its province. So I'm very worried and concerned when we do that quickly and hastily... And I'm not saying that doesn't mean we don't sometimes adopt models from other provinces, and learn from them, and learn from other countries. We can learn a lot. Like what's going well and what do we keep doing? But it's not always going to fit with NS. So some of the concern I have is that these standardized models we are taking from other provinces or other countries without really an analysis or a critical reflection or discussions with our community members, our marginalized community members about is this going to fit, what do you think of this model, what does this kind of look like? So there's none of that. And then we're sometimes then standardizing based on a population in another country where there might be millions of people or have different resources and different services and different cultural context. And then we're saying, well, this is the one-size-fits-all for here. So that can be a little concerning sometimes.
– Annie, supervisor

Social workers struggle with how to address the social determinants of health that are influencing peoples' struggles. They are at a loss about how to approach these issues within managerialized and bureaucratized mental health services.

We know the issues around...the society we live in, what are those big factors in a person's life, the connection, the bonding, attachment in big and small ways, have somebody come in and say my problem is I'm experiencing racial prejudice... But that is that person's biggest problem probably and it is very real and something ought to be done with it. But because we can't, well I can tell you to do this and this and that will sort your racial prejudice problem, it's not going to work. Because oh my god I don't know how to deal with that you know, maybe a medication or something that you know we'll give you some Valium, or maybe you can see a psychiatrist. The kind of despair that there could be anything meaningful done and we do end up with all

those strategies, like you're depressed or you're dealing with social stigma, how can we give you some skills, evidence-based skills, to deal with it?
– Valley Focus Group 2, provider, R4

COPING WITH AND SUBVERTING SYSTEMIC BARRIERS

The following comment indicated the way in which some social workers resist the pathologizing construction of clients in the mental health system.

I always say to the people that I see, you don't need a diagnosis to see me, I don't work with diagnosis, I work with people. And you know, we work on what's important to you, and what your goals are....So kind of while being co-opted into that symptom-focused and that diagnostic-focused, trying to reframe some of that in a way that's a little bit less pathologizing and a little bit less stigmatizing. – Jess, provider

A social work provider expressed surprise when they were supported by management to be creative and support the emerging needs of the community.

So this summer I gave a group...You know, some of them came and said, "Can we do something with these kids this summer?" And I said, "Well, whatever. Just tell me what you think your budget will be and away we go." And we did what they call a behaviour activation group. Which I would have actually said it's more like a social interaction group for these young people. It was highly successful. And so one of my social workers said, "Can I write for a grant from this local group that gives money for things like this?" And I said yes, because I think it's a great idea. And she was actually stunned. She didn't leave my office, she said, "Are you kidding me?" "Pardon?" Because I thought she had left. She said, "Nobody has ever allowed us to write for a grant or do anything like this." And I said, "But this is what they need, right. They don't need to have therapy with you guys. They need to go on walks, and they need to go to the gym, and they need...Like this is the stuff they need." And so she was saying, "Well, this doesn't fit with the hierarchy." And I said, "Well, they're not going to fire me. So if I get in trouble, I get in trouble."
– Elaine, supervisor

One social work provider raised an ethical concern about whether they should continue to work within a system that does not appear to be meeting the mental health and addiction needs in the community.

And it's just our capacity and demand is just not equalling. And then when you bring forward these concerns, you could end up with a situation where you ethically have to decide can I continue to work here? And I think this is where social workers end up deciding on leaving. And then the hard part around that is we know that advocating from the outside isn't as effective. And so, you know, it's that like do I stay and advocate and try to shake things up or do what I can, or do I abandon ship and stay true to just my personal path? So it puts people in a pretty hard spot that care about the community and the kind of service that they're receiving. – Rural Focus Group 1, R3

THE COMPLEXITY OF MENTAL DISTRESS: CO-EXISTING MENTAL HEALTH AND ADDICTION

Many participants identified a connection between mental health and addiction.

And sometimes we're just focused on treating the symptoms, that we're not seeing the whole picture. So in some ways I wouldn't say it's well integrated because we're missing those life experiences, those of health pieces, and we're sometimes missing the addiction pieces or the substance use pieces, and how this is all inter-related. – Annie, supervisor

I mean we know that if the guy is both an alcoholic and using violence, if you just try and stop his violence without attending to the alcohol, we know that's not going to be that helpful. Or if he's got a serious anxiety disorder, which is very common, for those guys who are like wired and on edge 9 out of 10, walking around the planet, they're volatile. They need help. So those pieces are important – both the addictions counselling and having access to psychiatry. – Barker, supervisor

Karo, a service user, identifies an interconnectedness between mental health and addiction.

And I also need somebody to talk to and friends, family, it's pretty loud, I mean it's too heavy for them to you know, everybody's got problems. I would not want to you know have my friend as confidante, I have my friend you know use...Yah because sometimes I don't know if it's because of my lifestyle or because my mental health bring me to that lifestyle but you know I can go really, really well for like half of a year and then everything goes down and I don't really know where that comes from and I don't see it coming, so somebody suggest to me that probably I have developed kind of two problems connected, like two mental problems that they are connected. Or it's just because of the, because my addiction is alcohol so or it's just because of alcohol so it's really important for me to quit drinking after we know better.
– **Karo, Service User**

Many service providers commented on the relationship between mental health and addictions. Some service providers are strong supporters of a harm reduction approach.

I guess I'm just very comfortable with the harm reduction approach, and just realizing that, you know, the ultimate goal is to keep people safe. And that keeping people safe covers a wide spectrum of issues. Not just in terms of the actual maybe consumption of substances or addictive behaviours but what are the other kind of determinants of health and what do we have to do in terms of reducing harms across the spectrum. So I guess I kind of use a wide angle lens when I approach addiction treatment. – **Jane, provider**

So or working with people who have been on methadone programs or you know any kind of harm reduction but and treating that concurrently is not something that I believe an individual practitioner should do in a private practice. I think that's a team approach and that's when I think things work best for individuals who are concurrent disordered. – **Harriet, provider**

Service providers express various levels of comfort working with substance use issues.

I do feel equipped to do deal with substance use issues in the mild to moderate range along with mental health but not so in the more moderate to severe range. This often requires a team approach and in private practice

I am the only provider. I would refer these situations to someone with more training. – Opinio

Barker seems to express some reservation about being able to offer counselling in this situation.

I mean we know that, you know, of course, if the guy is both an alcoholic and using violence, if you just try and stop his violence without attending to the alcohol, we know that's not going to be that helpful. Or if he's got a serious anxiety disorder, which is very common, for those guys who are like wired and on edge 9 out of 10, walking around the planet, they're volatile. They need help. So those pieces are important – both the addictions counselling and having access to psychiatry. – Barker, supervisor

Heidi, a service provider, adopts an abstinence approach here. Whereas, a harm reduction approaches can be used to help people and to address mental health struggles.

Often our clients are concurrent disorder. So they're dealing with addictions and mental health at the same time. And that's a big challenge because we know that you can't treat mental illness if people are using. And they're often using to cope with mental illness. So it's quite a circle, right. – Heidi, provider

Like Heidi, Sara, another service provider, identifies the use of substances as a way to cope with mental health struggles.

Anxiety, depression. Trauma would definitely be one. Living in Cape Breton, the majority of people have a low socioeconomic status. Which brings along with it a lot of other concerns. Of physical health concerns. There's not a big emphasis in this community on physical health. So when your physical health is deteriorating, your mental health...It's difficult to have good mental health when you have poor physical health...So the patterns we see are those patterns that are entrenched of poor coping, drinking as coping skills. Smoking and doing drugs is a coping skill. Being socially isolated. And then the trauma histories and low socioeconomic status, and poor-quality food. – Sara, provider

Specifically, anxiety, depression, and trauma are associated with substance use.

I'd say a lot of the young people I work with struggle with anxiety and mood. I find it's very rare that I have a young person I work with who is struggling with their mental health where there's not, there's also this family component where there's some dysfunction in the family or addiction issues or other things going on. So I would see like that to be a big theme, the family piece which we are sometimes not able to address very effectively depending on the willingness of the parent. I see kids who have a lot of anxiety about school and their future and that and like increasingly a lot of young people who are really frustrated with sort of the way things are and like the sort of the injustice in the world, which has been really cool to see.
– Leaf, provider

Anxiety, concurrent sometimes with alcohol use disorder. Depression. Post-traumatic stress. Adjustment stuff. Bereavement – which I just categorize under adjustment stuff because we're not supposed to see people just for bereavement. What else? Who else? Yeah, I mean that's the typical. There's other outliers that are different. But that's the "bread and butter" of the problems, I'd say. – Jill, provider

Kit, a service user, connects mood and use of substances.

Yah I think that I got sober and then started to experience mood changes more like intensely which is why I ended up seeking care. – Kit, Service User

One provider emphasizes the importance of establishing a relationship with the person struggling with these issues and not putting them in a box.

That the idea being that you see the person as a person, and you're essentially forming a relationship with them of sorts. Which I mean obviously again is fraught with difficulty when you use the term relationship because you can't be forming relationships with people in that capacity. But basically a relationship in the sense that... And then you get into all this stuff of transference, countertransference, blah, blah, blah. But essentially providing something – Well, I think you're a safe person to talk to.

And then from there, you might use different things...Or even keeps them sober, you know. So those are things...So trying to look at the biopsychosocial, which is one of the models that we were using in Addictions for a while, that I kind of fixated on because it was like everything. So it's basically the person you encountered, the person you tried to figure them out from there. And whatever...Rather than I'm going to put you in a box
– Doug, provider

Haze, a service user, supports Doug's view that the relationship is very important in the work.

I've seen people with PhDs in psych and I've seen social workers and it depends on the person have done their work. So if somebody has not, and that's something we discussed was if you take this Masters and you don't do your own work then you will not be the counsellor that you could be if you did for anybody. And I think for me that's the key, it's like where, the first counsellor I had was in a third marriage, he was an alcoholic in recovery and she was amazing, and she was a social worker, she just yah she was amazing...like if somebody hasn't experienced trauma whether it's alcoholism or whatever or addiction in the family, it's hard to describe it, it's hard for somebody to connect because if they don't, like I don't know what it's like to be an alcoholic cause I'm not but I know what it's like to live around addiction for sure.
– Haze, Service User

Stigmatizing attitudes toward substance use is reported to be an ongoing issue.

I think there's still some particular conditions that are highly, highly stigmatized though. Substance use is one of them. – Kelly, supervisor

A number of service providers reported that people who use substances within the mental health system receive poor treatment.

The biggest problem for me recently is how people with substance use problems are being treated...And I feel like they're being given inadequate services, and they're being not offered services because of that stigma. And saying, "Well, you have to quit this before we'll address your

anxiety.” But I don’t feel like the process of what needs to happen is being respected, right. And I don’t think that clinicians are actually aware.
– **Jill, provider**

And I think there’s nothing more insulting personally for me when you have mental health and addiction problems...when people talk to you like you are an ignorant. Like my actual case worker in income assistance, this is what she does with me. – **Karo, Service User**

In addition to stigma and judgement, a number of barriers are identified including wait times and specific services. It was reported that there are not enough specific services in community for people who use substances.

Well there are, there are but there’s not enough and there’s not enough mobile, there’s not enough mobile service. So there is, the people that we see, the majority of people we see are not, do not want to go to the hospital, don’t want to go to the police department, don’t want to go into some therapists office. If you happen to catch them walking down the street maybe.
– **Blanket, supervisor**

I am a Case Manager and I work with marginalized youth and their families every day. There simply are not enough services and supports for this population, particularly with regards for those youth who have concurrent disorders (mental health needs and substance use issues). An 8-week program at AIS doesn’t simply meet these youth’s needs and many are left in the system I work within with untreated mental health needs and substance use issues.
– **Opinio**

Well, that’s the thing. So you have a youth calling me Monday who is willing and ready to start addiction treatment and maybe even withdrawal. But they go through a Choice appointment that’s 2 months down the road.
– **Halifax Focus Group, R2**

One supervisor identifies the complexity and challenges of marginalization that can underly mental health and substance use issues.

*Sixty-eight percent of children in care in this country and in Nova Scotia experience homelessness after they finish up their time in the child welfare system and a lack of attachment and feelings of rejection that people have you know certainly exacerbates stress and anxiety... No, no I don't think it is. For the population that I've been working with all these years, I know there's a struggle for everybody to get physical and mental health services in this province, I know that, it's not just us, it's not just our clients. But I still think they are at the very bottom of the list. Like I would get service much more quickly than somebody who is in one of our shelters even though I might have to wait a whole long time, I'd get in faster than they would. – **Blanket, supervisor***

Mark, a service provider, also describes the complexity of mental health, addiction and marginalization.

*Yah well context is big right cause it's, it's one thing I struggle with actually with child welfare, in my position, is like they just see that, they're angry because they're addicts, they're coming off, they're coming clean. I'm like that's not really why, like they're more than that, don't paint everyone with a brush. Because maybe they have trauma in their childhood and that's why they're addicts. Maybe they just don't come because they were dating someone who was using. We don't know and we can't assume, cause both happen to be honest right. I mean you probably know yourself that trauma, addictions is often related to traumas in people's eyes but it can also be just something in general that happens to them right? There's no one, cookie cutter again right? There's no one conforming thing to it all. – **Mark, provider***

Leaf identifies family issues as common among youth who are dealing with mental health and substance use issues.

*And often I find that seems to come in the context of like issues with some family dynamic issues that are involved in that. I find it's very rare that I have a young person I work with who is struggling with their mental health where there's not, there's also this family component where there's some dysfunction in the family or addiction issues or other things going on. – **Leaf, provider***

INTEGRATING MENTAL HEALTH AND ADDICTION

The amalgamation of mental health and addiction services has been an objective of Nova Scotia Health Authority under the tiered framework. There seem to be multiple problems with the operationalization of this, to the degree that a full amalgamation has even occurred. However, social workers expressed concern about addiction services being absorbed by mental health. This absorption reflects the emphasis on efficiency and short-term work that does not address the social factors that influence substance use problems.

But basically to say when they're talking about mental health, does addictions just become another 2 or 3 pages of DSM? Because it's a different world than just everything else in mental health. It is a world onto itself. Because people have to realize there's a lot more social factors, there's a lot more things involved. – Doug, provider

In the neoliberal and managerial context in which these services exist, attention to social factors has been subsumed and reduced to symptom management. The loss of addiction specific services is described in the following comment.

But when I was with Addictions that was before it merged. So it was Addiction Services only, and Mental Health was separate...the fear was that it would be swallowed up by Mental Health – which is what happened...Detox centres have been closed. Beds have been cut. Twenty-one, 28 day programs are a memory. And those were things that worked for a lot of people. And they're inconvenient, they cost, they're very difficult to work in. But they made a big difference in a lot of people's lives. But if you have money, that's the type of therapy you get. Which is the funny part. The health authority, "No, no, no, that's not evidence-based." But if one of them gets sick, you know, they're going to Sea Ridge or they'll be going to...What's the big one? Donwood in Ontario. So I mean that's where the people that have money go. – Doug, provider

Supervisors reported that the amalgamation of addiction services into mental health services has been poorly done.

They were integrated at an administrative level so we were going to be one department and under one director. The services themselves at the frontline are not nearly as well integrated as they should be, as they could be I guess I would say. I think we've integrated probably more mental health into addictions because we see, but we haven't integrated the addictions harm-reduction model into mental health. And I think addictions is more comfortable, I know they say they're not because they would say they haven't sometimes had specific training but if you actually see them work they're more comfortable working with the individual who has, living with mental illness and substance use than mental health is with mental illness and substance use. I think we really need to move to a much more integrated harm-reduction model. – Tena, supervisor

They felt the transition was very poorly handled, and they felt that addiction services were viewed as the poor cousin to mental health services. They didn't feel that new people coming in were given adequate training around addictions.

Well I know from our clinic lately there's been some problems with that because we have a couple of people who specifically worked with people with addictions and they've been monopolized by mental health so they've had to become really, really creative to actually get the clients with addictions. So it's been pretty challenging to actually have somebody who actually knows what it is to work in addictions, who has the skills for that. So it's been a challenge. – Gladue, supervisor

Many participants stated that in Nova Scotia when the delivery of addictions services were absorbed by mental health services, something important was lost.

When Addictions was Addictions and not subsumed under Mental Health, Addictions did work with a larger social framework and understanding. And in the last number of years, the medical model, using the DSM-V, has gained even more ground in the system, given that mental health and addictions will be seeing only people who fit a certain tier three criteria for moderate to severe mental disorders. So what happens to the people who are grieving or depressed who are ineligible according to that criteria? – Karen, provider

Karen also raises the contribution feminism has made to connecting trauma and substance use.

There's a whole rich literature on feminist analysis of addictions and substance use. And then you add in the whole trauma piece, the understanding of violence and trauma and how that is a strong factor in women's substance use, you know, to calm the body, to "forget" about the pain, to block things out, not remember, shut down the feelings. So you add that piece in in terms of a feminist approach to working with violence and trauma in terms of understanding why women turn to substances or to gambling. – Karen, provider

I don't think they're mutually exclusive – addictions and mental health. People numb out because they're anxious or, you know, they were sexually abused as a child. They're using addictions to numb out. So I mean often we tend to treat the addictions first and try to get into the mental health issues secondary to that. But often it's interspersed, the modalities. – Al, provider

According to one focus group member, all clinicians are doing addictions work. It is not clear whether these clinicians receive any specific substance use training.

So as of April 1, every clinician that works in mental health with our system will do addictions work. Not just the 3 people that are there now. And so for us... For me, when a family is to call or a youth is to call, I need to know certain things to know that I need to send them... So I like to know like are they on medication, are they using? If so, what, how often are they using? Because just to get the drugs they're using is huge, right. To know that they're on that plus mental health meds. – Halifax Focus Group, R2

Many providers reported a loss of addiction-specific services.

And the fear was that it would be swallowed up by Mental Health – which is what happened. – Doug, provider

I know that there has been some of the limitations that I've heard from people are things like wanting to access something like withdrawal management services but there being like a two-week wait list or someone being told you're

actually not a priority right now because you're detoxing off of I don't know, like an opioid rather than alcohol and that, or it's been two or three days since you've taken the substance so maybe right now we have to prioritize someone else. I also know that transportation has been a bit of a limitation for some individuals so I do work with folks that are kind of like in a more rural/sub-rural community so there's little to no public transit so that becomes a large barrier as maybe like o.k. if a bed does become available or if a clinical becomes available or if an appointment comes up, how are you going to access that appointment. – John, provider

I don't know what's happening at the moment. I heard stories too about the services being absorbed by mental health in a sense and you can see in kind of the overall organization being mental health. I had this interesting role as a problem gambling specialist which was designed to be 40% clinical and 60% sort of community development of trying to look at health promotion and the community that was supporting the symptoms that we were seeing inside the agency. That was an interesting role and I've been wondering myself what the heck happened to those positions across the province, do they still exist and what are they doing now? – Rural Focus Group 2, P3

In the past, there were specific women's services in NSHA. This included a women's services co-ordinator role which was designed with 40% clinical and 60% community development and health promotion. The design of these and other similar positions were innovative because they permitted a wider scope of social work practice that could facilitate the design of innovative programs that included not only harm reduction approaches but also community interventions and public health initiatives. These positions have been eliminated within Mental Health and Addiction settings across the province.

The need for further education related to harm reduction approaches is discussed below.

...That's what really made it very difficult for at least one person to be comfortable with substance use clients, cause they're really concerned if someone is cutting down, what if I advocate that they cut down too much and then that harms them or I don't advocate they cut down enough and that harms

them. You know it's, the question didn't make much sense to the substance use people in the room but there were very real concerns for that person. Yah so just bouncing back to [name]'s point there, really there's a big thing in how do we look at it in terms of how can I help someone rather than how can I provide a whole solution. Anyway that's, I'm not sure if that really twins with that or not. – Rural Focus Group 2, P4

The person below suggests that the amalgamation of addiction services within mental health services and the subsequent reliance on the CAPA model has resulted in a massive loss of services to people seeking specific addiction services, in part because of the intake process and wait list pushes them beyond their endurance.

...we have found that getting the figures from our district at least and finding the number of people that get through an intake to a first go around or choice appointment as they call it or a regular first, in substance use has massively dropped off like massively, it's like the codfish before the moratorium you know but it just suddenly it was gone, you know you get almost none, it's empty. So why is that? There's people still there. And I have had one or two people coming in who have tried to come in in one way and for one reason or another they've gone in to me through another route or some other, or second go around, something has happened. And we can say well there's no way that I would go through the intake process and wait the way that it was asked for, or the way that it was left with. And something that has changed and the one thing that did change, was an intake process and really tried to do something, a very long drawn out effort to try to improve intake. It may have improved it in some ways but as far as substance use it completely took it out because it became something that people would not endure and more so than some of the other things that people with substance issues seem to be more willing to say no this is just not worth waiting for. – Rural Focus Group 2, P4

The following comment also indicates a sense that addictions services have been subsumed into general mental health services.

I don't know what's happening at the moment I heard stories too about the services being absorbed by mental health in a sense and you can see in kind

of the overall organization being mental health. When I first started working for Addictions Services it was a standalone commission, I think that's what it was called I can't remember. But it later became attached to mental health.
– Rural Focus Group 2, P3

The perception that addiction services being provided through the umbrella of the CAPA service delivery model was failing to meet the needs of teens was made in the following comment. For teens struggling with substance misuse a sense of urgency and need to be seen immediately is pronounced.

Like for teens, there's not a lot of them right now. And then when we do have clients who need addictions care with like the ORP clinic – opioid recovery program – those ones are pretty straightforward....I didn't really get to do the addictions role of how it was intended. And so how I believe it was supposed to be is that you have half your caseload, 50% addictions, open for addictions. And that would mean that you would see teens almost immediately who are struggling with addictions to do that assessment, get them connected to services, have them working towards a plan to address their addiction recovery. However, now because of this influx of clients and a decrease of staff, if I want to see an addictions client, I put them in during a random time that I have to fit them in between sessions or something like that in order to actually see them in an appropriate amount of time. Otherwise my next addictions Partnership is in the middle of February. So the kid will call today, so if they need a Choice, they actually probably wouldn't get a Choice until November or whenever they're booking. And then when they see me, they wouldn't get put into my Partnerships until the next Partnership, which would maybe be...So at this point, that's like 4 weeks away. So they've completely gotten rid of I guess privileged space for teens dealing with addictions.
– Rural Focus Group 1, R1

As this focus group was conducted in January the participant is noting a teen would need to wait close to eleven months for a choice appointment.

The following comment illustrates the complexity of addiction work which often must address an intergenerational component that is trauma responsive to both a history of childhood adversity and domestic violence while acknowledging the cumulative oppressive impacts of poverty.

History of...Well, here, because our clients are the children, but often the parents have a trauma background in terms of maybe being, you know, domestic violence. That's very high. Compounded with, in the old days would be mostly alcoholism. So that would compound. And then poverty. So that kind of mixture. – Rural Focus Group 1, R5

The Health Authority justifies these changes to addiction work as “evidence-based,” yet they are not adequately based on the research literature that clearly shows a strong relationship between mental health, substance use and trauma. Moreover, there is a need to train service providers to deal with the concurrence of these struggles rather than simply amalgamate everything and subordinate them to mental health.

Given the growing invisibility of addiction services due to amalgamation, there has been a corresponding growth of private treatment programs in the province. This development suggests the growth of a two-tiered system where the wealthy can afford access to private treatment programs and the majority of Nova Scotians have limited options.

The Privatization of Addiction Services

Our consultation suggests the amalgamation of Addictions Services with Mental Health Services had been to the detriment of Addiction Services. This was echoed in the reports of multiple providers.

And now they've been amalgamated since the amalgamation of the NSHA. And Addictions has just become subsumed under Mental Health. So you hardly ever hear anybody speak of Addictions anymore. – Karen, provider

For people that do call us with addictions, and we end up having to refer them to the addiction services intake. And they know that it's going to take a while, especially for withdrawal management, like the detox programs. People will call themselves or they'll call about someone who is using and wants help now. And then they're told they have to wait. And that just doesn't work for them. They just can't wait. So yeah, money is a huge barrier. – Samantha, provider

When you look at what's happened with the system and the services in addiction for people that are addicted, per se, whatever their underlying thing

is, they've crashed in many areas of the province. Detox centres have been closed. Beds have been cut. Twenty-one, 28 day programs are a memory. And those were things that worked for a lot of people. And they're inconvenient, they cost, they're very difficult to work in. But they made a big difference in a lot of people's lives. But if you have money, that's the type of therapy you get....If you're the run of the mill person, you don't get in there. It's \$400 a day." – Doug, provider

A CBC news story confirmed Doug's perception that addiction treatment is becoming increasingly privatized during an interview with Barry McNeil, program manager of the New Horizon Addiction Rehabilitation Centers in Sydney, NS. During this interview McNeil noted that in his previous role in Addiction Services for the Cape Breton Health Authority, detox residential services were reduced despite the demand (Martin, 2018). The New Horizon program costs more than \$20,000 for 45-day programs. There are other private addiction treatment facilities opening in several areas of the province in what Terradyne Wellness, Drug and Alcohol Rehab Center program director Laurie Burns refers to as the "addictions industry" (Terradynewellness.ca, 2020). The price for their 21-Day Comprehensive Package is \$13,400, all-inclusive. Similarly, the Ledgehill Treatment and Recovery Centre offers a 42-day program that costs \$28,350 (Ledgehill Treatment and Recovery Centre, 2020). Crosbie House, another private treatment facility located in New Minas, offers an all-inclusive 28 day program and two years of after-care for \$9800 (Crosbie House Society.com, 2020). This sampling of the private options available for detoxification and treatment of addictions in the province points to the need for further research to determine if those who cannot afford these programs have their needs met in our healthcare system.

SOCIAL WORKER PROFESSIONAL SATISFACTION

On the Job Training and Professional Development Opportunities

Social work service providers identified a paucity of training opportunities in their workplaces. It was noted that employers didn't support expansion of knowledge and professional growth and development.

We received a memo at the health authority that there would be no support for attendance at workshops or conferences. It wasn't in the budget. And that the focus would be on cognitive behavioural therapy. And at certain times, a small number of staff would be supported to attend workshops. Which was kind of code for we'll pick the people who can go. And so it became very clear that if I wanted to up my clinical game, that I would have to pursue that on my own. – Jane, provider

Many participants believe the NSHA advocates a Cognitive Behavioural Therapy (CBT) as an approach and supports training in this model but if social workers wanted to expand their skill set beyond that intervention they had to pay themselves. Social work provider reported a greater access to training opportunities, but also echoed the favouring of “evidence-based” approaches such as CBT and DBT and solution focused strategies.

More and more we're trying to look at you know what gets called evidence-based but so evidence-based for a major depressive disorder, research shows CBT to be effective right. And so they are trying to standardize that as first approach we try so then it might be CBT with if there might be some DBT with that, or just CBT you know something added on. So there are two or three main therapies, CBT, solution-focused, dialectical behaviour are the biggest models I guess. And there is the expectation for new clinicians that you learn CBT that seems to be a bit of the focus now. – Tena, provider

However, a service provider noted that while there was often lip service paid to the provision of training, it was slow in materialising.

So we've advocated a lot for trauma training. There's a lot of trauma in our area. And even before I started... So I've only been here 2 years and a couple of months. And so even before I started, they'd been saying trauma training is coming. So... But there's nothing that's happened. And so we're kind of stagnant in our educational opportunities unless we want to finance ourselves to get those. – Focus Group Rural 1, R1

It was observed that the CAPA service delivery model actually flattens professional differences and claims to honour skill development which is supported by specific

training opportunities. However, these are regulated so that social workers with expertise in therapeutic responses such as narrative therapy are silenced. A service provider sums this up succinctly.

So we had some difficulty with that over the years. CAPA came in. And that became a big equalizer amongst the staff because it was no longer about what your profession was but what your training was. So if we were feeling that we were trained and competent, and that's seen by ourselves, you know, and our association supports that, if we felt we had the training and we did get...We all got the training in CBT and other types of...EMDR, DBT. All of us were provided with training, it didn't matter what our profession was. And then some of us were involved in helping train others. So I actually had a chance to work with the head of psychiatry and helped train others, all the staff. And found that interesting. I felt like in some ways on the one hand it was very helpful to learn best practice approaches. But on the other hand, there were some trainings that were missing. And I was wondering about, well, what happens to all these trainings that we had learned all these years ago – narrative trainings and all the different things that I loved. I said what happens to that? – Halifax Focus group, R3

Supervision

Social work supervisors described their style of supervision as flexible and relational. In one instance, Elaine described her style varying between persons she supervised as in some cases she was more relaxed and informal but in other cases she would exert her authority.

Well, so my supervisory style I would say is largely...I want to say it's non-hierarchical but that's not in fact really true. It would depend on the person. So I think my supervisory style is a combination of that – social construct, social theory – but also are you working with the client on a common goal and do you have the skills to get them there? Which might include training in cognitive behavioural therapy or dialectical behaviour therapies or whatever seems to suit the situation. – Elaine, supervisor

One supervisor, Daisy, described providing individual supervision and monthly group supervision while another supervisor, Gladue, reported that she makes herself available as a sounding board and provides social workers with the space to “talk it out” and “come up with a solution themselves.” There was some discussion of the organisational setting and how that produced tensions between organizational agendas and community agendas. Annie, a social work supervisor, said she approached such tension by guiding social workers to be creative and to come up with other ways of addressing issues.

It was widely agreed that supervision is important but many of the service providers indicated that they got very little, if any supervision. James, a service provider described receiving supervision from a psychologist but finding that this did not meet his needs as the guiding values and theoretical perspectives between social work and psychology are very different. He requested social work involvement and now the head social worker comes for an hour a month but he commented that:

She’s really there more to help troubleshoot some of that, and I mean bring in some of the discussion on sort of social work ethics and how we do it but it’s not enough. It’s not nearly enough for what we need. – James, provider

Another issue which arose was being supervised by another profession. Many mental health social workers are part of an interprofessional collaborative care team so they turn to non-social work peers for feedback and advice. As Tena, a supervisor, observed:

What’s the scope of practice for an MSW, what’s the scope of practice for a BSW, what’s the kind of care that only a social worker can offer in acute, or in whatever they’re working? And that I believe is watered down, I think the value of an interprofessional collaborative care team is critical but you don’t get the specific to your discipline, that gets missed. – Tena, supervisor

A number of service providers spoke about having a supervisor from another discipline, sometimes quite removed from social work, such as a business manager or an engineer.

Like I have a boss who’s not a social worker. And they would...There were periods of time where they would question not my systems work or not... but the clinical work. And I mean I ended up having to have the conversation with them that you aren’t qualified to question my clinical work. You are qualified to question my assumptions, my other work, my other stuff.

You know, the supervisory aspects. Like all but the clinical work, you are absolutely qualified and should be questioning. But you aren't qualified to question my clinical judgement. You just aren't. – Barker, provider

Some service providers described developing their own system of peer supervision to fill in the void created through a lack of supervision.

So like if I need to debrief with someone then I do it with my coworkers... He's very understanding. He was in the same role that we're in now. I think the only tension that might come up is like he's more concerned about liability. So he would be more likely to recommend we bring someone in involuntarily even if there's just a little bit of risk because he's now more concerned about if someone was to go wrong, it falling on the team. Yeah, I think that's the only issue. – Samantha, service provider

Harriet, a very experienced service provider, described setting up her own clinical supervision group which she has worked with for over 20 years.

My supervisor could be a nurse or an occupational therapist and that person may not be well versed in social work practice. And the skill sets that social work brings into the field. So because I saw the deficit within my paid employment when I was oh my god 32 years old, and I'm now 50 yah for the last 20 years I've been working with this clinical supervision group and we have leveraged our own clinical skills and reflective teams to be able to support each other both in a race/gender/LGBTQ population lens. – Harriet, provider

Supervision, Management and Administrative Responsibilities

Supervisors expressed some frustration at the limits to what they can do. They are situated between frontline social workers and the hiring organization and must navigate between the two. Blanket, a supervisor, said that she tries to use an anti-oppressive style of leadership where she provides space for employees to be empowered and she expressed satisfaction with a peer group of her own with other executive directors. Gladue, another supervisor, identified the organizational

limits to her authority or power, and alluded to the large numbers she is expected to supervise which necessitates brief or infrequent contact. Annie, another supervisor, expressed feeling isolated as she feels she is always questioning the system and being disruptive.

So what's also very difficult is because you don't have people sharing the same set of values or world view, a lot of those projects get terminated even though they have high value or in your opinion or social work's opinion, they may have a high society value. So a lot of those projects either because they're too big, it's too scary for people, people don't want to address those social determinants of health pieces. So that's hard to witness repeatedly within a system when you're witnessing things being shut down that should never be shut down. As a matter of fact, should be amplified and highlighted.... So in some ways that creates a lot of kind of value dissonance, I guess, is what I would say. So your own values aren't matching up with your practice sometimes and the work you want to be doing. – Annie, supervisor

Annie also identified the neoliberal mandate for unlimited productivity and responsabilization as unrealistically heavy workloads are given to supervisors, and even after extended service there is little sympathy for needing a break or some time out. The fear of being replaceable is always hovering in the background and there is little sense of appreciation or humanity.

So it's kind of like a robotic assembly line. "Oh, we like you but if you have to go that's okay, we'll just get the next person kind of come in to kind of fill in for you." So there's this mentality... And I think that that does trickle down to the social work level as well that you're replaceable. And so you may have individuals that value you but the system itself doesn't value people. It values that productivity, I guess. So sometimes that hasn't felt very supportive. – Annie, supervisor

Work Satisfaction

Service providers expressed a range of aspects of their jobs that they found satisfying. For some, it was a sense of autonomy and professional independence and for others

it was hearing people's stories and a sense of making a difference. Service providers in private practice reported a different experience from those in institutional or organizational positions.

I like the flexibility. You know, I've worked in different organizations over my career where there wasn't a lot of flexibility. Where, you know, there was a lot of bureaucracy and stuff to what I did. So I do like the freedom to be able to choose the clients I wish to work with.... Like there's other private practitioners at the organization. So we do have meetings together. Once a month we have supervision meetings. We still debrief with each other, talk to each other when we need to collaborate. I think it would be difficult just completely on my own. – Grace, provider

A supervisor reported that she found mentoring younger social workers very satisfying.

The part I actually like best is clinical supervision and mentoring younger social workers....I've taken over a clinic in which morale was quite low. And so I think what I'm most proud of at this point is that people are engaging more. I'm getting a lot more people volunteering. So I've spent time talking to people about what it means to work in a large bureaucracy, and what they can engage in and what they can't. So I feel most proud about that. – Gladue, supervisor

For others, it was the interdisciplinary teams that they felt a valued member of.

What I like best is my interaction with all the people I get to work with. So I get to work across a lot of different disciplines. Mostly social work, psychology, psychiatry, nursing, youth care work. So it's a very dynamic role in terms of getting out there and seeing different...not just in urban settings but also rural settings. – Annie, supervisor

A number of service providers identified collegiality as a significant source of job satisfaction and also of support. Harriet, a Black social worker, identified collegiality and team support in a difficult job as the source of her greatest satisfaction, and described how she derives great sustenance from her Black co-workers.

So I depend on my colleagues who have, some are more seasoned than me, some are younger than me but my interdisciplinary colleague base that is outside the formal system to help influence and give me critical feedback on my practice...I think what I've done is mitigate those struggles. So as a Black person who works in mental health to mitigate the micro-racial aggressions from patients and from colleagues, I again have been able to, I depend on my clinical supervision team. – Harriet, provider

In contrast to this some social service providers reported exclusionary and unsupportive colleagues and a toxic working culture.

I had a situation where a colleague who also was the one who made a comment, went oh my god are you actually gay, you have kids. I'm like oh my god. – Mark, provider

In one instance, a service provider reported that he was leaving as he found the toxic work culture intolerable.

I've made acquaintance with a couple of clinicians. It's been very difficult to be part of the team, feel like a team. Management not being supportive, nobody accountable. Everybody's looking out for their own safety....Enough so that yeah...I mean I changed my life to come here. And I'm leaving now. I mean I don't want to leave. Like it's been 6 months. My whole life is transferred here, trying to make a new life. And the job is bad enough, the climate is bad enough so that even if I have dear friends around, that I just don't want to do this job anymore. I'm going to go crazy working in mental health. And I'm worried about mine. – Rural Focus Group 1, R6

In a similar vein a number of service workers discussed burnout which was often connected with the tension between the organizational agenda and their social work values.

So the moral distress is unreal. People seeing families and knowing they can't support them as they should be doing, you know, that's very hard. The other part of it is they don't want to acknowledge it -- People are leaving, really good people who are committed are going out the door because they just can't

cope psychologically. They're saying too it's not safe. It's psychologically not a safe workplace. And it's unethical. – Bewildered, provider

A supervisor expressed the same frustration.

And the more crispy people get... It's not the clients that burn me out or make me crispy, it's the system. It's like, you know, I've been trying to transition a client for a year, and the system won't work for me. Those things are just like ahh! They're just annoying. And they're so big that it's like how long am I going to keep on chipping with this spoon before I say fuck it and go, you know, work in private practice with people with insurance who have a lot more resources. – Kelly, supervisor

Participant Recommendations

The participants in this study overwhelmingly suggested that the current provision of mental health services (including substance use) need to be changed. Overall, 98% of the participants, believe that there needs to be changes made to the current provision of mental health services. (Opinio, n=111/113). The participant recommendations fall into four broad categories:

1. the valuing and advocacy of the social work professions and its social justice lens,
2. institutional influence and regulation,
3. restructuring the choice and partnership approach (CAPA) structure of mental health service delivery to offer more accessible, flexible, diverse, and community based services which can more effectively provide services to concurrent issues such as mental health distress, substance use and trauma, and
4. the amalgamation of mental health and addiction health service structure needs to be further developed. Training is needed around addictions and on the co-occurrence of mental health and addiction, so that the relationship between mental health and addiction is effectively addressed and that addiction work is not simply subsumed under mental health.

Value Social Work Professionals

The vast majority, 82% of social workers (n=92/112), reported that their training and perspectives do not have enough recognition in the current service delivery system.

*Given social workers make up a large portion of the frontline therapists in Mental Health and Addictions it would be nice to have our opinions/theoretical approaches acknowledged as valuable and effective by the Health Authority and Department of Health and Wellness. More social workers in senior management might help with this. – **Opinio, provider***

*My job is worth doing every day because people are feeling it's a useful investment of their time, right. And so you would get job satisfaction and giving that control back. You know, you hear my voice, I can influence the system, I can develop programs, or I can throw an idea on the table and you might say, "Yeah, let's throw that up the line to Legal or wherever, upper management, and is that possible. And do you want to take that on?" Like people are master level professionals here. They can take on those practices and leadership roles. And then if people are happier, people might want to come here [to work]. – **Rural Focus Group 1, R2***

Overall, this consultation suggested that most participants believed there needed to be more flexibility in the scope of mental health services for social work practice.

*Well, a problem that bothers me...I feel like we should be able to do a broader continuum of work. On one end, I feel like we should be able to do some of the psychology that psychologists do. And on the other end, I feel like we should be able to do some of the advocacy, resource...helping people with resources. Leaving our office occasionally to help someone. Out of the box – that's what I call it. Yeah, just having a broader platform to work from. – **Jill, provider***

*I would like to have a bit more voice in the interaction and how, if we are able to spend that time once the client's stable, to deal with the systemic issues. How that would increase quality of life and prevent the back and forth, in and out of hospital. So it would be a much more financially prudent way to treat our citizens basically. If we can do all the work necessary and provide the supports necessary, it's going to prevent rehospitalization. – **Heidi, provider***

So from those practical ways, to just being able to consult with and include first voice in planning and organizing services and supports to meet the needs of communities. And to be honest, probably also being able to go out

into those communities and not being...just to decrease the barriers and the power imbalance of them having to come to you at your clinic. And all of that stuff, right. So just having a connection to the communities and the individuals that we serve, and including their voices and their expertise in the services that we offer. – Jess, provider

Social workers report the need for greater freedom and autonomy in their practice. When asked whether they were satisfied with the role of social work in the provision of mental health services only 35% indicated they were satisfied (n= 39/111).

I think social workers need to be able to do what they were trained to do and that really is working with whoever your client or your participant, whatever label you want to put, to find a solution or to kind of talk it through and think outside the box. And I'd like social workers to be in the field, I'd like people to be able to access people when they need them instead of having gobbling waitlists, it's not fair to the people in this province and it's not fair to the people who are trying to provide the service because they feel guilty and clients feel unvalued. – Rural Focus Group 2, P1

With this education and experience, the social workers and myself should be able to make decisions regarding services and case plans without recommendations from other service providers in the health system. – Opinio, supervisor

Promote and Strengthen Social Work Professional Identity and Collective Voice

There is a strong position among social workers that our professional identity needs to be strengthened. Part of this involves strengthening social work identity among ourselves, and another part of this is promoting the social work identity among other professionals and society in general. This requires educating others about what social work is and what it does.

Social workers in this study suggest there is a need to increase awareness about the social work profession.

So just to answer the question so I don't go on, you know, I do really feel like we're in the early stages of educating people about what is it that we do. And I don't know if we do it on our teams as much as well. Because it's hard to kind of grasp, I think, and share that. But if we could... I think we've doing a bit better. I think over the years there's been a bit more. You know, I've done some research and I can find things online to say what we do in mental health services. It will lay it out in terms of all the different roles that we can have, and that we can do therapy, we can do advocacy, we can do... It lays it out. And it's nice because then you have something right there.
– *Halifax Focus Group, R3*

There is a need to strengthen social work's professional identity.

The other thing that I think with the change is what I miss in a way is having a stronger sense of who we are, what underlies who we are. But the piece that we can easily miss is like every other group we tend to say this is our service, this is what we can do for society. We don't ask so much the more humble-making question of where do we fit in society, and what little piece could we maybe add. We tend, like everyone I think, to say well what can we do to fix it rather than what's our contribution, which part of the stone soup can we bring? – *Rural Focus Group 2, P4*

If I was able to be more political in my role, that would be amazing. And if there were clear mechanisms for getting organizational support for pushing those sorts of things forward in a consistent and coherent kind of way, that would be lovely. And of course if we're talking policy big picture, like legislatively, there'd be like a million policies that I would change
– *Miller, provider*

Address Institutional Influences on Social Work Practice

The Dalhousie School of Social Work, the Nova Scotia Health Authority, the Nova Scotia College of Social Workers, and the Canadian Association of Social Work Educators all have influence over the practice of social work. The participants in this consultation shared their perspectives on these influences.

Dalhousie School of Social Work

As was noted earlier in this report, participants frequently state the Dalhousie School of Social Work offers a strong critical anti-oppressive and social justice theoretical approach, but historically it has not been linked sufficiently to direct clinical practice. Some providers note they received direct practice skills in their practicums, and learned on the job. At the same time, there is pride and commitment to a social justice approach that social workers are not prepared to abandon. However, this has left providers lacking confidence in their ability to respond directly to the clients they meet in their practice; as they feel ill prepared to respond to the mental distress they are confronted with, they are more prone to co-optation away from this theoretical social justice approach to simply following the dominant bio-medical framework which characterizes mental health and addiction services.

Nova Scotia Health Authority

Better communication is needed between Nova Scotia Health Authority leadership and frontline staff that allows for greater professional autonomy and consultation in policy process and decision making.

I feel like the biggest thing that is needed is for senior management to actually talk to frontline staff and listen and use that to inform their decisions. I feel like that, cause I'm trying to think supports that are needed, like yah we get into meetings where we vent about this shit but we do already and that stuff doesn't really help. – Leaf, provider

The first thing I would say is include staff in your policy-making, and include the community in your policy-making. So the first thing would be to be I guess more inclusive of who's enacting these policies. ... So the one thing I would change is how do we start having better conversations with our staff and with the community members about who are impacted by these kind of policies. – Annie, supervisor

The Nova Scotia Health Authority needs more public transparency.

I mean the only other thing that I'd like to add because I'd like to see it in the paper, is that it would be nice if there would be more transparency with the health authority and the public so that they could see what's happening. Like there are so many secrets and there are so many pretend ideas. Like this big advertising that like our wait to intake is shorter, people have no idea that means that they're wait to first appointment with a physical person is longer. Because intake's just on the phone. – Sara, provider

PROFESSIONAL ASSOCIATIONS

Nova Scotia College of Social Workers (NSCSW)

Increase Focus on Social Work's Participation in Mental Health Services

There were suggestions that the College should adopt an advocacy role supporting the value and efficacy and unique contribution of social work approaches to mental distress. This would mean articulating what it is that the social work profession can offer and how this is different from bio-medical model services and responses.

Nova Scotia College of Social Workers helping social work to have a stronger voice, because as well-meaning as the college may be, when I think of my interactions with the NSCSW, there has not necessarily been a lot of focus on sort of mental health and the needs... we just need like a stronger identity and a stronger voice and we just need to be able to do that. I think that my gosh we're so great at advocating and doing these things for others, why can't we apply that to ourselves? Why can't we do that as a group right and really make the changes that need to happen. – James, provider

Increase Advocacy for Social Work Profession

There were numerous allusions to the lack of public knowledge and understanding of not only what it is that the profession has to offer but the unique and valuable

contribution to mental distress social work expertise and knowledge bring to the table. This gap in understanding extends into other health professions that are centrally positioned in the delivery of mental health services and follow the bio-medical model which is entrenched in an individual deficit approach. There was a belief that the college could promote public and professional knowledge in this sphere.

Like I've always wondered as an association of social workers, if we start having...We talk about having a voice but, you know, do we really advocate loudly when this is something that we are also passionate about? – Grace, provider

It's really about so what is social work, what is our skill sets and how are we put in those damn jobs right now that maybe halfway fill our skill set. I feel that the mental health field would immensely benefit from social workers being put in positions where they have the full leeway to provide everything they can within their scope, their skill set and I think that this is minimized and as social workers we're now pushed to do not only unethical work but work that we could do so much more for the system yet we're seen through a medical model lens and our productivity or our contribution to the system is seen through that lens which to me has no sense. So what the social work profession should advocate for right now is that or have that lining up for what we're trained for. – Stephane, provider

The colleges need to have the right way to say things because governments are just going to turn to those agencies that are training skilled technical social workers and they're going to take these people that fit into their plan of mental health, their vision of mental health. The colleges need to try to have influence at that level. Where those decisions are being made to what is mental health looking like and what should it look like, and to go with solid evidence of no, this is what a good response to mental health and a good community response to mental health should look like, and this is why you need social workers. – Rural Focus Group 1, R6

Province Needs a Child and Youth Advocate Office

Social work service providers identified the need for Nova Scotia to have a child and youth advocate to specifically advocate for the needs of children in the province.

The advocacy...We don't have a child advocate in the province. Did any of you attend that meeting? The president of the NSCSW was there. I'm trying to think of the correct term. It's a position...I think there's a general advocate right now. But people are lobbying for somebody specifically for children. And that person would be a good voice too if that ever comes to be. The association wants to see that happen. Because it's more along what most provinces do. And for some reason we don't have that position. – Rural Focus Group 1, R5

Canadian Association of Social Worker Educators

It was noted that the social work profession is often aligned with child welfare services and disparaged as the people who take children away. This builds on the previous idea that there needs to be some kind of public education campaign whereby the breadth and expertise of the profession is showcased. Some responders expressed that the provincial and national colleges could assume this role and others suggested that schools of social work could address this.

I'm on the board for the Canadian Association of Social Workers and one of their goals is to promote the profession of social workers on a national level and talk about the things that social workers do rather than you know other than just child protection because everybody kind of gets painted with that brush right, you're a social worker you're going to take my kids, oh stop it. – Rural Focus Group 2, R1

We do have a national body and we do have provincial bodies in most provinces and I think, I don't know how many schools of social work, but I think that's a really good idea if we could all kind of get on the same train and start promoting that in a different way. – Rural Focus Group 2, R1

Nova Scotia Social Work Union

While social workers frequently felt devalued, with other professionals ignorant of the professions expertise and specialized knowledges, they also experi-

enced little professional autonomy and sometimes feared being replaced by other professions. Despite these concerns being, thematic unionization was seldom raised as an issue. However, several social workers in this consultation did report on their observations, particularly about nurses who they believe are often better situated in the mental health hierarchy than they are. It is noted that nurses have a very strong union that protects their interest. A specific Nova Scotia social work union would advocate for issues that have been addressed in this consultation such as the need for professional work autonomy, respect for social work practice, clear role definition and social work practices consistent with training, and consistent collective voice and identity of social work.

One of my fears and maybe one of the trends that I see is slowly social work positions being replaced. So they're either cut or they're going to nursing. Nursing is...they've got a lot of power. And they've got a lot of power because they've got one union...Like my union's great. But because social workers are spread across, that one united voice is lost...In rural NS, there's a heck of a lot of MEDs coming in. So if we want to continue to hold these positions, which they come with power, right, so the social work voice is on these teams, what are we doing as a field to say we need to stand our ground, we deserve to be here, our clients need us?
– Kelly supervisor

RESTRUCTURE MODEL OF CARE: REIMAGINING THE CAPA SERVICE DELIVERY MODEL

Social Work's Social Justice Voice

It was expressed that repositioning social work would require repositioning the entire system of mental health care service delivery. It was suggested that to centre social justice in the delivery of these services, there needs to be a return to truly holistic client-centred service with respect and recognition of the contributions that each profession can bring to the table. There was a criticism of CAPA as a system which blurs professional differences, reducing services to generic professional skills and omitting the unique contributions social work can contribute – social justice, human rights and the social determinants of health.

And I would say it's not just repositioning social work, it's repositioning the whole system. You know, to me it would be a social deconstruction of how we're doing things right now with that dominant world view... And I feel like social work is one of the voices, if not sometimes the only voice, that brings that social justice, human rights, social determinants of health, understanding people in the context of their environment lens to the table. And I'm hoping that some of this research will help better understand that lens a little bit more, and how invaluable it is to the system. As opposed to working as opposed to the system. It's not hey, what are all these systems doing wrong but it's how does social work, work within those systems to stretch some of this stuff up so we're getting people the services that they want and we're all working more collaboratively together? – Annie, supervisor

I guess I was just thinking about how in terms of changing things or reimagine like our CAPA in our province is I feel we've gone from one end to the other, the mantra within CAPA is we're all the same, all professions are the same no matter who you get you're going to get the same delivery of service and while I can understand that there's, why people that value, but we don't have to have that lens on everything and I think we'd still like to be able to speak from our professional lens and have some part in that. – Valley Focus Group, P3

Government Needs to Invest in Basic Needs

There was recognition that underfunding and under resourcing are fundamental problems and barriers that not only undermine mental health care but are also pervasive in the community and contribute significantly to mental health distress.

I really do believe that if we changed, it would be a real hard sell, but look at what's happening right now. People are reaching out to one another, the government is trying to give people money so that people can live, why didn't we do that before? But if we turned it upside down on its head and we thought o.k. what do people need? They need a place to live, a safe affordable place to live, they need good food that they like, they need to feel that they belong in a community and, and, and. So if we did that, mental health care costs would go down,

physical health costs would go down, more money would be made and it's just, I know it would take a lot to do that but I really truly believe that we need to start and that needs to be led by social workers I believe, is that we need to start looking at people. And taking care of people first. And we say it but we don't do it.
– Valley Rural Focus Group 2, P1

Increase Client Mental Health Service Accessibility

There was recognition that accessibility is woefully inadequate and that this is a combination of inadequate funding, the rural/urban divide and excessive wait lists.

Service delivery needs to be more accessible, especially for youth attending school. Greater privacy for those seeking services - public waiting rooms are an issue. The wait time to see a public therapist is far too long. Private insurance plans need to include social workers under mental health - not all do. As a supervisor of Adoption Services at MFCS, the majority of my team hold MSW degrees. – Opinio, supervisor

Client Resources Need to Be Increased

The Opinio survey revealed that participants strongly believe there are not enough available resources for their clients and recommend the need for the provision of more re-sources. Among participants, 97% (n= 109/112) indicated that they did not believe there were adequate resources in the community to support the well-being of their clients (i.e., affordable daycare, affordable leisure, affordable housing). Similarly, 85% (n=89/112) believed there are not sufficient day programs or services available within the community for their clients such as drop in programs, faith-based group activities, or volunteer work support (question 41). When asked whether they experience barriers in offering mental health services, 96% (n=107/112) responded that they experienced barriers which included a lack of resources, lack of control and lack of opportunity to implement change.

Yeah, be respectful. Have information about courses you can take. Have information about things like assistance things. They don't have information about the resources that are available. – Ann, service user

Community Options Need to Be Increased

There was recognition that mainstream mental health care is strongly centred on the individual. However, community based work has been shown to be very important and especially as a preventative and maintenance system which can provide additional supports and resources for those who are perhaps isolated or disconnected or members of marginalized groups.

*The mental health system needs to think outside the box of traditional mental health services like Walk in clinics; use model like mobile crisis team but do preventative work ; walk in mobile mental health service; meeting people where they are at in the community. Too many silos between services.
– Opinio, provider*

More money, absolutely, but I think and I think there's other things besides money that you know we may need to restructure the model of care. When we do that the public thinks that means you're taking something away where in fact it might be reallocating the resources more to the community where we need it but then politicians hear oh they're not going to like that so they don't do it and we end up in this you know vicious kind of circle....to me that comes back to early identification, healthy communities, health promotion. What are we doing to promote health and wellness at a you know long before we're needing an acute kind of care delivery? – Tena, supervisor

I think there should be more programming available that is more community-based and more like wellness-based. So you attend groups or you do things maybe not when you're feeling 100% but when you feel like stress is starting to build or there's different issues in your life. And it's more preventative. ...So I would prefer to see a system where we have something in place like the community clinics but that are less like sterile and like medical-looking, and are more like warm and comforting.... So like creating a safe place for people to talk about what's going on, and then learning how...like the mind and body connection... I know some family practice clinics do this but I was thinking that it would be great if we could come to a place where there's counsellors in family practice clinics, just like there are doctors, and everyone is assigned a counsellor. – Samantha, provider

The Mental Health and Addiction Services system would benefit from having an army of well-trained BSW assisting clinicians with outreach work in the community both for mental health and addictions. I really like my job - concurrent with a strong addiction focus. Unfortunately I don't always like where I work. But I strongly believe that systems can often only be changed from the inside. – Opinio, provider

Participants in this consultation believe that services need to be more accommodating and flexible meeting people where they are at. This involves asking the community what it needs.

It's kind of making ourselves more available to them, so kind of more accessible and presenting it in different ways outside of medical model, kind of taking out some barriers right and I feel like sometimes we're on this pedestal looking down on folks right. It's more so you know going to where they're at and getting word out there so going into different communities, like resource centres, family centres that bit to just having more open discussions, inviting folks in in terms of challenges they've had with mental health organizations in the past and asking them how they would feel better served. What would make them feel more comfortable right I think is huge and being able to move forward and getting those numbers, cause there is such a shortage in terms of like there's limited numbers of people coming in like we know they're having similar concerns and need help but we're not seeing the numbers come in right? So lots of questions surrounding why and why are they often presenting to us, you know in that crisis moment right, there's more preventative work that could have been done right? – Susan, provider

Participants repeatedly advocated for client-centred, accessible services in the community.

So we're structured in sessions where sort of people are coming to us. Which are difficult sometimes to get to. Instead of doing those community work and those community pieces and being involved in the community. So some of what would reduce I think some of this angst in the things is having more people but also having those people out in the community, building those relationships, building those kind of connections. And I think we've done a really good role

with that with the schools – having clinicians within schools. I think that’s the start of that. But I think having more people but also just switching up the structure of what we’re doing altogether in terms of where our resources are located. They’re all located in the same areas, kind of. Right here in... So stretching that out, being more community-based, doing work within the community. And working with people on what’s important to them, when it’s important to them would be kind of a key around that. So having that flexibility in the system to be able to make the judgement with the person on what their needs and what’s best for them, I think that could be a way as well. And having training in multiple models so that we can keep those multiple perspectives right around those, I think that could be helpful as well. – Annie, supervisor

Service users in this consultation believed that Community Mental Health needs to be more accessible to the community than it currently is.

I think it would be nice if it was less stigmatized and more people were doing it and more accessible to people too. – George, service user

I just feel that everybody should have this availability and the province is working on that which is terrific but my doctor you know taking that step to get somebody in his practice is awesome. I just wish that everybody had an option like I have. – Dennis, service user

I guess where things are located is obviously a huge overhaul that would have to happen but I think that having services in these two huge high rise glass buildings in Dartmouth can be really not accessible for a lot of people...I think that the interaction with the social worker has to be one of the most engaging interactions because it’s how you initially decide whether or not you want to continue seeking care. – Kit, service user

One social worker provider suggested that offering drop-in counselling as an option would be effective.

We don’t try to say well can we do something today that will help you, cause the most effective mental health program I saw was single shot counseling in East River, it was their most effective program ever. They completely destroyed their

waitlist using this and what they did was they would take people in for one session and say what's the matter, what have you tried, and perhaps if you did this a bit as well or if you did a little more of what you've already done or if you did this or that, would that help? And they're yah that would really help and they go away. Eighty percent didn't come back. – Valley Rural Focus Group 2, P4

The importance of listening to the needs of those accessing services is stressed by one service user.

Social work in the Nova Scotia Health Authority needs to be more holistic and think outside the box while really listening to the needs of those accessing services: Think outside the Health Authority you're working for, look into the holistic world and all the adjuncts that really support because we hide all this trauma, we don't just hide it in our minds, we hide it in our body... And explore outside of a social work degree. In the past that I've done... like retreats and survivor retreats and weekends of counselling... And being open and listening to your clients to what their experience has been because sometimes I'm sure things come up that they haven't heard of, like they're not aware of in the area and so, listen, really listen. – Haze, service user

Address Diversity and Mental Health Inequity

Social workers and service users in this consultation stress that we need to be aware of diversity and being able to respond to people's diverse needs. There is a need to emphasize greater diversity in the hiring of social workers and for people to be able to have choices in who they see as therapists.

I think that it would have been helpful to talk with somebody who might even be from a different cultural and religious background because I think that that is one thing that definitely separates cultures, their spirituality and their beliefs. ... just talking to somebody who's very open about their practices and their relationship with reality and being able to have that bridge where it's like well now we're sitting in an office together and this is that culture. We sit together and we talk just to understand each other with the basis of peace and communication. – Moon Baby, service user

The participants in this consultation recommended that we need to consult diverse communities about what would decrease barriers to accessing services and help build better mental health services.

I feel like there needs to be more of an active voice for service users in designing and creating services, particularly youth. Cause I've seen that model work. I also feel like I don't know if this is necessarily related to social work, but like peer services don't seem to be as big of a thing here as they were in Ontario and I found that a lot of people that I worked with found having like a peer like formalized peer mentor services to be really, really valuable to them...And yah but having more reform for service users would be really great especially like marginalized service users and not just like a tokenized, we're going to listen to your voices and then write a report and then never do anything with that report but in like a substantive kind of way...That they should also prioritize hiring more marginalized people.
– Leaf, provider

So I think that's going to be lacking in terms of where we go and again just being, maybe I want to see a queer-identified therapist or I want you know I'm Black, I want to see, so I think even that. We're not responsive to that, so I see that. – James, provider

I mean we need to increase the diversity within our staff and within our organization. – Jess, provider

Trauma and Diversity

Participants strongly recommended that there needs to be more specific focus on the impact of trauma especially for marginalized groups. Further there needs to be more awareness around 2LGBTQIA+ issues.

The effects of trauma are serious. Approaching violence is extremely important because people are not able to be their ideal selves for the sake of themselves and for the sake of others, when we have this kind of trauma in society. So bullying is actually extremely serious, it's not just like a phase,

this attitude of oh they'll grow out of it, oh it's just a phase, oh you'll get over it, that is the most unhealthy attitude....the label of the LGBT agenda, when you use the word agenda, it makes it sound like a manifesto which is awful because that's not what we wanted to be compared to and that's not what it's supposed to be either. We're simply trying to prevent trauma so as to allow individuals to experience the fluidity that is available to all of us and to build a unique kind of confidence that's just about freedom. It is about freedom. So these are all really important concepts that are crucial to the identity of anyone. So I think that awareness is a step, the constant step we have to take, just awareness. And to definitely yah move beyond LGBTQIA, it's good it's there but it's really about integrating that everywhere and basically stating like we are not just LGBTQIA+. – Moon Baby, service user

Mental Health and Addiction

Participants expressed significant concern about addictions being subsumed under mental health under the effort to amalgamate the two. Many viewed the loss of addictions-specific programming as problematic, as they are not convinced that addiction elements are adequately addressed. Further, there is concern that often people have worked in mental health but not addiction and do not have any training to work with addiction. Amalgamation of mental health and addiction is not the integration model advocated by CAMH. If addiction work becomes invisible as mental health is elevated that is not sufficient. Participants note that when dealing with addiction and mental health, diversity and mental health inequity need to be addressed and be culturally responsive. Co-occurring issues of mental health, substance use and trauma need more services. Specific training related to addiction and substance misuse, including harm reduction and gender-specific approaches is needed. An increased range of services specific to addictions that would include increases in non-profit community-based programming, and harm reduction treatment programs are required. The programming needs to address the common co-occurrence of mental health issues and trauma.

Stephane, a service provider, suggests that special training is required to do addictions work.

I: *With regards to, I mean either your current role or your previous role, were you looking at mental health issues as well as substance use issues?*

R: *Yes and I guess yah in my two roles, the one I was doing before and when I was in private practice too.*

...So I'd say that's, as a social worker, I lean more towards approaches that are harm reduction influenced if you want. Yah a lot more than, but then again so harm reduction has also a lot of limitations when it comes to severity.

I: *Do you feel as though you have enough training to work in this area, particularly with regards to substance use and addictions?*

R: *Definitely not.*

I: *Would you say that the expectation of your organization is that you work in this area?*

R: *In NSHA yes 100% and that I provide treatment too.*

I: *Was there an opportunity to get more training?*

R: *No. – Stephane, provider*

Leaf, like many other participants also expressed concerns about how mental health and addiction have been amalgamated.

This is a big issue in our team right now because the health authority even though mental health and addictions is like formally integrated there used to be like separate addictions teams and mental health teams and when they integrated they never gave like crossover training so all of us are trained in mental health stuff but have never had any formal training in addictions but we're supposed to just do it. So you just kind of cobble shit together, like I would say I use largely like a harm reduction kind of approach but most of the time when we have kids where addiction is a significant piece they go to one of our like addictions community people who do more addiction-specific work but we are, they are talking about like running a training for us in addictions stuff but they've also been talking about that for ever so we'll see. – Leaf, provider

Summary of Participants' Recommendations

1. Value social work professionals

2. Promote and strengthen social work professional identity and collective voice

3. Address institutional influences on social work practice (Dalhousie School of Social Work, NSHA, IWK, NSCSW, CASWE)

Nova Scotia College of Social Workers should increase advocacy for social work profession.

4. Social workers need to have a specific Nova Scotia social work union.

5. Restructure model of care: Reimagining the CAPA model

Move way from efficiency and fiscally constrained services to client-centred service that is multi-dimensional rather than a one size fits all medical model.

Incorporate bio-psycho-social collaborative and relational models for social workers that do not individualize, decontextualize and medicalize peoples struggles.

Recognize the continuum of mental health distress that needs support, rather than focusing on the most extreme.

Social work needs to work within the system to be the voice of social justice.

Services need to be more varied in terms of choices, models of delivery, and number of sessions clients can be seen.

Government needs to invest in basic needs.

Increase client mental health service accessibility; address barriers.

Client resources need to be increased.

Community options need to be increased.

Diversity and mental health inequity needs to be addressed in a culturally responsive way.

6. Co-occurring issues of mental health, substance use and trauma need more services

Specific training related to addiction and substance use is needed, including harm reduction and gender-specific and culturally appropriate approaches.

Specific training related to working with the effects of trauma is needed.

An increased range of services specific to addiction services should include increases in non-profit community based programming and harm-reduction treatment programs. The programming needs to address the common co-occurrence of mental health issues and trauma.

Discussion

Social Justice, Social Work Education, Practice and Identity

The neoliberal political and economic system in tandem with the dominant, largely unquestioned bio-medical model of mental health services produces a problematic landscape for the practice of social justice-based social work. The rationalized, fiscally constrained, efficiency-based, reduced social welfare principles of neoliberalism, alongside the individual and decontextualized focus of dominant medical assumptions about mental health, result in a politically powerful and ideologically consistent framework. Together, neoliberalism and medicalism both individualize and medicalize mental health distress and suffering, with little to no concern for social determinants of health. Consequently, a prescriptive formula for public mental health services emerges that centres on cutting costs, services, and resources. The research literature and consultation conducted here on social mental health and addiction services in Nova Scotia bring to light social workers' critical view of these services and an overall indictment of the medical mental health system. Our conclusion is that social work as a profession needs to be repositioned in the mental healthcare system.

Some participants of this study critique the ways in which universities prepare social work students for employment; some participants critique universities' priority of meeting the managerial demands of the mental health system, demands which can conflict with the goals of social work education. Social work education can most often be characterized as prioritizing an anti-oppressive and relational approach and the development of a critical analysis. This education can create dissonance with demands of social control and management of risk often found in social workers' workplace contexts (Banks, 2011; Johnstone, 2015; Ross, Hall & MacDonald, 2019).

The training of social workers, particularly at the graduate level, cannot and should not be reduced to the current demands and limitations of the workplace's tiered framework and CAPA service delivery model. In other words, social work

professional training should not be held to the constraining neoliberal demands of the current mental health care system, i.e. CBT as the preferred “evidence-based” approach, “efficiency-based” short-term work, application of DSM assessment typology, and the bio-medical-model construction of mental illness. Within the modified CAPA service delivery model at play in Nova Scotia, these features represent the preferred measure of skill. This preference is aligned with neoliberal bio-medicalism, which conflicts with a social justice-based approach to social work practice. That we do not educate social workers to practice in this way, does not mean they are not well trained or have no clinical skills. According to Baines (2020):

The concept of “skills” needs to be problematized as it is not neutral. In actuality, the skills concept is central to powerful discourses that systematically undervalue the social work skills and practices associated with social justice, social change, policy analysis, community development and mobilization, grassroots services, social movements, and advocacy. What these social justice skills have in common is that they provide tools to question and challenge the status quo, expose inequities, produce empowering counterstories, and draw people together to redress injustices (p. 9).

Social workers are trained to focus on the development of strong, collaborative, and respectful therapeutic or clinical alliances with their clients. Ethical practice includes transparency, client self-determination and choice, and an understanding of the overall context of people’s lives and struggles, including attention to their basic social needs. The social determinants of health are central to social work practice, but are not encouraged and too often absent in dominant individualizing, pathologizing, and medicalized approaches. Social workers explore individuals’ struggles within their social environment, including experiences of oppression and marginalization, such as violence, sexism, racism, homophobia, and poverty. We explore what makes sense about clients’ struggles and work with people to find ways of resolving or improving their life circumstances and mental health/substance use struggles.

Participants in this study frequently state that the Dalhousie School of Social Work offers a strong, critical, anti-oppressive, and social justice theoretical approach, but also report that it has historically not been sufficiently linked to direct clinical practice. Some providers note they received direct practice skills in their practicums during their studies, and learned on the job, but typically with little to no extra formal training offered by their employer. At the same time, providers report pride and

commitment to a social-justice approach. This discrepancy has left providers lacking confidence and feeling ill-prepared for the workplace and thus more prone to co-optation away from a critical approach and toward the dominant bio-medical framework which characterizes mental health and addiction services in Nova Scotia. Subsequently, not having sufficient bio-medical training, alongside the expectation to adopt the bio-medical model, leaves social workers between a rock and hard place. The expectation that social workers practice within a bio-medical model does not fit with anti-oppressive training. These are conflicting paradigms: one is primarily social and one is primarily bio-medical.

In 2011, the Dalhousie School of Social Work participated in a consultation with key stake holders, including government representatives, IWK, and NSHA management, and responded to critiques that the school does not offer sufficient skill training. The school has added several new courses with stronger clinical skills at the graduate level (MSW) and has integrated these courses into an anti-oppressive social justice theoretical approach. This has resulted in the development of what we are calling critical clinical social work. A book has been authored by Dalhousie faculty on this approach entitled *Critical Clinical Social Work: Counterstorying for Social Justice* (Brown & MacDonald, 2020). This book has a pragmatic focus on clinical skills and practice borne out of a social justice framework. The Dalhousie School of Social Work will not abandon its commitment to social justice; this theoretical approach can be integrated into intentional, direct clinical social work practice. Further, the labour force and government cannot dictate the professional and intellectual frameworks that universities or professions adopt, as universities are governed by principles of academic freedom. What this continues to mean, however, is that social workers are taught a critical clinical approach, yet upon graduation are expected to practice in mental health service delivery contexts that are organized around one-dimensional, bio-medical treatment strategies.

According to our own governing body, the Canadian Association of Social Work Educators, graduate degrees in social work will not and cannot be reduced to one technical approach, namely cognitive behavioural therapy, which is highly compatible with the bio-medical model, particularly when adjunct pharmaceutical treatment is recommended. This will need to be addressed in repositioning social work in mental health in Nova Scotia. As the participants in this study have strongly suggested, they need more autonomy and flexibility to practice social work. Social workers are employed in many settings, including child welfare, criminal justice, health care, research, policy, teaching, private practice, community development, and frontline

community work. Moreover, changes need to be addressed on multiple levels. As mentioned above, the Dalhousie School of Social Work is committed to offering critical clinical skills in the form of new graduate-level courses, which will begin in the fall of 2020 (Critical Clinical Practice Foundations and Interventions, and Critical Clinical Practice and Intervention in Social Work). Another two courses have been recently developed: Postmodern and Narrative Social Work Practice, and Critical Approaches to Mental Health and Addiction in Social Work. Opportunities for specialized independent studies also exist. In addition, our continuing education program regularly offers Counselling Skills and other courses. The Faculty of Health also offers a Mental Health and Addiction Certificate Program which is overseen by the School of Social Work. Additional electives are available at Dalhousie and throughout Canada. Thus, social workers will have more clinical skills education, but they will be grounded in a social work social justice framework not simply conforming to the bio-medical model. Overall, the approach of the Dalhousie School of Social Work continues to be critical of the biomedical model.

When allowed to enact its values and unique expertise, social work praxis offers a complementary perspective that can enrich existing bio-medical services, but when made completely subordinate to bio-medicine that rich potential has been suppressed. It will therefore take further negotiation and collaboration for social work to find an appropriate fit within the NSHA, and so we invite the NSHA to participate in this necessary dialogue with both the NSCSW and the Dalhousie School of Social Work.

The NSCSW needs to continue to elaborate upon its commitment to social justice and mental health, helping to build a collective social work voice and identity and to advocate for a stronger understanding of social work in the community. It is committed to repositioning the role of social work in mental health and addiction services. The College has designed an advocacy strategy and committed resources in order to expand the worldview of mental health and wellbeing for all government officials, policy makers, service providers and residents of Nova Scotia.

Utilizing the content of this paper, the NSCSW intends to publicly raise a critical analysis regarding its current mental health strategies as well as express the core values and principles that should frame and drive policy decisions to foster greater well-being and mental wellness. The College is committed to increasing access to critical clinical social work practice with a focus on person and family centred services. They have a clear plan to provide public education on the role of social workers in mental health and addictions in order to ensure that the profession is recognized as a mental health profession. They also intend to explore regulatory

practices to determine what they need to strengthen in order to ensure that there is a well-defined and clear scope of practice that includes critical clinical skill and family-centred practice that are grounded in a relational approach.

Inequities in and barriers to mental health are recognized by the service users, providers, and supervisors who participated in this consultation. Indeed, researchers have described racism as a health crisis (James et al., 2010). It is clear that the current system reinforces social inequities. Sheppard, an African Nova Scotian counsellor, believes many African Nova Scotians are suspicious of the services offered by mental health and addictions because they do not see themselves represented in these systems and have felt misunderstood (Sheppard, 2016). It is fair to say that this is how many marginalized people feel.

Social justice holds a special place within social work practice, theory, and knowledge. Social work is the only profession with social justice as a central part of its code of ethics (Canadian Association of Social Work Educators, 2005). As a central value, it is not an optional add-on but a set of values that should undergird every interaction, every relationship, every policy, and every aspect of the social work endeavour. However, social justice and “skills” are increasingly set up in opposition to each other, with measurable, “clinical” social work practices viewed as the only skills needed in today’s underfunded, neoliberal workplace (Brown, 2016). This formulation views social justice practices as non-skills and an aspect of social work that is added on if time and resources permit. This marginalizes social justice social work practices as laudatory aspirations that are seen as largely unachievable and unaffordable in the current context (Baines, 2020).

Often what is diagnosed as a mental health “disorder” and treated with medication reflects efforts at coping with life circumstances and experiences. Examples include “binge eating,” “eating disorders,” “hoarding,” and “substance use.” Depression and anxiety are often associated with life experiences of trauma and violence. Social workers are trained to use critical analysis and problem-solving, harm reduction strategies, and advocacy within a social justice lens. As social workers, we cannot apologize for offering stronger clinical approaches that enable in-depth exploration of problems, rather than the neoliberal efficiency-based biomedical model that often attempts to reduce significant and complex struggles to a limited number of prescribed sessions with CBT as the prescribed method. Through this consultation, we found significant evidence that social workers are co-opted into the medical model. They fear being replaced by other professions, are isolated in their own professional identity, are often supervised by other professions, are expected to use assessment

tools not designed by social workers, and are expected to practice within models and frameworks that do not reflect the ethics of social justice in social work. They are expected to refer to the DSM, while being critical of the focus on diagnosing and labeling. Social work service providers and supervisors consistently report that they feel undervalued and that other professions do not seem to know what social work is. They note that there needs to be greater flexibility and scope to their work. They report that they are not consulted about their work, have little opportunity to have impact on the services offered, and that their voices are not heard. Social workers' professional training and professional autonomy and judgement are minimized and undermined. All told, and consistent with the research literature, we are reaching a critical point in the professional identity of social work.

If social work intends to maintain its professional integrity, this dissonance must be addressed. Rather than taking the same approach that is taken with clients—defining the problem through a deficit lens and blaming clients for their problems rather than looking at the systemic creation of the problems—the system of mental health and substance use must be restructured by repositioning social work and drawing on the value of social work skills. It is not social work that is limited; it is the neoliberal, bio-medical delivery approach itself. Creating community based social work social services for mental health and addictions that values what social workers offer, rather than demanding compliance and co-optation into a paradigm that is not only not ours but often the antithesis of our training, is not a tenable approach. This current situation has, according to some researchers, produced a crisis of identity in social work (Carney, 2008; Ferguson & Lavalette, 2013) and for many of the participants in this consultation a sense of moral distress.

In this consultation social workers reported that they are able to make many important contributions to mental health services and could make more contributions if the structure of service delivery were altered. Social workers committed to social justice and working with people and their mental health and substance use struggles find they often need to bridge the gap between “expert”-based understandings, which reflect a bio-medical paradigm, and people's own understanding of their experiences. Research suggests that a conventional “disease management approach” is often an uneasy fit with people's own understandings of their experiences. In other words, there is often a significant gap between bio-medicine and individual experiences.

In addition to expressing their concerns about how their practice is constrained, participants in this consultation expressed the ways in which social workers can struggle to be authentic to their commitment to social justice through acknowledg-

ing social inequity and experiences of oppression. For instance, social workers have always recognized and attempted to respond to widespread experiences of childhood adversity, experiences of violence in relationships, and trauma. This recognition of the impact of cumulative life experiences helps in understanding the ways in which individuals cope with adversity but such understanding often conflicts with a bio-medical model that seeks to identify what is wrong with the “patient.” Social work has recognized the cumulative impact of these experiences across the lifespan, supporting the need to look beyond the bio-medical model and narrow individualized responses to address interpersonal and social causes of mental health challenges (Houston, 2016; Larkin et al. 2014).

A disease-management bio-medical model is not aligned with the needs of Nova Scotians who are challenged by substance misuse and/or addiction. As noted in our literature review, most Nova Scotians have been negatively impacted by either their own or a family member’s misuse of substances and/or addiction. Acknowledging and responding to experiences of violence, childhood adversity, and trauma is central to addiction treatment and often requires extensive programs to assist in healing. The substantial decrease in detoxification units and residential and gender-specific programming historically offered as a part of a continuum of care in addiction services has resulted in an increase in private treatment programs (e.g., Crosbie House Society, Ledgehill Treatment and Recovery Centre, and Searidge Foundation). This move to privatization of services further marginalizes the poor and detracts from the declared vision of the NSHA, which is healthy people, healthy communities – for generations.

Participants of this consultation struggle with finding a balance between individual and contextual approaches within a dominant bio-medically-based system where it is difficult to practice a “personal is political” approach rooted in feminist, anti-oppressive, and social justice analysis. Yet, the individual and their social context are not separate. Feminist work in mental health has argued for the importance of acknowledging the material-discursive aspects of peoples’ struggles which situates struggles, such as depression, anxiety, substance use, and post trauma, within the dual and necessarily intertwined context of peoples’ lives and bodies (C. Brown, 2018, 2019a; Lafrance, 2009, Lafrance & Stoppard, 2007, Ussher, 2010). From this view, a bio-psycho-social model is most effective as it is able to recognize the relationship between the body, mind, and society. In the case of schizophrenia, bi-polar “disorder,” or major depression, the body is clearly part of the story. Consistent with a social work view, it is not, however, the whole story, nor can this be the entire focus of providing mental health services. We can adopt approaches to mental health that do not dichotomize

the individual. However, social work as a profession objects to how the biological is elevated in importance and the social is invisibilized.

Social workers wrestle with the dissonance between their professional training and education and working within the constraints of various interlocking systems. The goal of critical analysis is to help generate alternative practice approaches that can produce greater social justice and equity. Given opportunities for constructive dialogue, social workers who have refined their critical analysis are positioned to make unique contributions to the evolution of systems to better equip these systems to meet the needs of clients or patients. Workplaces can help develop social work clinical skills in more collaborative ways that value the unique lens social work students bring. Failing to resolve these tensions can leave students struggling with their professional identity, particularly in workplaces that appear not to value this learning (Baines, 2017).

Social work service providers, supervisors, and service users in this consultation were clear that the current approach to mental health and substance use needs to change. We need to develop an alternative to our current implementation of the CAPA service delivery model, one which does not forsake the well-being of service users and quality mental health services in an effort to cut costs and to uphold a limited bio-medical model. More services need to be located in the community, and respond to ongoing consultation with service users and community members about what they need. In the current system, top-down instructions are issued from the Ministry of Health and Wellness. The CAPA program as a response to the problem of wait times is one example. However, wait times have not been reduced under this CAPA approach. As many participants indicated, people can receive an initial assessment and then wait a year to actually see a mental health service provider, so the wait time is invisibilized rather than changed. More overtly, severe mental health struggles have been emphasized and the people who deal with poorly articulated or not easily diagnosed mental distress fall through the cracks. Resources need to be expanded and provisions made for longer-term counselling and relational work for individuals, groups, and families. In addition, the repositioning of social work in a reconfigured service delivery system would allow social workers more opportunities to address the structural inequities and barriers in the mental health system that social workers observe but are unable to respond to in the current system. A bio-psycho-social model rather than a bio-medical model would be broadly inclusive and allow social workers and other professionals to address the mental health marginalization and inequities identified in this report.

Participants in this consultation have reported that the amalgamation of mental health services has resulted in the subjugation of addiction services. Our findings

revealed that the distinct contribution of addiction services has been subsumed and largely lost in the integration process. As the field of neuroscience grows and as the emergence of new pharmaceutical drugs to treat addiction expands, addiction is increasingly explained as a brain disease: The emphasis on neuroscience in biomedical approaches toward addiction “...promotes neuro-essentialist thinking, categorical ideas of responsibility and free choice, and undermines the complexity involved in its emergence” (Buchman, Skinner & Illes, 2010 p. 36). As such, the bio-medical approach diminishes the influence of psycho-social factors, which has been a distinct knowledge contribution of addiction services and of social work practice. The result of prioritizing a brain disease model of addiction has been to diminish a personal sense of agency, which has been the hallmark of addiction treatment, by implying addicted people are unable to exercise control over their substance use. Further, the assumption of peoples’ lack of choices and control contradicts existing National Drug Strategy policy which includes a focus on harm reduction. A brain disease model also negates an understanding of the ways in which globalized capitalism, largely unregulated, socially constructs a demand for addictive substances and gaming opportunities as demonstrated by the growth of casinos, “Big Pharma,” and “Big Alcohol.” The intersection of bio-psycho-social elements is central to well-being. Instead, thoroughly integrated understandings of the relationship between mental health and substance use that understand substance use is often a form of coping, needs to be developed. We need to develop harm reduction and controlled use programming that is sensitive to differences between women’s and men’s mental health and substance use issues. We also need to develop culturally appropriate programming, in particular for African, Indigenous, and 2SLGBTQIA+ Nova Scotians.

There is a need to explore how we can develop a social worker union to better reflect and support the unique practice of social work. The development of a social work union in Nova Scotia would help to protect the professional autonomy, practice, and identity of social workers practicing within bio-medical models and serve to situate social workers’ voices in ways that can shift the dominance of the bio-medical model to allow social workers to practice according to the principles of social justice. The unionization of social work would begin to address social workers’ sense of being marginalized, disempowered, disrespected, devalued, and unequal in the bio-medical model. Like nurses, social work practitioners would be professionally empowered in their work environments. They would be better positioned to determine the number of sessions provided, wait times, type of clinical work and assessments, continuity of care, and the working paradigms adopted in their mental health and addiction work.

Further the amount of paperwork social workers are weighed down by could be regulated and controlled within a social work union rather than imposed within an efficiency-based and fiscally restrained agenda. This would allow social workers more professional power, control, and autonomy over their work and help to strengthen social work's identity.

Report Recommendations

The following recommendations are derived from the literature review and the consultation process with service users, service providers and service supervisors. They are meant to influence policy, practice and education in Nova Scotia related to mental health and addiction services. This report advocates a range of social justice based critical clinical person-centred interventions.

Social Policy and Prioritizing the Mental Wellness of Nova Scotians

Adequate funding is a foundational requirement for effective mental health and addiction services for all Nova Scotians. We conceptualize inadequate funding as one of the harmful consequences of the dominance of a neoliberal philosophy that results in reduced public funding and the provision of only skeletal services. This is a very short-sighted approach as there are enormous costs accrued through inadequate services and by ignoring the impact of the social determinants of health. We consulted with a Dalhousie University health administration economist who specializes in health equity, and subsequently recommend a more socially responsible approach to mental health and addiction that is also fiscally intelligent. However, the budget for mental health and addiction services needs to be increased for our recommendations to be adopted and for the subsequent well-being of Nova Scotians.

Recommendation 1

Substantially increase financial support for public mental health systems to ensure that we can meet the mental health needs of all Nova Scotians with particular attention to rural areas. We recommend that the province increase mental health and addiction services to represent 10 per cent of

the total Department of Health and Wellness budget as recommended by the World Health Organization. This will include a commitment to prevention which means addressing social inequities, trauma and gender-based violence.

Recommendation 2

Provide a guaranteed income for Nova Scotians to assist with many of the stresses and inequities that emerge from poverty. The research is clear that these factors contribute to mental health and addiction struggles.

Recommendation 3

Re-examine the tiered framework and the application of the CAPA service delivery model to ensure that there is a stronger focus on a bio-psycho-social model integrated through community work. The social determinants of health are well established and need to be fully incorporated into the design of mental health and addiction services. Each person's mental health is shaped by various social, economic, and physical environments operating at different stages of life. Risk factors for many common mental health problems are strongly associated with social inequalities: the greater the inequality, the higher the risk. The current focus on fiscal restraint and efficiency does not comport with the design and delivery of a model of practice that can adequately address the mental health and well-being of Nova Scotians. People must come first.

Recommendation 4

All policy created by the Department of Health and Wellness regarding mental health and addictions services needs to ensure that policy outcomes lead to greater equality and equity of services. The NSCSW and the Canadian Centre for Policy Alternatives (Nova Scotia) provide a strong framework to facilitate policy directions.

Recommendation 5

Ensure that all Nova Scotians have access to person-centred individual, group, and family mental health and addiction services. Explore and create a plan for all regulated mental health professionals to bill services to the province's MSI program.

Addressing Social Inequities in Mental Health and Addiction Services

This report emphasizes the important influence of the social determinants of mental health. The NSCSW identified comprehensive and long-term responses to current social inequities which centred on ways to improve mental health care services in Nova Scotia that addressed: the dominance of the bio-medical model; the type of services offered; access to services; culturally appropriate and community-based services; mental health inequities, stigma and discrimination; the impact of trauma; increasing mental health resources; and funding and prevention strategies. We support advocating and striving for these fundamental social justice principles to improve access to quality mental health care among all. Improving the social determinants of mental health among Nova Scotians is a critical aspect of early prevention and well-being. Vulnerability for mental health and substance use problems are associated with social inequities for example of class, race, gender, sexual orientation and age as well as childhood trauma and gender-based violence.

Recommendation 6

Ensure the hiring of more diverse social work supervisors and social work service providers (gender, race, sexual orientation, age, etc.). This will provide a more accessible service for diverse and marginalized service users.

Recommendation 7

Develop and offer community and culturally appropriate and specific services to African Nova Scotians, Indigenous communities, 2SLGBTQIA+ people, and other identified groups, to address the consequences of historical and intergenerational trauma, marginalization, oppression, and discrimination.

Recommendation 8

Offer gender-specific services that address co-existing issues of mental health, substance use, and trauma. Men and women do not have the same mental health experiences and needs; mental health services need to reflect this.

Critical Clinical Mental Health Programming and Community Collaboration

This community collaboration was vital to making recommendations that reflect the conditions, views, and experiences of Nova Scotians. This meant consulting with people in different geographical locations – urban and rural – as well as holding consultations with different actors in the health care system, in order to build a comprehensive understanding of the current context and effectiveness of service provision from multiple perspectives. We explored perceived gaps in service and barriers to effectiveness, such that the resulting data would inform our recommendations for change. The consultation collected socio-demographic information and explored and compared differences between rural and urban contexts in terms of population needs, types of mental health service availability, accessibility, and wait times. This process is crucial to address the mental health of Nova Scotians and must be utilized in the development of mental health policies and programs.

Recommendation 9

Provide greater opportunity for social work input on policy and practices. Policy will be more effective and reflect the point of view of service providers if they are involved in the creation of policy that affects their practice. Those who deliver services also have critical information about what works and doesn't work in mental health service delivery.

Recommendation 10

Operating plans and strategic documents created by the Nova Scotia Health Authority or the IWK should involve extensive consultation with front line service providers and supervisors, service users, community organizations and municipalities to ensure that strategies align with needs. Effective and appropriate policy cannot simply be produced from the top down and must consult with those providing and receiving services.

Recommendation 11

Social work positions should provide an opportunity to link critical clinical social work practice with community-based work, advocacy, programming and policy. Critical clinical approaches do not individualize, or pathologize people's mental health struggles, and seek to work collaboratively with people to create countersto-

ries about themselves and their lives that they feel will work better for them. This approach looks to individuals' life /social history and the overall social context of their lives, including their families and relationships, to understand how struggles have emerged. A social justice perspective on mental health recognizes the need for social changes including increased resources and supports.

Recommendation 12

Ensure service delivery is collaborative and contextual, by repositioning social work in the hierarchy of service delivery, and by valuing the training and knowledge of social workers. Often social workers are required to adopt a bio-medical model and specific approaches to practice such as CBT rather than using their own training, knowledge and skills as social workers.

Recommendation 13

A public health and education program needs to be expanded to increase public knowledge and awareness about mental health, trauma, and substance use, with attention to issues of prevention, stigma and discrimination. Public health needs to ensure strong communication lines are open between policy makers, supervisors and practitioners, across departments, agencies, and the community at large. Collaboration and intersection across services is recommended to avoid a lack of communication.

Life-Long Individual Mental Wellness and Healthy Communities: Social Justice Approaches to Social Work Practice

The bio-medical model of mental health and addiction services is deeply rooted in individualizing, decontextualizing, and pathologizing based on a diagnosis. A major limitation of the bio-medical model is its emphasis on the biology of the individual, which is often disease and deficit-based with little attention to the actual lives of people and the influence that their social worlds have on their well-being. Through both our literature review and consultation, structural factors that impede access and delivery of mental health services such as poverty, gender, race, and sexual orientation – particularly under the current neoliberal fiscal constraints of the welfare state and in subsequent service delivery – were identified. In this consultation, service users, service providers, and service supervisors identified the impact of intergenerational trauma, poverty, racism, and the particular risks

experienced by people who live with (dis)ability or transgender youth. As social workers, we understand the importance of relationships both in the therapeutic alliance and in people's lives. Individual, family, and community relationships, alongside structural constraints and barriers should be recognized as significant in addressing mental health issues and in the design of appropriate and accessible mental health programming.

This report contributes to a culture that emphasizes and values mental health well-being by moving away from an approach that interprets mental health within narrow abnormal/normal binaries. Individual mental health wellness cannot be separated from the social determinants of health, including experiences of social oppression and marginalization. Therefore, this mental health advocacy report focuses on mental health, equity, and social justice and concludes that social work needs to be repositioned as an active advocate for social justice in mental health care services.

Recommendation 14

Nova Scotians should be offered more community-based practice. This is not only more cost-effective, but more accessible to a diverse range of service users and better positioned to address issues of mental health inequity and the social conditions that play a significant role in the development of mental health struggles. These community-based services can include advocacy and support (including financial, housing, and legal support); individual, family, and group counselling; support for daycare/child or adult care; and transportation support.

Recommendation 15

Challenge the dominance of the bio-medical model and expand services to provide greater choice to social workers who work with mental health, trauma, and substance use issues through bio-psycho-social approaches which are person-centred, strength based, and non-pathologizing. Social work has been central in the development of narrative, feminist, empowerment-based, trauma-based, harm-reduction-based, and crisis-counselling approaches.

Recommendation 16

Develop alternative non-bio-medical services and resources, such as art/music/dance/animal-assisted interventions for children, youth, adults, and diverse communities. Build increased community resources offering sporting, arts-based activities, and social opportunities.

Recommendation 17

A range of mental health services and interventions should be available including individual, family, and group counselling, as well as community, financial, housing, and social supports. Individuals struggling with more severe mental health issues such as schizophrenia, bi-polar “disorder,” and major depression should be supported in a holistic manner that addresses their overall well-being, to avoid or reduce stigmatizing a person to a diagnosis. Supports should be ongoing as needed rather than focusing on short term interventions, for all those receiving mental health care services.

Recommendation 18

Remove current policy that predetermines the number of sessions a client can receive. A client might need one session or a hundred, and this should be determined via participation between the service provider and the client. Clients should be assessed for support that they need by the same counsellor for continuity of care, if this is the client’s choice. A preventive public health approach will provide support to people before their needs become more severe.

Recommendation 19

Where there are co-existing or concurrent relational injury, trauma, mental health and/or substance use issues, sessions of counselling should be provided across a wide range of mental health issues. These sessions should emphasize harm reduction and the therapeutic relationship.

Trauma and Relational Injury

Recommendation 20

Develop clear trauma-focused strategies, and approaches to counselling beyond trauma-informed. We recommend the development of trauma-based programs specific to women, African Nova Scotians, Indigenous communities, and 2SLGBTQIA+ people. While trauma-informed education is important, the development of mental health services to address trauma is needed.

Recommendation 21

Address co-occurring struggles of trauma, mental health distress, and substance use within a bio-psycho-social model that emphasizes the need for holistic attention to

relational injury and harm reduction. Research clearly establishes the relationship between trauma, mental health, and addiction. Too often these issues are siloed. These co-existing problems also often require longer-term work and support. In addition to individual counselling by trained social workers, supports may include family counselling, medication, group support, community, housing, and social and financial support. Integrating individual counselling with group support may also provide some cost savings in service delivery while also providing more in-depth and sustainable support.

Mental Health and Addiction

Recommendation 22

Develop a clear strategy for amalgamating mental health and addiction services. Use of substances is often a form of coping with trauma and mental health struggles. A non-disease, holistic harm reduction model can address the relationship between these issues. This supports an integrated approach to addressing co-occurring issues and should include trauma. Training is necessary to address co-occurring mental health and substance use issues.

Recommendation 23

Employ harm reduction strategies in all substance use counselling with specific attention to alcohol use problems. Controlled drinking strategies should be developed and operationalized in line with harm reduction as a choice for those who do not see abstinence as an option. This strategy is already in place for other drug use such as opioids and nicotine.

Recommendation 24

Provide appropriate and adequate critical clinical training for mental health practitioners to address substance use issues. Substance use work cannot be simply subsumed under mental health services without specific attention to the training of practitioners to work with substance use and to ensure substance use is adequately addressed.

Repositioning Social Work in Mental Health and Addiction Services: Professional Autonomy, Integrity, Value and Identity

Significant concerns were frequently reported about the dominance of bio-medical approaches – which render invisible the impact of the social determinants of mental health – alongside participants’ experiences of having their knowledge and professional training minimized. Through our literature review it was apparent that social work is facing a struggle of professional identity and autonomy across the world. Many social workers expressed a disconnect between the values and ethics of social work practice and the bio-medical model in the public health system. These tensions were exacerbated by the hierarchies in the healthcare system and the devaluing of the social work profession which often contributes to social workers internalizing bio-medical discourse and being co-opted into bio-medical dominance. Participants who work for the public mental health system reported not having the autonomy to practice within the scope of their social work training.

Recommendation 25

Recognize and broaden the scope of clinical social work skills. Social workers practice in a wide range of fields and locations, including social justice; forensics and the legal system; child and adult protection; health care and mental health care; rehabilitation; palliative care and grief; addictions; and frontline community work regarding, for instance, domestic violence, sexual assault, homelessness, and crisis counselling. Social workers also work in private-practice counselling and consultation, supervision, research, community programming, and teaching/educating in the formal and informal educational systems. They offer individual, couple, family, and group counselling as well as work with communities.

Recommendation 26

Prepare social workers through a social justice education lens to offer community-based work, critical clinical therapy, advocacy, and programming and policy development, as well as to establish and strengthen the social justice identity of the social work profession among social workers in the work place and in society at large. Provide practicums and courses that allow for this.

Recommendation 27

Strengthen social work identity through the Dalhousie School of Social Work, NSCSW, Canadian Association of Social Workers (CASW), NSHA and IWK. This would include educating the public and other professions on the field of social work. It would also include increasing the public profile of social work beyond child welfare and income assistance.

Recommendation 28

We need to ensure social workers are provided clinical supervision by social workers, as social workers know what social work is and how it should be practiced.

Recommendation 29

Draw attention to existing unions about social workers' concerns and needs and consult with labour groups about the unionization of social workers. A social work union, like those of teachers and nurses, would protect the professional autonomy, practice, and identity of social workers within bio-medical models, and serve to also situate social workers voices in ways that can change the unquestioned dominance of the bio-medical model that limits the scope of social workers' ability to practice. Unionization would then also allow social workers more opportunities to address structural inequities and barriers in the mental health system that social workers observe but are unable to respond to in the current system. For example, unionized social workers would be better positioned to determine the number of sessions provided, wait times, type of clinical work and assessments, continuity of care, and the working paradigms adopted in their mental health and addiction work, and to receive support from a social work supervisor. Further, the surveillance of social work practice through metrics and the significant paper work required could be regulated and controlled via collective bargaining undertaken by a social work union. This would allow social workers more professional power, control, and autonomy over their work.

Concluding Comments

Our consultation revealed striking consistency in the narratives of mental health service provision as told by service users, service providers, and social work supervisors in Nova Scotia. This consultation clearly indicates the need for a systemic overhaul of the mental health and addiction services in the province.

Social workers report significant dissatisfaction in their work due to a sense of being disempowered, voiceless, and devalued within a hierarchy of service provision. They struggle to bridge the dissonance between their professional training, which emphasizes social justice and relational strategies that are person-centred, and the dominant bio-medical model in the mental health system. The ethics of social work practice avoid pathologizing, blaming, and individualizing the mental health and substance use issues people face. Rather, social work ethics emphasize the context in which these issues emerge. Social work is on the side of social change and transforming social inequities and marginalization in mental health.

The participants in this study believe there is a significant need to provide a range of services that are community based and culturally appropriate. The needs of African Nova Scotians, Indigenous Nova Scotians, and 2SLGBTQIA+ communities need to be addressed. More diverse mental health service providers from these communities need to be hired to deliver services as part of this process.

According to those consulted in this report, the attempt to amalgamate mental health and addiction, whereby addiction is subjugated to mental health, is not working. These issues, in combination with the tiered framework and the application of the CAPA service delivery model that currently structures mental health and addiction services, are universally indicted by participants for their bio-medical focus and many barriers to access. All told, the implementation of the CAPA service delivery model is critiqued for its focus on efficiency and fiscal constraints over the well-being of Nova Scotians. Beginning with the ideological dissonance between social work and the bio-medical model and the devaluing of social work as a profession, and concluding with the structural barriers and inequities of the CAPA service delivery model, we have come to the overall conclusion in this report that social work needs to be repositioned within mental health care in Nova Scotia and that CAPA-based services need to be re-examined and mental health care services restructured.

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Appendix A

PARTICIPANTS SOCIO-DEMOGRAPHIC INFORMATION

Opinio Survey: Service Providers/Supervisors

There were 166 (stored) 115 (completed) people who participated in the online survey and most participants were service providers. The age categories that represent the most participants are between the ages of 30 and 44 (n=51) and 45 and 59 (n=47). The majority of the participants (n=119), identified their gender as female, 22 as male, one participant identifies as Male (cis) Two Spirit and another as gender diverse. Twenty-one participants are 2SLGBTQIA+ with identities that include: queer, gay, lesbian, bisexual, bisexual Two-Spirit and pansexual. One hundred and nine participants identified as White and other racial/ethnic identities included Indigenous, African Nova Scotian, African Canadian and Sinhalese. Most participants speak English as a first language; other languages of note are French and Sinhalese. The majority of participants were in relationships and 83 participants had children. Almost all (117) participants were employed full time, 17 are part-time, two are retired. Most participants had a master's degree in social work (93) with 42 participants educated at a bachelor level and three people with PhDs. Of those employed the majority work in the public sector, primarily the Nova Scotia Health Authority and the IWK. Other organizations included: The Confederacy of Mainland Mi`kmaq, Laing House and the People's Counselling Clinic. Fifteen providers identified as working in private practice, and 5 work in both private and public systems. Most noted their individual income category between \$60,000-\$79,999, while those with a combined income primarily indicate their income as middle with the income categories of \$100,000-\$149,999. Thirty-one participants are living with a chronic illness or (dis)Ability. Participants were split equally between living in urban and rural settings.

Interviews: Service Users

Sixteen service users participated in the study, ten people were interviewed and six completed the online survey. Most participants were between the age of 30 and 44 (n=8). The majority of the service users identified their gender as female, (n=11), males (n=3), and in the gender diverse umbrella (n=3). Most service users are heterosexual with six identifying as 2SLGBTQIA+. Those who identified with marginalized groups include 11 people who identify as women, six people as 2SLGBTQIA+ with intersecting identities of gender diverse and another person who identifies as African Canadian/Indigenous First Nations. All service users except one are White and all but one service user speak English as a first language with French as the other first language. Half of the service users are in relationships and half have children. Six service users are employed full time, two part-time and one person is retired. Seven people are receiving social assistance. The majority of service users have some post-secondary education. Most note their individual income as low or lower-middle with most people earning under \$30,000-\$39,999. Five service users live with chronic illness or (dis)Ability. Most participants live in urban settings.

Interviews: Service Providers and Supervisor

There were 40 service providers and supervisors that participated in individual interviews, 30 service providers and 10 supervisors. Most participants were between the age of 30 and 44 (n=13) and between 45-59 (n=13). The majority of the participants, 26 identified their gender as female, 10 were male, 1 participant identified as a transgender male, another as non-binary and one as Male (cis) Two Spirit. Most participants, identified as heterosexual (n=27/40) with 11 participants identified as 2SLGBTQIA+ (n=11/40). Those who identified with marginalized groups include 18 women, 10 identifying as 2SLGBTQIA+ with intersecting identities including; women, (dis)Ability, gender diverse and Indigenous. Other marginalized identities included two women of African descent and two participants who indicated other racialized. There were 32 participants who identified as White and other racial/ethnic identities included Sir Lankan, African Nova Scotian, African Descent, Lebanese/Scottish and Indigenous/Biracial. Thirty-six participants spoke English as a first language; other languages identified French and Sinhalese. Most participants were in relationships and 18 participants had children. Thirty four participants were employed full time, two retired and three were part-time. Most

participants had a masters' degree in social work, seven participants were educated at a bachelor level, and one person had a Ph.D. Of those employed, the majority worked in the public sector, primarily the Nova Scotia Health Authority (13) and the IWK (4). Two providers identified working in private practice, and two worked in both private and public systems. Most noted their individual income as middle class: eight with an income category between \$60,000-\$69,999, six with an income of \$70,000-\$79,999, five with an income of \$80,000-\$89,999, seven with an income of \$90,000-\$99,999 and six with an income of \$100,000-\$149,999. Those reporting a household income indicate their income as middle to upper-middle class with the income categories split equally between n=8 (\$100,000-\$149,999) and n=8 (\$150,000 +). Ten participants are living with a chronic illness or (dis)Ability. Most participants live in an urban setting.

Focus Groups

Fourteen people participated in three focus groups. Most participants were between the age of 30-44 (n=5) and 45 and 59 year of age (n=5). Most participants, 9, identified as female, 5 as male and 1 participant who identified as transgender. Of the participants, 86 % identified as heterosexual (n=12/14) and three participants identified as 2SLGBTQIA+. Among those who participated in focus groups 9 identified with marginalized groups: five people who identified as female, three people as 2SLGBTQIA+ and one person who identified as other racialized. All participants except one were White and 12 of the 14 participants spoke English as a first language; other first languages identified were French and Singhalese. Most participants were in relationships and half with children. Thirteen of the participants were employed full time and one participant was retired. The majority of participants had a masters' degree in social work, with two participants educated at the bachelor level. Of those employed, the majority work in the public sector, primarily the Nova Scotia Health Authority (n=7) and the IWK (n=2). Most note their individual income as middle or upper-middle class with an income category between \$70,000 and \$89,999 (n=4), between \$70,000 and \$79,000 (n=3), and \$80,000 and \$89,999 (n=3). While those with a household income indicated their income is middle class with the income categories varying almost equally between \$70,000 - \$150,000 (n=3), \$70,000 and \$79,000 (n=2), \$80,000 and \$89,999 (n=3) and \$100,000-\$149,000, (n=3). Two participants live with chronic illness or (dis)Ability. Most participants live in rural settings. There were seven people who participated in both the focus groups and individual interview.

