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Art Therapy: Three Models of Community-Based Mental Health Facilities

Adrienne Durst

A Research Paper

in

The Department

of

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and

Creative Arts Therapies

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Abstract

Art Therapy: Three Models of Community-Based Mental Health Facilities

Adrienne Durst

The deinstitutionalization movement has affected art therapy, along with the entire mental health care system in Canada. The shift from hospital-based care to community-based care for psychiatric patients has resulted in a subsequent expansion of community services to meet the needs of this population. The expansion of art therapy into the community is an inevitable outgrowth of deinstitutionalization. This research paper examines how art therapy has been integrated into community-based mental health facilities after deinstitutionalization. What role does art therapy play in the community and how has it been implemented? This primary question is explored through the assessment of three different community-based mental health facilities within the Montreal area. Through interviews with the art therapists from these three community-based mental health facilities, an illustration of how art therapy has been implemented is portrayed. This research paper explores the complex and challenging set of problems created for the mental health care system as formally institutionalized patients are dispersed into the community and the unique challenges that art therapists face within the deinstitutionalized setting.

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CHAPTER I

An Introduction

Along with deinstitutionalization in the mental health system in Canada, art therapy has experienced a simultaneous shift from a traditional and psychiatric model of mental health care towards a more holistic¹ and systemic approach. This shift from hospital-based care to community-based care was signaled by the release into “the community of formerly institutionalized psychiatric patients and the subsequent expansion of community-based services created to receive this population” (Foster, 1989, p.98).

1. Subject Area

Art therapy has been affected by the change that deinstitutionalization has had on the mental health system. This research paper examines how art therapy has been integrated in community-based mental health facilities after deinstitutionalization. Essentially, what role does art therapy play in the community and how has it been implemented?

In the 1950's and 1960's the treatment of people with mental illness in institutions came to be described and defined as a social problem. The proposed solution was deinstitutionalization, which as a policy and a process (Bachrach, 1996) has affected the mental health care system for nearly four decades. “Deinstitutionalization, which refers to a complex series of interrelated events and policy decisions, may be defined as, the replacement of long-stay psychiatric hospitals with smaller, less isolated community-based service alternatives for the care of mentally ill individuals” (p.4). In theory, deinstitutionalization consists of a three-part process. The first wave of the

deinstitutionalization process refers to the release of patients residing in psychiatric hospitals to alternative facilities in the community. The second wave of deinstitutionalization refers to the diversion of potential new admissions in institutions to alternative facilities. Lastly, the third wave of deinstitutionalization addresses the development of special community-based programs, combining both psychiatric and support services for the care of a non-institutionalized patient population (Bachrach, 1997).

Have these three elements of deinstitutionalization actually been realized over the last four decades? Bachrach (1996) states that the first two of the three processes mentioned above have been executed accordingly. Yet, the third and perhaps the most “critical third process, that of developing a full array of services in the community to meet the unique needs of a non-institutionalized patient population, has often lagged” (p.5).

The research presented in this paper is specifically oriented to the last ten years, that is from 1989 to 1999, which is better known as the third wave of deinstitutionalization. Research is geared towards the investigation of whether relevant new services have been developed in the community and how art therapy plays a role in the service delivery for people who have been deinstitutionalized.

In 1989, a former art therapy student at Concordia University, Martha Foster, wrote for her Master’s thesis, A Historical overview of art therapy since the advent of deinstitutionalization. The thesis’s objective is to investigate art therapy’s integration into a community-based mental health center, as well as to research the influences that have affected the field of art therapy within the deinstitutionalized milieu. Foster felt that the

deinstitutionalization movement opened up a door for the growing field of art therapy as she states, “The deinstitutionalized setting is an environment which encourages experimentation and development (despite economic restraint) unlike the stringent resistance met by art therapists in most larger institutions” (p.68). Foster (1989) follows with:

As mentioned several times, the deinstitutionalization movement created a vacuum in the mental health system. This period of flux encouraged creative license for the budding profession of art therapy to develop innovative intervention strategies and treatment programs for the chronically mentally ill. (p.98-99)

The 1980’s were described as a time of abandonment and neglect of the deinstitutionalized, chronically mentally ill. Foster (1989) was correct when she stated that there was a “vacuum in the mental health care system left by the deinstitutionalization movement” (p.97). There was a missing link in the continuity of care for people with mental illness at the time of discharge from the hospital to a functional integration into the community. Foster (1989) states in her thesis:

With the reversal in the economy occurring just when a reworking of this relationship was most necessary, the system became entangled between community and institution. As a result, many patients today remain in limbo, inadequately fitting into the institutional service system or into understaffed and underserved programs. That patients are caught in this bind indicated that there is a vacuum in the delivery of mental health services. (p. 64-65)

The deinstitutionalization policy of intended reform had, in its implementation, resulted in worsened conditions of care, created community resistance, and undermined patient re-integration. Cook (1990) in New Custodians: Spinning Wheels in Mental Health Services for Chronic Client, found that:

The premise of deinstitutionalization, that treatment in the community rather than in the institution would hasten recovery and prevent chronicity, required that treatment and rehabilitation resources be available in the patient's home communities. The growing body of clinical research literature on this era provides ample evidence and documentation of the lack of such resources. (p.16)

This research paper is complementary to that of Foster's. In a sense, the research is a continuation of where Foster left off ten years ago. What has been learnt as we have entered the third wave of deinstitutionalization? How have community mental health facilities with art therapy programs dealt with changes over the last ten years? What new issues have surfaced in reference to service delivery?

There is a scarcity of research on deinstitutionalization in terms of material on the evolution of new community-based treatment facilities for the mentally ill. There were descriptions of programs and evaluations of outcomes in terms of cost benefit analyses (Andrews, Hall, Goldstein, Lapsley, Bartels & Silove, 1985; Bond, 1984; Weisbrod, 1981; Weisbrod, Test & Stein, 1980), and cost-effectiveness analyses (Gilman & Diamond, 1985, Goldberg, 1991, Cannon, 1985, Nelson, Sadeler & Cragg, 1995, Rubin, 1982, Wilkinson & Pelosi, 1987) but there is little research on the actual day to day operation of these facilities: Who is staffing them? How do they organize and structure their work and their roles? How were the problems of limited resources and great needs

being tackled? For the purposes of this paper, the author felt that the best way to understand the mental health policy of deinstitutionalization and its consequences was to study the service providers who are given the responsibility for implementing and maintaining the policy.

Three models of community-based care facilities, that of the 1) CLSC Lac-Saint-Louis and Ensemble, 2) Expression LaSalle Community Mental Health Centre and 3) Arbour Expressive Arts Therapy Centre, have been chosen to illustrate the varying ways that art therapy has specifically been implemented. Through the interviews with the art therapists from these three community-based mental health facilities, an illustration of how art therapy has been implemented is portrayed. Has the vacuum in the delivery of mental health services been filled within the last ten years? What role has art therapy played in filling this vacuum? What issues are art therapists now faced with in community-based mental health facilities?

In Chapter Four, this research paper provides a summary of each facility, followed by a comparison of the commonalties and differences within each organizational model in Chapter Five. Generic issues are raised regarding organizational structure and dynamics essential to the delivery of mental health services and more specifically the role art therapy plays in the deinstitutionalized setting. As an example, questions posed are as follows: What is the history of art therapy within the community center? What population is being served? How are the needs of the population evaluated? How is the center funded? How has the center been affected by the cutbacks in the 1980's and 1990's? What is the role of the art therapist in the community-based mental health facilities? What is the facility's mandate or philosophy? How has art therapy

within the community helped to fill the vacuum left in the mental health care system after the deinstitutionalization movement? What is the future vision for art therapy? And finally, what are the limitations and strengths within the facility?

This research paper will focus on an assessment of the uniqueness of each approach, rather than make conclusions about which is the “best” model. Although in each interview the questions posed by the researcher varied according to the uniqueness of the “model” implemented in the community-based mental health facilities, a copy of the general questions posed are included (see Appendix A).

Preceding the interviews in Chapter Two and Three, the comprehensive work of Leona Bachrach (1976,1982,1987 a,b,c,d,e, 1989, 1996 & 1997) serve as a major reference for this section of the literature review. This chapter explores how the community mental health care system is a major achievement and a step forward, but that it still leaves a lot to be desired in that it has left some very significant gaps in the mental health care system (Bachrach, 1997). This chapter examines the current status of the deinstitutionalized movement and identifies some specific problems that may be traced directly to the implementation of the deinstitutionalization policy. For although the deinstitutionalization movement has demonstrated that indeed community care may be more humane and therapeutic, this is only achieved when certain prerequisites are met (Bachrach, 1997).

Bachrach discusses the need for a new, more realistic understanding of what successful deinstitutionalization entails and identifies a number of important conditions that must be realized in order to achieve better facility service delivery (Bachrach, 1997). These points serve to contextualize the mode of inquiry for the interviews conducted

with the art therapists. In Chapter Four and Five, analysis of the data collected from the interviews is discussed in reference to confirming or disproving the existing literature.

It is important to note, that the research investigated in this section is based primarily on the implications of deinstitutionalization in the United States. Due to the scarcity of the literature, the author had difficulty finding Canadian sources. However, the author shares the same point of viewpoint as Bachrach (1996) when she states that, “both the popular and professional literature (Thornicroft & Bebbington, 1989, & Schmidt, 1992) as well as personal observation suggest that other countries are encountering similar circumstances” (p.3). Health and Welfare Canada and the Health Services and Promotion Branch (1990) state that, “The development of mental health services in Quebec has followed major international trends” (p.114). Additionally, the information gathered from the interviews support Bachrach’s (1996) suggestion that the deinstitutionalization movement has similarly effected the mental health care system in other countries.

2. Methodology

The author could have approached the experience of art therapists in community-based organizations through examining personal and institutional documents, through observation, through exploring the history of the organization, through naturalistic evaluation, through questionnaires and surveys and through a review of existing literature. However, the goal of this research paper is to understand the meaning art therapists make of their experience in community-based mental health settings.

Interviewing was chosen as the method of data collection. In-depth interviewing is often described as “a conversation with a purpose” (Kahn & Cannell, 1957, p.49). For the purposes of this research, the author has chosen to follow the format of an interview guide, which is described by Maykut & Morehouse (1994) as, “A series of topics or broad interview questions which the researcher is free to explore and probe with the interviewee” (p.87).

The three art therapists chosen for the interviews have been selected for the interviews based upon their expertise in the research area. All three are in positions of command at the community-based mental health facilities and the author felt that valuable information could be obtained from them as they hold positions of authority within the context of how art therapy is implemented in community agencies. Marshall & Rosen (1989) call this type of interviewing, elite interviewing: “Elites are considered to be the influential, the prominent and the well informed people in an organization or community” (p.94).

The methodology consisted of first contacting by phone the program coordinators of the art therapy programs at the three community-based mental health facilities: Nancy Humber at the CLSC Lac-Saint-Louis and Ensemble, Julia Olivier at Expression LaSalle Community Mental Health Centre, and lastly Alice Hogg and Laura Goldberg at Arbour Expressive Art Therapy Centre. The semi-structured interview format includes specific questions related to the subject area of this paper with instructions that these questions be used only as a guideline and could be answered directly, be modified or disregarded entirely.

The author formulated the questions based upon information gathered from literature reviews on the current happenings within the field of community-based mental health care. As well, Bachrach (1997) identifies certain preconditions that need to be met by community-based services in order to provide more humane and therapeutic care, with this in mind, certain questions have been formulated with the goal of exploring how these preconditions are met or if they are even relevant in the community-based mental health facilities that are investigated. Additionally, some questions were formulated so as to ascertain an overall perspective of the organizational structure, which forms the basis to examine the dynamics essential to the delivery of mental health care services. The questions used were given to participants in advance to the actual interview, with adequate preparation time for participants (see questions in Appendix A).

The interview took place at the respective site of each center and lasted for an average of one and half hours. Some participants were called on again for additional interviews. Written consent forms were presented to interviewees prior to the participation in the interview (see Appendix B).

The interviews were audiotaped and used in verbatim form in this research paper. The subjectivity of the claims made and based upon the information derived from the interviewees is acknowledged. The complete verbatim from all three interviews can be referenced in the Appendix of this research paper (see Appendix C, D, E). The author felt that it was necessary to include the entire document of the verbatim rather than simply quote abstracts from it. Each interview contained such a wealth of information that the author felt it would serve as a comprehensive referral base for readers. Additionally, the author felt that for historical purposes the document should be made readily available,

for the opportunity to compare with time the changes that may occur in these different community-based organizations. All the interviewees reviewed the written verbatim from their respective interview prior to publication for the purposes of verification and approval.

3. Limitations of Research Paper

Although this research is oriented at the investigation of different viewpoints of art therapists working in the community, further research is needed in terms of gaining an understanding of the client's experience and perspective of community-based mental health facilities. As well, further research on how art therapy is implemented in the institutions is needed, in order to gain a deeper understanding of how community mental health facilities are managing in the deinstitutionalized setting.

This research is not intended to be representative of all art therapy programs run in community-based mental health facilities. It is important to stress that the research is not geared at an assessment of the effectiveness of community-based mental health facilities but rather to understand the meaning that these three art therapists make of their experience in community-based mental health settings. In addition, the paper investigates generic issues pertaining to organizational structure and the dynamics essential to the delivery of mental health services in these three community-based mental health facilities.

Lastly, in the conventional use of the term, deinstitutionalization refers to the social policies aimed at moving people with both psychiatric and intellectual disabilities from large residential facilities to the community. Due to the delimitation of this paper,

this research is specifically geared to persons solely with psychiatric illnesses. However, the author is aware that the deinstitutionalized movement affects people with intellectually disabilities as well and that this requires further elaboration and study beyond the scope of this paper.

An exception is made with Arbour Expressive Arts Therapy Center, for their clientele is not composed of people who have been deinstitutionalized. Therefore, for the purposes of this paper, the focus in the case of Arbour Expressive Arts Therapy Center is to explore how this community center operates within the community at large and the reasons the directors may perceive as to why the deinstitutionalized population is not utilizing their services.

4. Relevance of Research to the Art Therapy Profession

While this research paper should prove to be interesting to anyone working in the mental health profession, it should be especially useful for art therapists who want to survive and prosper in the community-based mental health facilities in the coming millennium. The research will provide an overall perspective of how art therapy is implemented in community-based mental health facilities in the Montreal area, as well as providing a follow up assessment from the research done by Foster (1989) as to how well art therapy has filled the vacuum in mental health services since the deinstitutionalization movement. This research paper will hopefully encourage further investigation into possible strategies and interventions within community-based care facilities to better meet the therapeutic needs of the deinstitutionalized Montreal population.

CHAPTER TWO

Deinstitutionalization: Definition and Background

1. Definition of Deinstitutionalization

The definition of deinstitutionalization is constantly shifting. “Many have objected to the term ‘deinstitutionalization’ for its imprecise, inaccurate or confusing definition and use” (Foster, 1989, p.3). Bachrach (1997) explains that the word deinstitutionalization has so many interpretations that it can be described as a “proverbial elephant” meaning that “people are bound to judge this phenomena according to which specific part of the beast they view and to how far away from the beast they stand” (p. 23). In essence, deinstitutionalization looks different according to the viewpoint one takes, whether it be as a deinstitutionalized psychiatric patient, a community-based mental health worker, an institutional worker or as a legislator, for example.

The standard definition of deinstitutionalization refers to the social policies which when implemented transfer both psychiatric and intellectual disabilities from large residential facilities to the community. However, Bachrach (1997) feels that the deinstitutionalization movement involves more than this and elaborates on the definition as also involving:

the replacement of long stay psychiatric hospitals with smaller, less isolated community-based service alternatives for the care of mentally ill people.

According to this definition, deinstitutionalization is not limited to the reduction of psychiatric hospital censuses, even though this is a common understanding of the term (Bachrach, 1987, 1989). Rather, this definition extends beyond hospital depopulation to include the provision of alternative services. Downsizing or

closing those hospitals is thus a critical part of deinstitutionalization, but only a part; it is not all of what that concept encompasses. (p.23)

So in practice, deinstitutionalization is comprised of three separate processes. The first wave of the deinstitutionalization process entails the release to alternative care facilities in the community of formerly institutionalized patients. In the second wave, potential new admissions to psychiatric hospitals are prevented or diverted through the provision of community alternatives in treatment. The third wave, considered to be particularly important, addresses the establishment and maintenance of combining both psychiatric and community support systems for non-institutionalized people receiving mental health services in the community (Braun et al. 1981, Bachrach, 1997). All three processes have to be carried out fully. Unfortunately, what occurred in the early years of deinstitutionalization was that the first two processes were carried out but the third was neglected. Patients were discharged from institutions without adequate community services in place to help the deinstitutionalized integrate into the community. The result was nothing short of disastrous in many cases (Bachrach, 1987d, 1996, 1997).

2. Inception of Deinstitutionalization

The historical framework with which deinstitutionalization took place has often been described as including a host of factors that played a combined role in the development of the deinstitutionalization movement.² These factors include, 1) the ineffectiveness of hospitals to adequately meet the needs of the chronically mentally ill, 2) the availability of psychoactive medications, 3) the general enthusiasm for the philosophy of community care among social reformers of the day, 4) the growth in the

number of mental health professionals of all disciplines and lastly, 5) economic factors, all of which contributed to the deinstitutionalization of the chronically mentally ill.

Research found that “hospital treatment was relatively ineffective in helping people establish a sustained community adjustment after discharge” (Foster, 1989, p.14). Long term chronic care tends to “foster social and economic dependence” (Roth, 1970, p.61). “It creates norms and behaviors which reinforce the dependent role of the patient, (and) these behaviors are frequently at odds with those needed to survive successfully in the community” (Rutman, 1976).

Additionally, findings indicate that conditions in hospitals were deteriorating. There was much criticism aimed at the harmful and dehumanizing effects of institutionalization on patients. There were numerous critiques of the scandalous conditions within many psychiatric hospitals’ back wards. “Over crowded and understaffed administration placed more emphasis on management than on treatment. This led to abuses and to the institutionalization syndrome characterized by the patients’ withdrawal, apathy, and infantile behavior (Paul & Lentz, 1977)” (Foster, 1989, p.15). This body of work has raised awareness about the limits of institutional care.

The availability and rapid spread of effective psychoactive drug, became “revered as a virtual cure-all for core psychotic symptoms experienced by the chronically mentally ill” (Foster, 1989, p.19). The introduction of these new medications in the mid 1950’s alleviated the most bizarre manifestations of psychosis and influenced the hope and confidence of administrators, caretakers and families about community reintegration. It was thought that patients within the institutions would now be able to live in the community and receive maintenance treatment in the deinstitutionalization setting.

Civil libertarian values emphasized the rights of the mentally ill to influence their own destiny, as well as legislative and judicial decisions that supported patients' right to be treated in the 'least restrictive setting.' Bachrach (1997) states that "it was at that time widely, even passionately, assumed that community care for mentally ill people would be more humane and more therapeutic than hospital care" (p.24). The ideological base for community care was that it would provide a real opportunity for reintegration into the community for patients, as well as establish the potential for independent and semi-independent living, promote dignity and the principles of normalization, and generally provide a better quality of life for these individuals. Normalization and community living increasingly became accepted as the guiding ideology for services for people with psychiatric illness.

In addition, there were economic motives for reducing or shifting the cost of care for these patients. Capital and operating expenses for total institutions were enormous and increasingly governments and advocates saw the economic benefits of community living (Canadian Council on Social Development, 1985). Essentially, it was assumed that community-based care would be more cost effective than hospital based care (Bachrach, 1976, 1978, Thornicroft & Bebbington, 1989).

After World War II, there was a sudden increase in all types of mental health disciplines. "As an outgrowth of this expansion, these therapies branched out into deinstitutionalized settings promoting the decentralization of treatment for the chronically mentally ill" (Foster, 1989, p.19). Generally, this period was characterized by growth in the number of mental health professionals, which laid the groundwork for community-based psychiatry.

a) Summary

A variety of factors have influenced the advent of the deinstitutionalization movement. The combination of all these trends encouraged the making and implementation of deinstitutionalization policies. Bachrach (1996) summarizes these points succinctly when she states:

First, it was widely, even passionately assumed that community-based care would be intrinsically more humane than hospital-based care. Second, it was similarly assumed that community-based care would be intrinsically more therapeutic than hospital-based care. And, third, it was further assumed that community-based care would be more cost-effective than hospital-based care (Bachrach, 1976, 1978; Thornicroft & Bebbington, 1989) (p.5).

What is interesting is that these assumptions are that- assumptions. They were never tested empirically. Now four decades later from the inception of deinstitutionalization, we have a history to evaluate whether these assumptions are valid. Bachrach (1996) summarizes that we know that community care can be more humane and therapeutic, however only if certain preconditions are met. These certain conditions refer to comprehensive services for deinstitutionalized patients and the subsequent community resources that implement the services. Bachrach (1996) states that, “We have also begun to understand that if one considers all the hidden costs associated with responsible programming, it is generally not accurate to conclude that community services will result in substantial savings over hospital care (Alderich, 1985, Kovalesski, 1993, Okin, 1978, 1993)” (p.5). Deinstitutionalization policy makers did not anticipate the many hidden costs in community care for example, the “indirect costs incurred by

other community agencies that are called upon to deal with the patients, for example, police, courts, emergency rooms, family agencies, etc. (Kirk & Therrien, 1975).

3. The History of Deinstitutionalization

Following the United States, by 1955 Canadian psychiatric hospitals began the process of deinstitutionalization. However, as patients were discharged from the institutions, there was a lack of adequate programs or facilities in place to support the influx of patients into the community. The supports and services necessary for community adjustments were not in place (Breakey, 1996). The Roeher Institute (1995) states that, “Deinstitutionalization policies of the time were later criticized because people leaving institutions often found themselves on the streets or in overcrowded boarding homes. In effect, the policies moved people from large facilities but provided little income, housing or social supports for people once they moved” (p.1).

The second wave of deinstitutionalization policy began in Canada in the 1970’s. It was a time of focusing on the expansion of community-based service systems to provide people with alternate support systems. In Quebec, there was a 40% drop in the number of patients in psychiatric hospitals. “Universal, free of charge care was inaugurated.... Attempts were made to harmonize the social and medical dimensions, within the framework of an overall community intervention” (Health and Welfare Canada & Health Services & Promotion Branch, 1990, p.115).

By the late 1980’s, the third wave of deinstitutionalization, there was a shift in focus. A number of debates were geared towards the recognition that institutionalization of people with disabilities was ultimately an issue of their basic human rights and

well-being. Research by the Roeher Institute (1995) found that:

Those advocating for deinstitutionalization policies began to cast the policy question in terms of how human rights and the conditions of well-being could be secured for people. As the issues related to deinstitutionalization policy expanded from simply moving people from facilities to group homes, questions of “institutionalization of the community” began to emerge (p.1)

In Deinstitutionalization: An Analytical Review and Sociological Perspective (Bachrach, 1976), Allen (1976) a deinstitutionalized patient, described his experience with the community as:

Regardless, of what treatment programs exist in the community, they surely are not providing enough therapy. I myself see many, many people who so far as I can tell, are untouched by anything that resembles treatment....I believe the majority of board and care residents live in an isolated, removed, seldom-changing, untouched world. There is a very real possibility that yesterday's back wards of state mental hospitals are becoming today's board and care homes (p.12)

By 1980, a mental health policy was integrated in Canada with a focus on the theme of partnership and the recognition of the individual's potential, his/her social context (friends, family), the community and those who provide interventions (Health & Welfare Canada & Health Services & Promotion Branch, 1990)

Since the 1970's, Canada has increasingly responded to the greater need for support for deinstitutionalized persons by funding mental health programs that are designed to provide assessment, treatment, rehabilitation, accommodation, and other vital services (Wasylenki, 1991). Overall, however, the Canadian community mental health

services delivery system continues to lack true structure, organization, efficiency and commitment to provide adequate care to those who require help the most, chronically mentally ill people (Wasylenki, 1991).

Recent provincial policy makers have proposed a broader focus for mental health services. For example, British Columbia and Quebec have adopted a focus which encourages the need for programs throughout the continuum of care to address the biological, psychological and social issues associated with mental disorders (British Columbia Ministry of Health, 1987). It has been widely acknowledged that, as the federal discussion on mental health affirms, the needs of individuals with mental disorders go well beyond the treatment and control of symptoms (Health and Welfare Canada, 1989)

CHAPTER III

Third Wave of Deinstitutionalization

This literature review takes the vantage point offered by the third wave of deinstitutionalization, as it examines issues that have presented themselves with the shift from inpatient to community care. There are a number of different issues that must be addressed in order to improve service for people with mental illness.

The author's intention is to give a context to the type of concerns community-based mental health facilities in this decade of deinstitutionalization are contending with. The issues that are presented serve to give a context to the line of questioning in the interviews of the three art therapists in Montreal community-based mental health facilities. What are the challenges that confront them in light of the changes and issues presented in deinstitutionalized settings? Also how can art therapists work most efficiently in the community-based mental health facilities in order to respond to these challenges?

It must be strongly emphasized that the issues presented here are separable only in theory. They are completely intertwined and artificial separation of them at this time is made only for taxonomic purposes.

1. Summary of Issues in Deinstitutionalization

Deinstitutionalization is a major achievement and step forward, yet some very significant gaps in the mental health care have resulted (Bachrach, 1997). As previously stated, the first two processes in the deinstitutionalization movement have proceeded more rapidly than the third. The numerical shift from inpatient to outpatient care has been

executed. However, this third stage and most important one, that of providing adequate and accessible community alternatives to hospitalization has fallen short. Although the deinstitutionalization movement has demonstrated that indeed community care may be more humane and therapeutic, this is only achieved when certain prerequisites are met (Bachrach, 1997). The treatment, care, and rehabilitation of persons with mental illness must be drastically improved. It has even been said that the plight of persons with serious mental illness has been labeled as a 'systems failure' (Wasylenki, 1991). It has been suggested by many (Anthony, Cohen & Farces, 1990; Bachrach, 1987a, 1987b, 1987c, 1987d; Talbot, 1988a, 1988b) that solutions should take the form of changes to the entire service delivery system. To be successful, it is essential that these solutions must be driven by client need, not by political agendas.

There is agreement in the literature on the changes that are necessary to effect major improvements in the current mental health system (Bachrach, 1987, Bachrach, Talbott & Meyerson, 1987, Talbott, 1988a, Wasylenki, 1991). Bachrach's (1997) article, Lessons from the American Experience in Providing Community-Based Services, explains problems accompanying the deinstitutionalization movement in the United States and discusses critical lessons reflecting its biopsychosocial legacy. Bachrach reflects on the history of deinstitutionalization and states that:

To say this differently, deinstitutionalization has provided us with a biopsychosocial legacy, "an adjective that implies the interaction of biological, psychological and sociological events as they affect the lives of mentally ill people (Engel, 1977). Such a biopsychosocial view demands that we consider not only the biology of mental illness but also the sociological context of care and,

most particularly, the special circumstances, needs and hopes of individual patients, as we plan mental health services with them and for them (Hartmann, 1992). (p.28)

Bachrach (1997) goes on to say that this “‘biopsychosocial legacy’ may be depicted as a series of lessons whose observance is basic to the provision of humane and sensitive community-based care” (p.28-29). Included among these lessons are, continuity of care, communication between service providers and service providers and their clients, an understanding of the need for individualized treatment, accessibility of services and flexibility in systems of care. These points are only part of the deinstitutionalization biopsychosocial legacy, and are of course not exhaustive. Due to the delimitations of this paper, other equally relevant issues have not been addressed ³. The issues in deinstitutionalization are as follows:

a) Continuity of Care

Fragmentation and lack of coordination in services are among the most widely and heatedly discussed in the literature (Bachrach, 1976). In the past, in institutionalized settings, comprehensive care for psychiatric patients was relatively easy to obtain, primarily because patients were centralized within the institution. Today, by contrast, the authority for providing services is typically divided among many separate health and human service agencies in the public and private sectors. The resulting problem is inadequate and fragmented service systems.

“Instead of having all services available in a single place, patients must now be aggressive in navigating through a cumbersome series of disjointed program sites”

(Bachrach, 1997, p.28). A former patient makes this observation: “Sometimes it seems as if the mental health care system has become so complex that one needs a college degree just to be a patient” (Bachrach, 1976, p.16).

The recognition that severely mentally ill patients have enduring but ever changing service needs has led to the development of programs designed to connect patients with services in a timely and orderly manner. “In other words, the patient must have ready access to all of the many services that are required for treatment and rehabilitation and this is what we call continuity of care” (Bachrach, 1987c, p.64).

Bachrach identifies a number of important conditions that must be realized in order to achieve continuity. Care must be available over a long period of time, clients must be treated individually, care must be comprehensive and flexible, obstacles to accessibility must be overcome and there must be communication between client and service providers and among the various service providers involved in his or her care.

Continuity of care means that the service system must be accessible to the patient in several ways. Feldman (1974) lists three components of accessibility; geographic, financial and psychological. Bachrach (1987) states that:

First of all, there must be psychological access. The services must be offered in such a way that the patient will not be frightened or upset by the intervention.

Second, in addition to psychological access, there must also be financial access.

The patient must be able to pay for the services.....Third, the services must be also geographically accessible. The patient must be able to reach the location where the services are provided....And, finally, particularly for a patient who is

chronically ill or disabled, the services must be accessible over long periods of time (p.64).

Case management was developed as a principle process at the client level to achieve continuity of care. Case managers are mental health professionals who assume responsibility for ensuring that patients receive appropriate care. “Case management is the integration of services for each patient, one at a time. It implies that someone in the system of care is taking charge and seeing to it that all the little bits and pieces of the fragmented service system are falling together in some coherent way for the individual patient. It’s absolutely implicit in the notion of continuity of care” (Bachrach, 1987c, p.72).

b) Client Involvement in Service Planning

Patients must be involved in service planning to the fullest extent possible and the experiences, values and personnel goals of the individual patient must be acknowledged in the planning process (Heinseen et al, 1995; Sartouris, 1992). This in requires that the person be informed about the nature of his or her illness, its symptoms, course and possible consequences.

Consumer participation is empowering, through supportive policies and approaches, which enable people to gain greater control over the factors and conditions that influence their mental health. Some provinces in Canada have taken action by increasing consumer input into decisions, which affect them, especially at the local planning level (i.e. New Brunswick, British Columbia, Quebec). Including service users

in the process of needs assessment also helps to ensure that their rights will be acknowledged and protected (Health & Welfare Canada, 1989).

An extension of this lesson involves consulting with patients' families as well, whenever that is feasible. Relatives often have expert knowledge that is otherwise unavailable to service providers. Before deinstitutionalization the concept that mentally ill people or their relatives could or should participate in service planning was not widely held. Deinstitutionalization has, however, given us the opportunity to explore the benefits of such involvement and there is now widespread acknowledgement of its efficacy (Roger, 1995).

c) Need for Individualized Treatment

Service planning must be individualized and tailored to the needs of specific individuals. Prior to deinstitutionalization, people with mental illness were in institutions for prolonged time periods. In the institutions, "There was relatively little variation in their treatment histories and individual differences among them were easily overlooked" (Bachrach, 1996, p.6). However, in today's community settings, these differences have become difficult to ignore. It is increasingly apparent that patients vary not only in their diagnosis and functional levels, but also in their symptomatology, available support systems and treatment needs. Clients must be assessed and served, based primarily upon their varied needs (psychiatric and general) rather than their diagnosis (Muller-Clemm, 1996). It is vital, if service delivery is to be efficient, humane and therapeutic, that service delivery facilities realize that the 'one-size-fits-all' approach is not appropriate for people who need mental health care.

d) Accessibility to Hospital Care

It is essential to facilitate access to hospital care for patients who need it, for as long as they need it. It was a misconception that with deinstitutionalization, the need for the psychiatric hospital could be eliminated and that people with mental illness would never again require extensive resources for inpatient care. There is a subgroup of persons with severe mental illness whose symptoms are largely untouched by current treatment or rehabilitation efforts and who may require life long supervised living arrangements. This population consists of those who have the most severe, disabling and chronic forms of severe mental illness. However, the majority of persons with severe mental illness can lead relatively normal, productive lives in the community, due to appropriate diagnosis, treatment and rehabilitation. There are others, who by nature of their impairment, are unable to become fully integrated into the community.

e) Flexibility in Systems of Care

Service systems must be flexible and open to change. Bachrach (1987d) states that, “the authority for providing services is typically divided among many separate health and human service agencies in the public and private sectors and successful programming depends upon the fine tuning of initiatives that originate with separate, and sometimes competing, authorities.

As previously stated, providing comprehensive care to people with mental illness in institutions was relatively easy, for all the services could be located in the same institution. But now community-based mental health services must be prepared to make adjustments and alter their planning concepts as patients’ needs change.

Long term patients with mental illness, precisely because of their illnesses and related disabilities generally require a wide variety of psychiatric, medical, social, rehabilitative, residential, vocational and quasi-vocational services (Belkin, 1992). Some also need sanctuary or asylum, an escape from the pressures and threats of the world (Bachrach, 1984, Wasow, 1993). Some may require such asylum temporarily until a crisis can be resolved although others may need it indefinitely (Bachrach, 1996, p.7)

A tremendous amount of energy, organization, and creativity is required if agencies are to work together collaboratively. Franklin, Kittredge & Thrasher (1975), signal that difficulties lay in defining boundaries, designating a domain and a set of tasks or activities over which the organization claims jurisdiction. The roles of general psychiatric units, psychiatric hospitals and community support services and programs need to be redefined to facilitate close cooperative working relationships and inter-agency linkages and communication. Relevant agencies have to have open lines of communication.

f) Summary

Deinstitutionalization has often proceeded with a rapidity that has provided too little time for careful planning for community-based programs, to meet special requirements of target groups. However, it does appear we can presently reflect on the future of the movement. As we approach the beginning of a new century, we have to reflect on the past lessons that deinstitutionalization has bestowed and plan and implement humane and therapeutic community-based mental health care.

To conclude, it is apparent that issues presented here are separable only in theory. There is a real sense of intertwining as each issue is interconnected with the other. We have learned that service planning which fails to acknowledge the biopsychosocial realities of people's lives will be incomplete, inappropriate and at best only marginally successful. As previously noted, community mental health care is potentially more humane and more therapeutic than hospital care, but that the potential is realized only in the presence of certain preconditions.

CHAPTER IV

Art Therapy in Community-Based Mental Health Facilities: Three Examples

As previously stated, deinstitutionalization has created a change in the service delivery for people with mental illness, signaled with the shift from a traditional and psychiatric model of mental health care towards a more holistic and systems approach in the community. Deinstitutionalization, therefore, has placed a new responsibility on the community and society at large to meet the needs of the deinstitutionalized population and to acknowledge the right of each of its members to adequate mental health care (Foster, 1989). With this expanded view, it is important to look at how art therapy's present role in community-based centers is implemented and how art therapists are responding to challenges presented in this deinstitutionalized era.

This chapter will review and summarize the data collected from the interviews with, 1) Nancy Humber at CLSC Lac-Saint-Louis and Ensemble, 2) Julia Olivier at Expression LaSalle Community Mental Health Centre and, 3) Alice Hogg and Laura Goldberg at Arbour Expressive Arts Therapy Center. The complete verbatim of all three interviews may be referenced in the Appendix (C, D, E) of this research paper.

The interviewing process was approached with a commitment to understand each person's perspective. The author discovered various perspectives or realities on a range of topics covered – an important concept in qualitative research. Keeping this in mind, whenever possible in this section of the paper, the author presents direct quotations to maximize these varieties of perspectives.

Lastly, it is important to note that not all points covered in the interviews are summarized in this chapter. Due to limitations on the scope of this paper, the author made

choices as to what to highlight in relation to Bachrach's lessons in the previous chapter, that of continuity of care, an understanding for the need for individualized treatments, accessibility of hospital care, communication between service providers and service providers and their clients and flexibility in the systems of care.

1. Description of the CLSC Lac-Saint-Louis and Ensemble

Nancy Humber, the director of both CLSC Lac-Saint-Louis's mental health team and Ensemble's psychiatric day center (which is housed in CLSC Lac-Saint-Louis) was interviewed on June 4, 1999 at CLSC Lac-Saint-Louis. Ms. Humber studied in the United States and received her Master's degree in Art Therapy. Prior to her training in art therapy she was a teacher and obtained another Master's degree in Philosophy of Education. Presently, she is completing her Doctorate degree in Psychology. Additionally, Ms. Humber has further training in psychoanalytic psychodynamic psychotherapy.

a) The History of CLSCs

Following a reform of health social service delivery systems in 1973, a new type of institution was established in Quebec, the local community service center (Centres locaux de services communautaires, CLSC). It is a provincially funded and governed organization whose mandate is to provide primary health and social services through a comprehensive and continuous treatment program. "The creation of the CLSC was the result of the restructuring of the health care system in Quebec after the introduction of Medicare. Its organization was based on the belief that diminished reliance on hospitals

as a primary care center would improve the link between professional health services and the community” (Foster, 1989, p.72).

CLSCs strive to promote practices that encourage user involvement, that facilitate the development of a holistic approach, that aim, through a universal and multidisciplinary approach, to raise the health level of its designated clientele in order to improve the social considerations of the individual and the community as a whole; and to encourage citizens to take responsibility for community problems and improve the community through its development.

b) The Role of the Art Therapist at CLSC Lac-Saint-Louis and Ensemble

The following discussion is summarized from the verbatim interview material that appears in Appendix C. Excluding Ms. Humber, combined there are three art therapists at Ensemble and at CLSC Lac-Saint-Louis. Two art therapists are employed by CLSC Lac-Saint-Louis and one by Ensemble.

The first art therapist to join the CLSC mental health team has a background in art therapy and social work. Ms. Humber (June 1999) explains that the position was not an art therapy position but:

Rather, it was a Human Relations Agent position, but we felt that we needed somebody who was really diverse, who could be creative, because we had a very limited service to offer. The person had to be able to work with an enormous range of clients, from teenagers up to the aged, people who could come in and say they have this ordinary life difficulty. In some instances, they needed a social worker approach and in some instances, it was much more of a straight art therapy

approach. Very often, it was somewhere in between, and it was just the approach that the professional we hired developed. (p.98)

Originally, the Human Relations Agent category, a unionized category, was intended strictly for people with a degree in sexology, psychology, social work, or criminology. The definition, according to the union, did not include art therapy, so it was the willingness of the personnel department to add a Master's degree in Art Therapy into the same category.

The second art therapist at CLSC Lac-Saint-Louis was hired to work with children and was given a specific mandate on prevention in terms of mental health issues. "So that mainly means that she is working with children which are at risk of developing mental health problems themselves, either because of particular conditions that they suffer or because they have parents who have severe mental illness" (Humber, June 1999, p.98). This art therapist received referrals from social workers in the CLSC, who are already working with families in difficulty. The assessment process not only looks at the symptoms of the child, but also investigates whether the symptoms are reflective of the family's problems. In some cases, the entire family may be followed in family therapy, in addition to their child being seen individually or in group art therapy. And lastly, the third art therapist works at Ensemble with people who have psychotic illnesses.

Ms. Humber stresses that the art therapist's professional profile in a public agency is not based on the individual's personal professional profile. An art therapist in a public setting must realize that professional responsibilities overlap into other areas. "It's very important in the professional development of art therapists that there is a realization that the training that you do, for instance in group or individual art therapy work, will only be

a part of a job definition. It's your discipline. A job definition, a job description however never stipulates that you just open your door see a client and then the client leaves- that's what you do in private practice. (p. 101)

In the public realm, Ms. Humber explains that professionals are hired because of the training they have in order to meet the identified needs of the client. "So when you are hiring people, as an employer, you are not concerned with preserving the identity of the worker. That is simply not the thinking" (p.100)

When working in a public agency Ms. Humber states that sixty percent of the professional time is spent actually working with the clients and the other forty percent is spent doing a variety of things that have to do with such things as administration. Ms. Humber explains that in the CLSC Lac-Saint-Louis, the art therapists on staff have become very implicated in the ongoing work in the CLSC and through this involvement, their profile becomes much larger. "People see them not as just clinicians but as a whole part of the social fabric, and of the fabric of the institution itself. They have a role in shaping the vision of the institution" (Humber, June 1999, p.102).

When Ms. Humber was questioned as to whether art was used as therapy or as psychotherapy, Ms. Humber replied that she thought it was a "false question." "I'm an art therapist and there are three other people here that are art therapists and I would find it impossible to squeeze myself into any one of those boxes"(p.102). The art therapist's orientation starts where they were trained, however Ms. Humber (June 1999) states:

But they must, if they are going to be in the workplace realize that's just the beginning. It's a wonderful springboard and they have to follow their own lead. I mean if they are more interested in creativity-based or more interested in

psychotherapeutically based work then they will move in that direction. In the public domain, I know that I couldn't hire somebody who was not able to work within a broad range. I could not because we have a range of clientele to serve and art therapists as professionals have to meet the range of clientele, just the way any other profession does. (p. 103)

Additionally, flexibility of approach is vital if one is to be sensitive to the client's needs. "So the same art therapist who may be using almost primarily words with someone, with images just somehow adjunctive to the words, could with the next client, or with the next group immerse people very significantly in an art process, where in fact there is a significant product arising, whether it's a painting, a sculpture, or a group mural or any other artistic activity" (Humber, June 1999, p.103).

It is important to note that having three art therapists at a CLSC Lac-Saint-Louis is unique and not common to any other CLSC that the author is aware of. The author hypothesizes that Ms. Humber's authoritative position in the CLSC and as a trained art therapist may have helped create an entryway for other art therapists to follow. This is illustrated by the expansion of the job definition category of Human Relations Agent to include professionals with a Master's degree in art therapy.

c) Service Provision and the Client

There is no one-size-fits-all category for people who need mental health care at the CLSC Lac-Saint-Louis and at Ensemble, for clients are involved in their service planning, services are individualized and tailored to individuals needs. The therapist's

mandate in the CLSC and Ensemble is to follow the client's lead, and use the art therapy accordingly.

Clients are referred to the CLSC in two different ways. Teenagers and adults call the CLSC directly and first meets with an intake worker before working with the art therapist. Ms. Humber (June, 1999) explains that:

The intake worker tries to see, dependent on what the client has asked for, whether the client would be someone who might find art therapy useful. If the client is assigned to the art therapist, the art therapist doesn't start with the premise necessarily that she is doing art therapy with the client.... She will use her professional judgement of what's being presented, to decide or suggest that people move in a certain direction. (p.106)

For the art therapist working with children, referrals are accepted from social workers in the CLSC who are already working with families in difficulty. As well, the general public is aware of the services offered and call directly to inquire. In the latter case, the client still has to first meet with a social worker who does a family evaluation prior to referring the child to art therapy.

At Ensemble, eighty-five percent of the clientele are referred directly from the hospitals. These clients are not referred expressly for art therapy, but rather for the comprehensive day treatment program. An intake worker assessment is first conducted, which entails a long comprehensive semi-structured interview. Clients are assessed and served primarily by their actual identified needs (psychiatry and general) rather than on their diagnosis. The intake assessment person then presents the case to a multidisciplinary team of which the art therapist is a part. "Art therapy may be a part of what has been

assessed as a need. If there is a sense that some kind of therapy, whether a verbal or group or art therapy group, is recommended for the client, then the art therapist or one of the other therapists does a further evaluation for therapy” (Humber, June 1999, p. 105).

The issues of continuity of care and consumer involvement in treatment are addressed by Ms. Humber when she views her opinions on case management. Ms. Humber (June 1999) recounts that a couple of years ago there was an open forum at Ensemble for clients and staff to talk about the agency, during which time one client stated:

“Well, first of all I’m not a case and you are not my manager.” I thought that was exquisitely worded. I know that if I have need of a service somewhere, lets say, I have to have my appendix out, I don’t like the idea that I’m thought of as a case. I like that I’m thought of as a person. I’m not just bed number sixty-six with appendix on Tuesday. I’m more than that. (p. 118)

The CLSC has done work with other agencies on the West Island in developing a new more human case management model. The CLSC presents the concept that the client should identify the person they wish to have as the case manager. “So in our model that we developed, it could be the parent of someone with a mental illness, it could be a friend. So what we do now is include the client and the key person identified and everyone else who is included, in giving service delivery to that person” (p.118). Hence, people involved in giving services are also involved in supporting the case manager because if the case manager is a friend that the client has identified, then the agencies must be willing to work with that person to inform him or her about the availability of services and how to gain access to them.

Essentially, case management does not occur without the implication of the client and the choice of the client being involved as much as possible. This system of service delivery touches upon the issues of continuity of care, individualized planning and client participation in the service delivery. To the author, this model of case management in theory at least implies a guaranteed communication between service providers, service providers and case managers, case managers and clients. Achievement of this is not always easy for it implies that a solid linkage system between different agencies is established, that each agency has defined what domains they cover as well as indicating an ability to work collaboratively. In the past, and as been stated earlier, lack of inter-agency linkages has led to a system, which is fragmented, disorganized and inefficient.

d) Funding

Ensemble and CLSC Lac-Saint-Louis, both non-profit community organizations, are funded on a recurrent basis by the Regional Council in Montreal. Recurrent funding implies consistent funding, meaning that there is no danger that in two or three years funding could be withdrawn. However, on the down side, this type of funding dictates mandates for the mental health community center. Essentially, how the money is spent is controlled by the funding body, which is unlike the smaller community groups who have non-recurrent funding but are given more leeway and fewer mandates. Ms. Humber (June 1999) states:

The Regional Council for our territory, the island of Montreal, region six, determines what CLSCs get and what non-profit community groups get. They do their studies every year and they determine who gets what funding. So funding is

not something that you have very much control over. Occasionally, the Regional Council as an outgrowth of some kind of Ministerial directive will say, "O.K. we're going to put more emphasis on the next so many years on youth or on the aged or home care," and they will say to certain agencies, "Fine, you now have to also do this service and that service and here's the money for it and you have to do it." (p. 111-121)

Lack of control over how funding is spent has effected the art therapy programs. Ms. Humber explains that one of the visions for Ensemble was to offer a larger range of creative art therapies, yet due to fiscal restraints and directives from the Regional Council, this, as of yet, has not be actualized. "We've managed occasionally to hire a music therapist on a contract basis and we once had a drama therapy student who volunteered and we put on a production. But, you know we haven't been able to go further; the funding has not permitted us" (Humber, June 1999, p.99). However, through a funding program that the federal government has for summer positions for student art therapists, the CLSC has been able to hire students. "This is one of the creative ways that we've tried to give students a chance to develop a little bit more of their professional side of themselves in the workplace. It also enables us to expand the program that we give to the clients" (p.99).

e) Treatment Programs

CLSC's, in general, have the mandate not to do long term work because they are meant to be what is called, 'front line services.' Clients, on average, are seen for three

months. CLSCs are often the first place that, for example, a family or a couple comes with a problem. However, Ms. Humber (June 1999) states:

So, depending on the need of the client, we can make arrangements. The mental health mandate for CLSCs tends to be about six months, rather than three and that average range applies again because some people don't need six months and don't use it. So even there, there are people who come in for three months and some people who come for a year. That's our range. (p.107)

The art therapy program for children, runs for the duration of the school year, and additionally an eight week program is given in the summer. For Ensemble's psychiatric day treatment program, the mandate for treatment is for six months up to a year. However, once again, because the treatment is very individualized the possibility is open for a client to stay in therapy for another additional year.

The services offered at Ensemble are comprehensive. A client could be in a variety of groups, in one of several kinds of services and many clients are in them concurrently. Examples of services offered to clients are, 1) groups designed to increase assertiveness skills and motivation, 2) challenge outdoor outings groups, 3) nutrition groups, 4) community kitchens, 5) some clients are assigned a community worker who actually goes places with them in the community, for example helps them to go to the 'Y' and the library, 6) clients could be in a networking group in the community and lastly, 7) job search groups specifically for people with mental illness.

Additionally, a whole range of skill-based groups run by volunteers who teach such things as computer training, woodworking, and arts and crafts are offered. At Ensemble, art therapy is just one component in the treatment plan for clients. At

Ensemble, the entire person is taken into account. However, although community mental health facilities have a function to help and support the client throughout their illness, there also exists the responsibility of the worker to assist them in their integration into the community. Ms. Humber (June 1999) elaborates upon this and explains that:

I think the whole community-based thinking is interesting. I think the move to community-based services, while initially more humane than the institutional approaches, also has it's own dehumanizing aspect. At the start instead of people with psychiatric disorders living in an institution, they were off somewhere in the community, in another type of housing still with walls around them that keep them all together in one place. That was a move, it was a positive move we said, "Great people are out in the community and they are getting supportive housing and they've got workers who help them integrate into the community." However, there was a bit of fallacy there, because if you truly are talking about changing the myths of mental illness, if you truly are talking about integration or reintegration into a community, if you are truly saying that psychiatric illnesses are just one illness among many that anybody could have, then people ought not be housed in another institution. They shouldn't ultimately be housed in a community-based institution either. (p.108-109)

Ms. Humber signals the need to be aware that community mental health care programs should not foster a dependency of clients on services provided for them. Ms. Humber says that one of the objectives at Ensemble is for clients to be reintegrated into the community (to varying degrees) by the time they have finished their treatment. By this, Ms. Humber means that they should be involved in other services in the community

(i.e. the library, recreational centers, art classes, etc.) and not only involved in other psychiatric agencies. Ms. Humber (June, 1999) goes onto further elaborate:

So one of the aims of the treatment center is not only to help people adjust to their illness and learn how to manage and develop their social relationships and coping strategies, abilities and skills but also to demythologize both on the part of the client who often has not felt safe except in a psychiatric milieu even though it is out in the community and on the part of the community itself. To get beyond this, to say your illness is just like any other illness and you have a place in the community. So there is work on both sides, for the community to not see you as someone who is different from everyone else and there is work with the client for them not to see themselves as different from everyone else. So that's one of the important aspects that the community has to worked on. (p.109)

To conclude, Ensemble encourages their clients to transpose the interrelational skills that they acquire in the center to other relationships that they have outside the setting. The center acts as a bridge that links clients with society. The ideologies of community care are central to the mandates at both the CLSC and at Ensemble, as they provide a real opportunity for reintegration into the community for clients.

f) Assessment of Care

Both the CLSC and Ensemble conduct assessments of the quality of their services. For example, in Ensemble there is a policy of sending out every six months to an anonymously picked group of clients, a survey of the services that they have received. The CLSC has a similar policy, as it has an ongoing client survey process. These surveys

are indicative of client satisfaction yet, do not inform the center about the efficacy of the treatment. Therefore, in addition, at the close of groups, clients give further feedback on how they benefited from the group. "When they are actually discharged from the program there is another form that they complete. The main worker plus the client examine what the client feels they got out of it, what they liked what they didn't like, what helped and why. So that's a lot of canvassing of the client to get their perspective" (p.112-113). This sense of self-monitoring is extremely important when it comes to service planning. As previously stated, one goal of community care is to ensure that a continuum of services is easily accessible and available to meet a broad range of individual, therapeutic and support needs. Recognition that the involvement of the service consumers is an essential part of planning and developing services which will meet their needs. The experiences, values and personal goals of the individual patient is acknowledged in the planning process (Heissen et al, 1995; Sartourius, 1992). Ms. Humber explains additionally that:

At Ensemble, we've just started to move into doing some actual outcome research. Outcome research is very hard to do (i.e. you do something pre and post around the administration of a particular service). It's unyielding. It takes an enormous amount of time and the tools and the instruments are not very precise.... We've had three different times where we have had people from the outside come in and do a combination of the program evaluation, whether it's interviewing staff, looking at the structures that we have, meeting with people in the community, other agencies in the community and also clients (p.113).

g) Gaps in The Mental Health Care System

The author questioned Ms. Humber on whether she felt that the deinstitutionalization movement was successful, essentially if people who had been deinstitutionalized were being taken care of in the community and whether she felt that there were many individuals out in the community who really should be hospitalized. Ms. Humber (June 1999) expressed that she has seen a real evolution within community-based mental health care, within the last eleven years and states:

Well, I think that there has been a huge change. If you had asked me the question eleven years ago I would have said yes, but you are asking me the question now. I think the evolution of community-based services is just fantastic. I mean, in this area of the island, we have fantastic collaboration among the community agencies. We've worked very hard, through some very difficult times, to be clear about each of our own mandates so that we aren't stepping on each others toes but that we aren't having any client fall between the cracks. (p.115).

It appears to Ms. Humber that agencies are working together collaboratively. That the role of general psychiatric units, psychiatric hospitals and community support services and programs have defined their domains and are able to work cooperatively and develop inter-agency linkages. Additionally, community-based services seem to have increased to meet the needs of people who have been deinstitutionalized. As an example, the community has developed what is called intensive PACT teams in the community.

They follow clients in the community who would be just simply not clients for any other kind of service....These are clients who must be seen in their

homes....They do medication administration daily if needed. I mean it's a very intensive community following. (Humber, June 1999, p.115)

The community also has other kinds of community agencies that do a once-a-week following, as well as having outpatient department clinics at the hospitals, occupational therapy, job search programs specifically for people who have had psychiatric disorders, CLSCs and drop-in agencies. There are church supported apartments for people who have psychiatric disorders, as well as "mobile teams" that can see people twenty-four hours a day if needed. These mobile teams can go out to clients in the community to help diffuse situations that would have potentially sent someone to the emergency department. In this region of the city it appears that there are a lot of different community services which meet various kinds of needs. "There is no one way in the community. There has to be a lot of ways" (p.116).

Although Ms. Humber feels that the community is equipped to care for its clients in the community, this does not negate the fact that institutional care is still required for some individuals. Ms. Humber (June, 1999) elaborates:

Are there groups of people who perhaps will always need a very closed kind of care? I'm sure there are. I mean there are some people who live in institutions and I think that there is probably a small percentage of the population that does need that kind of enclosed care. These are people who have to be cared for, looked after with enormous compassion. So I think that at the other end, for people who need that we really should be looking into how we provide appropriate compassionate care for people who need that kind of being looked after (p.116)

Ms. Humber identifies a need for more housing as a gap in the mental health care system. Housing for people with psychiatric disorders are often grouped together, which creates smaller institutions and “ghettoizes people.” Ms. Humber favors the “normalization model” in which there is housing in “normal” apartment buildings. “Where the people in there are getting some extra support according to their specific needs” (p.116) Additionally, Ms. Humber (June 1999) feels, “I think there is much to be done in terms of the attitude of people. People are still not comfortable a lot of times to say that a family member has a major mental illness. The person is not necessarily comfortable themselves. Employers still are prejudicial to some extent. You know we have a lot to do in society” (p.117).

h) Art Therapy’s Future Role in Community-Based Mental Health Facilities

When the author questioned Ms. Humber (June, 1999) on what she perceived as the unique qualities that she perceived that art therapy brings to the client, to the team structure and the community at large, she states:

I think you are probably aware of this in the work that you have done but we’re still at a time in the development of art therapy as a profession where clients and other professionals will sometimes diminish what the potential is. You can’t blame them because they don’t have a clue. But, they kind of say, “Just art, how can art be helpful?” We are in a society where art doesn’t play a great role in the lives of a lot of people. If we would go back two hundred and fifty years ago, whether it was high art for a certain social strata or decorative arts for people of another social strata, art in some way was very often much a part of the lives of

almost everybody. Music was a part of the lives of the richest and the poorest.

The arts were more in everyone's life every day. I think one of the things that the art therapist carries is not just how art can be therapeutic but the whole bigger issue of where does engagement with art either as a doer or as an observer and enjoyer of it, where does that even fit into people's lives? (p.119)

Art therapy is extremely powerful especially because it finds its roots in the very basis of culture itself. And for this reason, it is not surprising that people with mental illness have instinctively responded to it as if it were a natural process. Art therapy creates an environment that allows their innate creative and imaginative potentials to be brought out (Gregoire, 1989). Art therapy's expansion into deinstitutionalization setting is a natural outgrowth of an expressed need by clients and patients for access to a creative means to explore their experience. Ms. Humber (June 1999) states:

A lot of the people, who come for the individual requests for therapy at the CLSC, seem to experience a lot of emptiness. That didn't use to be the case when people went to therapy. There's this sort of feeling of "I don't have much meaning" (p.119).

Ms. Humber identifies that the art therapy process has the special qualities to awaken or enliven a place in people where the importance of the symbolic, the importance of the nonverbal gets touched. Ms. Humber feels that there is a role for art therapy almost as a "societal therapy." She stresses that art therapists need to realize that they have a role to play in healing society and to introduce art into people's lives from a preventative level.

I could see workshops in art being done in businesses, in the communities; I see art therapists having a role....Art therapists went into this discipline in the first place because we believed in the power of art to change, and that change can be on an agency basis, it could be on a community basis. So I think we are people who believe in that quality of art and we develop our expertise to apply that in any one of a wide range of things....I think art therapists have to use all their creativity and again not to feel boxed in by the institutional model. Interestingly, we've moved the client out of it, let's move the therapist out of it too (Humber, June 1999, p.120).

i) Conclusion

Treatment at Ensemble is comprehensive. The author feels that this program takes into account and addresses the biopsychosocial legacy aspect of treating people with mental illness. Care is accessible to the client in the three components that Feldman (1974) lists as, geographic, financial, and psychological. What the author found remarkable was that such a variety of services were offered under the roof of Ensemble, which epitomizes the accessibility of care. As well, the entire person is being taken into account, the biological, the psychological, and the social context of their environment. In both CLSC Lac-Saint-Louis and Ensemble the role of the art therapist has grown and is not limited to the individual's personal professional development.

2. Description of Expression LaSalle Community Mental Health Centre

Two interviews were conducted with Julia Olivier, the coordinator of Expression LaSalle. The first one was held on June 1, 1999 with an additional interview on June 11, 1999. Both interviews took place at Expression LaSalle Community Mental Health Centre.

Julia Olivier graduated from Concordia University with a Master's degree in Art Therapy in 1992 and received her professional registration as an ATR in 1994 from the American Art Therapy Association. Ms. Olivier has been the coordinator of Expression LaSalle since 1993. The following discussion is summarized from the verbatim interview material that appears in Appendix D.

a) The History of Expression LaSalle

During the 1980's (the second wave of deinstitutionalization), a lot of criticism was generated surrounding inadequate resources to support people in the community. The government's response was to conduct marketing surveys and advisory committees were formed. The advisory committee would conduct a survey of what was in place and what the needs of the community were, based on the users themselves or the people who were working with the user. In 1989, the government hired a coordinator, an art therapist, to be a part of the advisory team for the region of LaSalle. The results from the survey indicated that there were no walk-in type services in the community, which meant that people who had been deinstitutionalized had to travel outside the Southwest territory to access services. The art therapist on the advisory committee voiced her ideas about

implementing art therapy services in this region and, in 1989 the first groups were established at the Centre which was then called *Expression LaSalle centre d'entre aide*.

Expression LaSalle Community Mental Health Centre was created in 1990. It is a non-profit community-based organization with charitable status. The Centre was called Expression LaSalle because it is based on the belief that self-expression in all forms, whether it is through art, movement, drawing, music or verbal expression, is of therapeutic benefit.

A Board of Directors composed of participating members (users of the service) and citizens from the Southwest region of Montreal administers the Centre. Members make up the majority on the Board of Directors, for five of the nine people on the Board are users of the resource and the remaining four are people who are concerned, interested, or working in this sector of the city.

Expression LaSalle is funded mainly by the *Regie Regionale de la Santé et des Services Sociaux*. Citizens of LaSalle and neighboring communities who are between eighteen and sixty-five years of age are eligible for membership. Services are free and available in English and in French. Weekly group therapies are available according to varied schedules. Art therapy, dance and movement therapy, discussion groups, drama therapy, groups for incest or sexual abuse survivors, meditation and relaxation groups, music therapy, and writing and poetry workshops are offered.

b) The Role of the Art Therapist at Expression LaSalle

Besides Ms. Olivier, there is one other art therapist on staff. She has been with the Centre for many years, contractually, and is now a permanent part-time employee.

However, when Expression LaSalle receives non-recurrent grants, Ms. Olivier frequently hires art therapists for a duration that can range from six months to a year. As well, occasionally in the summer months art therapy students are hired. The permanent staff at the Centre is composed of a part-time psychologist, a part-time movement/dance therapist, and a part-time music therapist. Expression LaSalle also serves as a training center for students in related fields (i.e. social work, psychology, and the creative arts therapies). Art therapy forms the base of the therapeutic interventions at the Centre and is, as well, the most established and requested of the group therapies offered.

Art is used primarily as psychotherapy at Expression LaSalle. At one point, the Centre experimented with running more of a studio model of art as therapy, yet these groups were not as solicited by members who were more interested in the psychotherapy aspect. Additionally, Expression LaSalle has tried to put on exhibitions of the client's work but this concept has not been embraced by members either. "They adhere more to the psychotherapeutic model, that the art is confidential to the therapeutic holding environment" (p.127).

c) Service Provision and the Client

Clients are referred to Expression LaSalle through outpatient clinics at the Douglas Hospital, as well as through the CLSC network and other community resources. This referral base can be attributed to Expression LaSalle's promotion of its services to other agencies. Ms. Olivier states that the Centre has worked hard to market itself, for example, a seasonal flyer is sent to a mailing list of two hundred and fifty resources, indicating the available services offered. Expression LaSalle is involved in inter-agency

linkages and appears to have built a solid referral base through promotion of the Centre. This clear objective appears to have resulted in a good communication and integration of Expression LaSalle with other agencies. They have established links between the community centers and the institutions as well as with general practitioners, police stations, and other community resources that are not even associated with mental health care.

Group and individual sessions are offered at Expression LaSalle. Individual services are offered on a short term basis. "We offer twenty sessions to people and if they feel they need to have another twenty sessions, their name can be put back on the waiting list. We only provide three rotations, so it is sixty sessions in all. We are not in the business of providing free individual psychotherapy to people" (Olivier, June 1999, p.127).

Group therapy however, is offered on a long term basis. Ms. Olivier states that due to the recurrent funding the Centre receives from the government it has been able to provide long term support to people in the community. "We all go through life crises, life passages, for example, death, divorce. We, meaning you and I, are healthy and perhaps are more resilient going through them. Whereas, someone with a mental illness perhaps may not be as resilient and will need to have greater support through it. So, our groups are here to help chronically mentally ill people on a long term basis" (p.123). By offering long term therapy, Expression LaSalle has been confronted with a dilemma. In providing therapy for a long duration, space has become limited, which results in clients having to be placed on a waiting list. "I know people who have been here in groups for five years and you know, it became problematic. We have people on waiting lists who

want to participate but can't because we have people using the services on a long term basis. We've thought of putting time limits on our services, but we are supposed to provide long term support in the community to the mentally ill" (Olivier, June 1999, p). One of the things that Expression LaSalle envisions changing is the duration of services Ms. Olivier (June 1999) states, "We are trying to respond to the needs of the community and adjust to the financial realities of what the government is transferring "budget wise" to us" (p.142).

To compound this problem, over the last three years Expression LaSalle has experienced an expansion in the population of people with severe and chronic mental illness using their services. Ms. Olivier feels that the increase of this type of clientele has to do with the closing of services in the hospitals, the restructuring in the hospitals and channeling people towards the community for psychological services and support.

Expression LaSalle therefore is meeting the needs of the clients they see but consequently the waiting list grows along with the expanded population. Who is going to respond to the people on the waiting list who also need the longer term care and support? Ms. Olivier (June 1999) describes this situation as:

It's not managed care like in the United States, where therapy is terminated based on a term, like two years. We encourage people to stay if they need it and they want it. They are the ones to determine what they want and for how long. People do leave after one, two or three years. (p.123).

Treatment at Expression LaSalle is very individualized and based also on the needs of the group. "Our intentions are always based on people's pace and where they are at psychosocially. Even though we think they may need to work on an issue, if they are

not ready to we're not going to force them" (p.131). Expression LaSalle endorses an approach to treatment that places the control into the client's hands. Members chose which groups they want to attend, what they want to deal with at any given time and how long they need a particular group.

d) Funding

Funding of the Centre comes from the Regional Board, with no penalty to Expression LaSalle if additional funding is received by way of donations from foundations or other government departments, foundations or other agencies. "So we can do fundraising and receive donations through private corporations and things like that. We are a registered charity" (p.134).

Additionally, funding is supplemented via grants from the government. However, Ms. Olivier cites that grants can be problematic as they are offered inconsistently, are time consuming in their application process and directive in their mandates. As an example, if Expression LaSalle receives a grant for fifteen thousand it would have to be spent within a certain time frame (i.e. ten weeks to six months). Such restrictions put demands on Ms. Olivier (June 1999) to hire someone full-time for a short duration of time.

Whereas, I would prefer to employ a person part-time over a longer period of time, which would enable the Centre to provide more different types of services to the members, which is what they want. Our members have repeatedly said that they don't want short term interventions, nor do they care to deal with more loss when the therapist has to leave. (p. 135-136).

Although Expression LaSalle's budget has increased since 1994 from forty thousand dollars recurrent from the Regional Health Board to one hundred and thirty thousand dollars, this Centre still has issues caused by lack of funding. Difficulties arise concerning appropriate staffing and hence service delivery is effected. Ms. Olivier (June 1999) states, "We benefited to a degree, but to really run Expression LaSalle as it should be run, it's not one hundred and thirty thousand dollars that is going to respond to the needs. We have a budget to rent this place, but the facilities, if you look at them closely aren't adequate" (p.134).

Ms. Olivier explains that the government outlined in the Quebec Mental Health Policy recently their intentions to divide all mental health care resources into a sixty/forty ratio. Sixty percent of the budget is allocated for the provision of mental health services in the community (ambulatory services) and forty percent for hospitalization that provides ultra specialized and more acute care services. Ms. Olivier (June 1999) states:

If we are to assume an important role in the ambulatory health care services, then we also have to be recognized financially for what we are contributing. Frankly, I was very happy that we received an increase in our recurrent funding, however it certainly doesn't measure up to what we need. I need twice that amount to run this Centre, in order to pay all my staff in an equal fashion and to have good facilities to work in. We can't afford better facilities or else I would have to cut into the staff budget. (p.135)

One of the problems that Ms. Olivier expressed is that when you try to run a center that is catering to this type of clientele and working within a clinical model, you need to staff it with professionals. The professionals that Ms. Olivier hires want to be

paid in accordance with psychologists in the hospitals or the CLSCs. Ms. Olivier (June 1999) explains that:

Unfortunately, I can't pay that. I don't have the financial resources to pay people what they actually deserve. I think that community resources suffer the syndrome of being the "poor cousin." Historically, when community resources first came on the map, they were staffed with volunteers or people who were willing to work for eight or ten dollars an hour. I can't find people to work for that today. Even in the field of the creative arts therapies, people are expecting to earn twenty or more dollars an hour. When you consider the serious nature of the work that we are doing, and the very fragile people, who are sometimes suicidal and who have major difficulties in judging between their inner and outer reality, it only makes sense. There is a lot of testing of boundaries and ethical issues that come up. It's a major responsibility to commit to working with people like that. It's hard work and workers want to be paid what they are worth, as well as for the difficulty of the job.(p. 134-135)

Unfortunately, as a consequence, Ms. Olivier has lost staff to better paying jobs. Additionally, this situation is complicated for those who stay at Expression LaSalle where a sense of inequality is created between the people hired contractually, who receive no benefits, and those who are hired part-time or full-time with benefits. This creates hierarchical difficulties and implicitly affects the staff environment.

e) Organizational Structure

The organizational structure of Expression LaSalle is composed of combining the model of a community mental health center with a clinical model of psychotherapy. Ms. Olivier (June 1999) identifies this as a strength but notes that difficulties are inherent in this type of organizational structure. She explains:

When you have a center being run by patients, the good side is that you know that the money is being spent on services that they want. Their needs are heard directly in the Board of Directors meetings and the Annual General Assembly. Objectives are constantly being modified according to the needs of the people using the resource. In that sense it is very positive, it is very, grassroots which is exactly what a community mental health center should be (p.140).

Consumer empowerment is emphasized by the direct involvement of clients in service planning. However, complications arise when a clinical model is introduced. "If you look at the Centre's administration from a psychodynamic framework, it's potentially incestuous. I have a lot of roles and I interact with members, personnel, students and the Board of Directors, there are a lot more boundary issues to be handled as well as ethical ones in a psychodynamic model" (Olivier, June 1999, p.140).

This model poses many challenges to the traditional hierarchical system and codes. As an example, Ms. Olivier frequently supervises employees or students who are providing therapy to a Board member, who actually is her boss. So if an issue or a conflict arises, Ms. Olivier is not in a position to be as objective. To avoid problems, Expression LaSalle has set distinct definition of roles and responsibilities for the people on the Board, for example, Board members are not allowed to be in therapy with Ms.

Olivier. If they have been in the past, they must wait a few years before being on the Board, so as to make the distinction between her role as an administrator and as a therapist. “We are always careful to avoid conflict of interest situations as much as possible. Since there is a limitation in the funding, the members, the personal and myself ultimately find ourselves in challenging situations” (Olivier, June 1999, p.141).

Another issue that was born out of the combination of both a model of a community mental health care facility and a clinical model of psychotherapy are ethical considerations. For example, Expression LaSalle does not keep hospital type dossiers primarily because members on the Board of Directors have as much access to the files as the staff, thereby creating confidentiality issues. Ms. Olivier (June 1999) elaborates by stating that:

One of the primary mandates of community mental resources is to promote the empowerment of members, their decision-making practices, and their inclusion in the running of the place. Many resources do this by allowing its members to volunteer in the day-to-day functioning of the place (i.e. answering phones, running programs etc.). Yet since we have the strong clinical and psychotherapeutic component in our resources, we can not have a member doing volunteer work because that person would be exposed to names, addresses and telephone numbers of the other members who might want to have their confidentiality protected (p.141).

Ms. Olivier states that this decision was born out of the philosophy that clients have the right to privacy and to respect what they wanted to share during a session. Again, consumer empowerment is highlighted as forming the base of Expression LaSalle.

The power lies within the hands of the client, which, historically, has not been the case in institutional based settings where the power of authority lay with the psychiatrist. Ms. Olivier (June 1999) states that:

Additionally, a lot of people come in to our Centre with negative perceptions of psychiatry. They do not want to take medications and feel that psychiatrists don't take the time to understand them. Psychiatrists are frequently perceived as dictating to them what they should do. We, on the other hand, try to endorse an approach to treatment that puts the control into the person's hands. Member's choose which groups they want to attend, what they want to deal with at any given time and how long they need a particular group. (p.138)

Lastly, at the present time, due to fiscal restraints Expression LaSalle has no formal mechanisms in place to evaluate their services. However, evaluation of services are addressed internally via the Board of Directors.

f) Gaps in the Mental Health Care System

When questioned about what gaps Ms. Olivier saw in the mental health care system, she felt that it was difficult to evaluate because the mental health care system is in a state of restructuring. The Douglas Hospital has been undergoing a major restructuring internally therefore there has been a lot of shuffling of services and people. With the closing of hospitals, a whole new work force had to be trained to work in the community. People are coming into the community from qualified areas such as nursing, social work, and psychiatry. Workers are being transferred into the CLSCs and towards the creation of mental health teams in the CLSCs. Ms. Olivier (June 1999) explains that:

Then, in the Southwest region of Montreal, the Douglas Hospital has adopted a model of community care which is comprised of Sector Teams. Each CLSC sector (five in all) now has a “Sector Team” who is headed by a psychiatrist and provides case management and community follow-up for individuals who need it and have a revolving door syndrome tendency at hospitals. One of the problems right now is that the hospital has limited qualified people to work on these teams and an abundance of people that have to be retrained because they are not skilled to work outside the hospital walls....So, at this time, the partners in mental health are trying to create a new network of services that include the community resources, the CLSCs, and the hospitals working together in partnership. A three party partnership....We are slowly building a new network but have to work through lots of misconceptions about each other. Opening lines of communication and working complementarily is a main goal. I think that community resources have to really work at being perceived as serious and qualified to work with the clientele that is deinstitutionalized. The hospital isn't the expert any more. It's like a change of mentality that the entire community is being asked to do because the government doesn't have the money to keep people in the hospitals. (p.143-144)

It is hard to even identify what the communities needs are let alone evaluate how services are working due to changing policies. “Plus, how can we evaluate the benefits or the outcomes of the changes in services if there hasn't been enough time for the benefits to have actually been put into place properly and allowed to help people” (p. 133).

Ms. Olivier identifies a population in the community that is not being reached adequately due to the lack of continuity of care in the system. She explains that in the

hospitals the patients have everything they need under one roof. Yet, when these patients are discharged the situation changes for them and they need help being guided through the system. “We have noticed that when hospital workers physically accompany patients out into the community and to resources like ours that people that we thought would never stay, stay when this is done and they come back” (Olivier, June 1999, p.129). Even though Expression LaSalle puts a lot of energy into promoting their agency to others, on the whole Ms. Olivier identifies that the mental health care system still lacks comprehensive inter-linkage between agencies and continuity of care for people with psychiatric illness in the community. Ms. Olivier (June 1999) explains that:

When hospitals, like the Reddy Memorial or the Queen Elizabeth were closing, the staff was forced to take their patients out into the community and make those links. The ones who did come with the psychiatric nurse or psychiatrist stayed because there was that physical accompaniment. Someone took the time to walk them through it and discuss the impact....I think sometimes that’s missing. (p. 129-130)

Better inter-agency linkage is a priority in the mental health care system with a tighter model between community resources and the institutions, so that people who have been deinstitutionalized are not alone and isolated in the community.

g) Art Therapy’s Future Role in Community-Based Mental Health Facilities

Ms. Olivier feels that the creative arts therapies are exceptionally well-suited to the type of clientele that the Centre works with, for these therapies provide clients with an outlet to explore the anxieties and preoccupations inherent in living with a mental illness.

Ms. Olivier (June 1999) states that, “It really provides them with a privileged space and tools to explore how it is to live with anxieties and preoccupations they have because of their mental illness. It’s like we are not in the game to cure them, we are in the game to help them with it, to help them accept themselves, and to tolerate what is happening to them” (p.128). Additionally, the art acts as a social activity, which responds to breaking the isolation experienced by so many people with mental illness. Activities at the Centre create links with people like themselves and with whom they can share ideas and get support. As well as encouraging an understanding of the client’s pathology and symptoms. Through these efforts, the clients learn a tolerance which they may transfer eventually to creating healthy relationships in their community at large.

Ms. Olivier views art therapy as being powerful and of having a certain privilege during staff discussions, as art therapists have a concrete element to discuss. Ms. Olivier (June 1999) elaborates by stating that:

From a team point of view, we see when the music therapist talks about her group, unless she actually records what the groups has done, she is verbally talking about it, and there is kind of a bit of an interpretation of it. Whereas, when we bring in an art object, it’s very pure. Each member of the team can project onto it and see it differently, however it is still more of a pure product or expression of the person. (p.139)

The permanency of the art piece is also extremely powerful for clients especially when it is used as a reference point or as a visual record of the client’s process.

It’s quite astounding to see when somebody hasn’t done a review of their artwork and the first time they approach it, the impact they have. Like when you see a

piece of art every week and you come back to it and when you see it all laid and are able to look at some sort of evolution that's happened or a change or no change that's happened. It's awe-inspiring. It can be very overwhelming for a client. I think it's very empowering because it's a huge validation of who they are. It's like holding a big mirror up to themselves. (Olivier, June 1999, p. 140)

Ms. Olivier feels that the growing role of art therapy in community-based mental health facilities relies on art therapists being viewed differently by the mental health care system. The work art therapists do has to be recognized as *en par* with the quality of work provided in the institutions. Over the last ten years, art therapy has come to be practiced in a wide variety of settings in the community and art therapists have been in a process of proving to other mental health professionals that they are just as skilled, and qualified to work with people with mental illness. "We provide assessment and treatment interventions like psychologists and social workers, but we have the added tool- the art and the creativity" (p.144).

Essentially, art therapy's successful integration into community-based settings highlights the need to continually educate co-professionals concerning art therapy's unique use of the language of art as a vehicle of communication and self expression for clients and as a therapeutic tool for mental health professionals. From Ms. Olivier's experience it has been the simple act of doing art therapy which has led to recognition of the Centre. Ms. Olivier (June 1999) states that:

From my experience working at Expression LaSalle for the last six years, the best proof that art therapy deserves its place in the new network of services are the results. Many of our clients are followed by psychiatrists or psychiatric nurses.

Our members give them personal testimonies of how art therapy in our community center has helped sustain them, combat a crisis, prevented them from being rehospitalized, helped them better cope with their interpersonal skills, helped them better accept themselves. We have been winning validation and receiving recognition through individual and small successes with our clients....I would never have received that validation or recognition years ago. They didn't know what art therapy was and there was no proof of how it impacted on clients. So I think the more that we are involved in the community and implicated, the more we will be taken seriously by other professionals. So I think that the more we are out there and seen *en par* with them, hopefully then financial recognition will come. Art therapy will be perceived as a viable option and not seen as a frivolous thing that should be axed first. (p.144)

With the continual impact of deinstitutionalized policies in the mental health care system more professionals will be entering into the community. With this influx, the art therapist must demand and secure the recognition that he or she deserves. The author feels that outcome research conducted on the therapeutic benefits of art therapy could play a role in legitimizing art therapy to other mental health professionals. As a growing profession we need to have research conducted on the effectiveness of using art therapy with this population not only for our own professional identity but to be able to promote art therapy in the community with a clear understanding of its benefits of working with people with mental illness.

h) Conclusion

Art therapy must obtain accreditation as primary therapy in its own right amongst mental health professionals, for without professional recognition art therapy will be the first area to be cut in times of budget restraint. Although Ms. Olivier states that recognition has been gained in the last ten years, it appears that further work has to be accomplished especially in terms of pay equity and funding for the smaller scale community centers.

Additionally, Ms. Olivier's perspective highlights, that the mental health care system is still very much in a state of flux and appears to be in a similar situation as Foster in 1989 described. Yet, it is clear that although within the last ten years art therapy has done much to fill a need in the mental health care system, it remains that art therapists are faced with legitimizing their role to other mental health professionals and gaining the recognition that they deserve.

It is important to note that Expression LaSalle is located in the same district as one of the last remaining provincial psychiatric hospitals- the Douglas Hospital. With its decreasing of services and downsizing of beds, it would be logical to assume that the Southwest region of the city is probably experiencing a greater shift and flux as services are redefining their domains and jurisdictions.

3. Description of Arbour Expressive Arts Therapy Center

Alice Hogg and Laura Goldberg were interviewed on June 11, 1999 at Arbour Expressive Arts Therapy Center, located in the Queen Elizabeth Health Complex. Arbour is a non-profit community-based center, which was officially started in 1997 by Alice Hogg, Laura Goldberg, and Stuart McIntosh the founding members. Stuart McIntosh has since relocated in Western Canada, leaving Ms. Hogg and Ms. Goldberg as the directors of Arbour. Ms. Hogg has a Master's degree in Art Therapy from Vermont College and Ms. Goldberg graduated in 1985 with a Master's degree in Art Therapy from Concordia University.

This interview was the shortest in duration and hopefully the center will not appear under represented in comparison to the two previous interviews. The reason for the interview length is due primarily to the fact, that at present, Arbour works with a population that has not been deinstitutionalized, even though the Center's mandate is open to help all types of clientele. Arbour's clientele consists mainly of individuals experiencing difficulties in interpersonal relationships. The author's choice to include Arbour in this research paper is based on an interest to investigate how this center operates within the community at large and the reasons that Ms. Hogg and Ms. Goldberg may perceive as to why the deinstitutionalized population are not utilizing their services.

The following discussion is summarized from verbatim interview material which appears in Appendix E.

a) Service Provision and the Client

From the inception of Arbour, it was clear to the directors that they wanted to establish more than a shared private practice. They wanted to create a center that supported and collaborated with other therapists in the community, as well as to offer a diversity of expressive arts therapies. Ms. Hogg (June 1999) elaborates upon Arbour's objectives:

One of the primary things we wanted was a place for clients to come and get services and for therapists to come and apply their trade and to not be so isolated. No matter where you go any private practitioner will tell you, that they feel alone. They say, "I have no one to compare notes with, and I don't have anyone to meet and join with." We were really hoping that therapists would be able to come here and do that with each other. But because everything else has been slow going, that's also been slow going. (p. 154)

Ms. Hogg and Ms. Goldberg describe the spirit of collaboration as defining Arbour. As an example, if a referral comes in and the requested service is not available at the Center, Ms. Hogg and Ms. Goldberg will network among people that they know to find an appropriate match for the client. This is accomplished either by referring the client or by trying to bring the appropriate therapist on board to join the Arbour team. This objective relates to the principle of networking among interrelated therapists to meet the varied needs of a diverse population. On a small scale, the principle of continuity of care is addressed as the directors help the clients receive appropriate care by guiding them through the system.

It is clear by Arbour's mandate that there is an understanding that responsible service delivery offers more than one modality or treatment approach, for clients have a variety of needs. Ms. Hogg, Ms. Goldberg, and the other therapists renting space at Arbour combined, have enough flexibility and diversity in treatment approaches to meet the needs of individuals. "Our mandate is wide open to anyone we feel that we can help. We now have four members, so between the six of us we have extensive experience with different populations" (Goldberg, June 1999, p.151). How art is used at Arbour again depends on the needs of the client, reflecting individualized treatment. Ms. Hogg (June 1999) describes that a sense of flexibility is inherent in terms of how the therapeutic benefits of art are used at Arbour:

I think we all pretty much work in a variety of ways depending on the clients that we have. There are two camps and most people fall in between somewhere that, art is therapy and that art can be used as a psychotherapeutic process. I am of the opinion, that art and psychotherapy are very much connected. But it all depends on the clients, some don't want something very insight oriented and there are some that are really just not ready for that. So we work at the pace of the clients.
(p. 148)

b) Art Therapy's Future Role in the Community-Based Mental Health Facilities

Despite Arbour's enthusiasm to collaborate with other therapists and agencies, this objective has been hard to achieve. Part of the problem identified by both Ms. Hogg and Ms. Goldberg is due to, 1) a resistance to sharing and collaboration within the profession of art therapy and, 2) a certain resistance to the creative arts therapies in the

community. These difficulties inhibit the full actualization of this community-based center to realistically address issues pertaining to effective continuity of care and accessibility of services. For in many ways, this center is just trying to survive, as the directors explain, “The top priority besides paying the rent, has been trying to get clients, trying to get other people to come here, to get the word out and let people know that we are here” (p.150).

Although collaborating with colleagues is essential to the growth of any professional field, Ms. Hogg and Ms. Goldberg feel that this remains a difficulty within the field of art therapy. In part, the directors attribute this to a lack of definition of the creative arts therapies. Ms. Goldberg states that even within the profession, if ten art therapists are asked what art therapy is, one will receive ten different answers. Ms. Hogg (June 1999) states that:

We are not a profession that’s as clearly defined as, “A is art therapy and B is not.” How many times has this article crossed my desk when I was doing all my studies (called Art therapy: What it is and what it is not). It’s a great article but I think it is pretty telling of where we are. We still don’t know what we are.(p. 153)

One of the members at Arbour said to Ms. Goldberg that another problem had to do with art therapy often not being seen as an recognized profession within the mental health care field. Ms. Goldberg (June 1999) recounts:

She (the member) was talking about an occupational therapist she knew who took one or two courses and then said, “I can do art therapy.” I (Laura Goldberg) was at a geriatric centre and when I began as their first art therapist I was introduced to the staff. A woman came up and said to me, “Oh, I didn’t know that they were

hiring another art therapist; I do art therapy.” I said, “You do? What’s your educational background?” She replied, “I’m a teacher but what I do is therapeutic.” She basically used to set up a still life for the residents and drew the outline for them and they would color it in. The Head of Rehabilitation called us both in for a meeting to set the record straight, “This is what you do, this is what Laura does, and you are not an art therapist.” But the center knew and loved her work because it was visible, framed, and hung everywhere. (p.152)

As a consequence, art therapists, Ms. Hogg says, are very protective of the jobs they have been able to cultivate. “In order to protect it people tend to not want to share. There is certain amount of territorialism. It’s not always very negative but sometimes it is and that can be a detriment”(p.152) Marketing art therapy in the community has also been a difficult undertaking, which has been met with resistance. Ms. Goldberg recounts when she graduated from Concordia University in 1985, the then faculty told the graduates that they were going to be pioneers in the field of art therapy, and that it was up to them to get out there and create jobs and educate people. Over the last ten years, Ms. Goldberg feels that she has done a lot of marketing of art therapy through presentations at universities and conferences, yet still finds a general lack of knowledge about what the creative arts therapies are in the community. Marketing can play a role in helping to educate people. “However, the problem with that, I think, is that I say this a lot, I feel like I’m preaching to the converted. I’m telling people all about art therapy who say, “Yes, yes, it’s so wonderful” (Hogg, June 1999, p.152). For all the marketing that Arbour has done with various hospitals and agencies, building a referral base has been difficult and slow coming. There is a great need for Arbour’s services in the community, even though

referrals have been difficult to obtain. Ms. Goldberg identifies for example, that people who are living with diabetes are in need. Ms. Goldberg (June 1999) explains that:

As another example, one population that needs help are diabetics who do not get the support they need. I networked and I went to all the major clinics, hospitals, eye clinics, centers, and pharmacies and met with the doctors and with diabetics in order to get referrals. I ran two groups, one which had four people and the other had five. I had someone in the group who has been diabetic for sixteen years and she said, "I'm still angry." One of the members said, "After sixteen years, you are still angry?" and she said that she was stuck in that anger. She stated that this group was an oasis because there was no where else that she can talk about these things, she felt that no one understands. So I know there is a need for this kind of work. Most doctors are reluctant to refer their patients. I've gone to the open houses at the Royal Victoria and the Jewish General hospitals at the diabetes clinics, to show what my work has consisted of and to meet the doctors and nurses, it's been slow to get going.(p.152)

Even though Ms. Hogg and Ms. Goldberg identify a need for their services in the community, securing the role they can play has been difficult. Ms. Hogg (June 1999) states that, "There are so many tried and true methods that have been around for decades, even centuries" (p.152) When art therapy is placed up to the "tried and true" methods of other therapeutic modalities, it seems to falter. Ms. Hogg (June 1999) attributes these difficulties in part to the state of the mental health care system.

I think the interest has been there for a long time but we live in a province, a country, which really supports health care for very little cost. They are doing

cutbacks everywhere and I still think that people find the concept of free health care very hard to let go of. None of the expressive arts therapies have ever really been considered mainstream, so you always had to pay for those....A lot of people are out on the street looking for something to do, something that makes them feel useful and contributing but the services have not been established yet. That is among the things we would like to do, to be there for that. But all of it is a very slow transition and just when people are starting to get used to that idea, we end up with more cutbacks, which means people are going to have to choose, are they going to pay for therapy, pay for their pills or pay their rent and buy their food. (p.149-151)

Ms. Goldberg (June 1999) feels that now, fifteen years later from the time of her graduation, that the profession is still at a stage of infancy compared to a lot of the other social services that people run to first and foremost and elaborates by saying that:

As far as I'm concerned, I think the profession is still at that level of being pioneers and trying to educate people and have it accepted. Those of us who practice art therapy and for the few that actually come and take art therapy all know how great it is. We all know how well it works, that there is nothing in the world like it. But to let people know exactly what it can do, how deep it goes and what it brings out, that process is difficult.(p. 149)

c) Funding

Compounded with the difficulties already presented, a small privately run center such as Arbour struggles financially. Arbour is non-profit and does not receive any

government funding. "The way the system goes is, that's it's hard to get funding when you are only non-profit. You really have to have charitable status. So that is our next step, but it takes a lot of money, time, and energy. It's expensive to get charitable status and it's not easy" (Goldberg, June 1999, p.150). Since both directors of Arbour have jobs outside the center (essential to supplement their income), they struggle with not having enough time to put into the center making it increasingly difficult to apply for charitable status. "We have spent pretty much all of our extra personal energy making sure that the business floats but up until now we really haven't had the time to be here on a regular full-time basis" (Hogg, June 1999, p.149)

d) Conclusion

Due to Arbour's private status, therapy is not free, which unfortunately excludes the deinstitutionalized population as they are often on disability or welfare and are not in a position to financially afford private therapy. The author feels that attempts to overcome this are achieved by, 1) by gaining charitable status and which make the services free of charge and, 2) continuing public outreach and promotion and education of the creative arts therapies, will hopefully result in more clients and contractual work with organizations. Outcome research conducted on the benefits of art therapy could play a role in legitimizing art therapy with other mental health professional, the community at large, which would as a consequence strengthen the art therapist's professional identity.

CHAPTER V

Future Development of Art Therapy in Community-Based Mental Health Facilities

Along with deinstitutionalization, art therapy has experienced a simultaneous shift from hospital-based care to community-based care as formerly institutionalized people are released into the community. This research paper has examined how art therapy has been integrated and implemented in community-based mental health facilities, through the assessment of three such centers that of, 1) CLSC Lac-Saint-Louis, 2) Expression LaSalle Community Mental Health Centre and, 3) Arbour Expressive Arts Therapy Centre. This research paper explores the complex and challenging set of problems created in the mental health care, as well as the unique challenges that art therapist's face within this deinstitutionalized setting.

Bachrach (1997) states that the deinstitutionalization movement has provided us with a biopsychosocial legacy, which implies that the interaction of biological, psychological and sociological events affect the lives of people with mental illness. Essentially, human beings do not experience their illness in a psychological or sociological vacuum, and service planning must recognize this. Now as we enter the fourth decade of the deinstitutionalization movement, we have a history to reflect upon, for we have learned that service delivery which fails to acknowledge the biopsychosocial realities of people's lives is incomplete, inappropriate and at best only marginally successful (Bachrach, 1997).

Although the deinstitutionalization movement has demonstrated that indeed community care may be more humane and therapeutic, this is only achieved when certain conditions are met. Included among these necessary conditions are: an understanding of

the need for individualized treatment, accessibility of services, continuity of care, communication between service providers and service providers and their clients and flexibility in the systems of care.

Chapter Four has outlined how these three community-based centers have addressed the preconditions necessary to ensure more humane and therapeutic community care. The three interviews form an interesting spectrum of art therapy community approaches, from Ensemble with an established and somewhat secure foundation with its liaison with the CLSC, to Arbour which appears to be in survival mode. All three community centers, the author feels, have demonstrated an awareness of the necessary factors required to implement responsible, humane and therapeutic service delivery in their centers, however, the determining factor that appears to facilitate this quality of care is based upon the financial standing of the center. For this reason, CLSC Lac-Saint-Louis and Ensemble, which experience the most financially secure foundation in the community, are best able to implement and address the factors necessary to achieve a continuity of care in their service delivery. Whereas, Expression LaSalle and Arbour, who have experienced lack of funding, have felt a significant reduction in the quality of services delivered.

These three community centers have illustrated that art therapy has helped to fill the vacuum in community-based care created by the deinstitutionalized movement. In a recent AATA membership survey, it was found that the majority of art therapists continue to work in the realm of psychiatric and other mental health problems (LaBrie & Rosa, 1994) indicating that art therapists do play a major role in working with a deinstitutionalized population. Essentially, art therapy has established itself in the

community and opportunities continue for art therapy to thrive and meet the diverse needs of the uncertain and less structured environments found in the deinstitutionalized setting. Bachrach (1989) states that, "It seems as if deinstitutionalization has given us the potential for improving services. We can now offer many programs to patients that are more relative, more imaginative and more responsible to their specific needs than what was offered to them in former years" (p.65). Mental health workers and providers are continually making progress in identifying the needs in the community in order to ensure that chronic mental patients, living in the community, are being cared for appropriately. With the changing policies and continual restructuring of services, both in the institutions and in the community centers, it is up to the art therapist to continue to secure their established position and to demand the recognition for their profession as a viable therapy for working within the deinstitutionalized setting.

Art therapy itself is not only a viable, but also, a versatile therapeutic modality. Since Foster's (1989) research ten years ago, art therapy has come to be practiced in a variety of settings in the community. Gregoire (1989) explains that art therapy is extremely powerful especially because it finds its roots in the very basis of culture itself. And for this reason, it is not surprising that people with mental illness have instinctively responded to it as if it were a natural process. Art therapy creates an environment that allows their innate and imaginative potentials to be brought out. Art therapists' expansion into deinstitutionalized settings is a natural outgrowth of an expressed need for access to a creative means to explore their experience.

This chapter summarizes the primary issues that art therapists now face within community-based mental health facilities. Two issues, those of, 1) the financial standing

of the community-based mental health facility and, 2) the professional identity of the art therapist and hence, public recognition of the role art therapy plays in community mental health are highlighted as they pertain to art therapy's continued growth in community-based mental health facilities.

The following discussion is summarized from verbatim interview material, that appears in Appendices C (Humber, June 1999), D (Olivier, June 1999), and E (Hogg & Goldberg, June 1999).

1. Discussion

These two issues, that of the financial position of the community center and the professional identity of the art therapist, are separable only in theory. The following discussion reflects a real sense of this intertwining. For, where there is greater financial security, the quality of services and staffing is higher, resulting in more efficient interagency linkage, public awareness of services, referrals and promotion of services. These factors implicitly effect the recognition of the role the art therapist plays within the community, with increased credibility and validation of the profession.

Art therapy has been implemented in each of these three centers quite differently. At CLSC Lac-Saint-Louis, art therapy is but one of several therapeutic modalities available to the client, whereas at Expression LaSalle and Arbour, art therapy forms the base of the available therapeutic modalities. In addition, with the different approaches through which art therapy is implemented, all three interviewees saw the present and future role of art therapy in community-based mental health facilities differently, as well as the factors that are necessary to ensure its continual growth.

Ms. Humber (June 1999), from the CLSC Lac-Saint-Louis and Ensemble, identified the need to expand or branch out beyond the preconceived conceptions that we have about art therapy. She states, "I think that art therapists have to use all their creativity and again not to feel boxed in by the institutional model. Interestingly, we've moved the client out of it, let's move the therapist out of it as well" (p.120). It is interesting that this point of view is expressed by Ms. Humber specifically, for it is the author's impression that art therapy and the art therapist's professional identity at CLSC Lac-Saint-Louis and Ensemble is quite secure and established within the safety of this larger facility. Is it for this reason that the use of art therapy and the role of the art therapist has been able to flourish and is now ready to expand?

Treatment at Ensemble is comprehensive compared to Expression LaSalle and Arbour. The author feels that their program take into account and address the biopsychosocial legacy aspect of treating people with mental illness. The CLSC and Ensemble also stand apart from Expression LaSalle and Arbour in terms of funding issues. It is the facility that receives the highest government assistance and has been able to provide accessible care to the client in the three components that Feldman (1974) lists-geographic, financial, and psychological. In both CLSC Lac-Saint-Louis and Ensemble, the role of the art therapist has expanded and is not limited to the individual's personal professional development. Ms. Humber stresses that the art therapist's role in a public setting should overlap into other areas and as this is practiced within the setting at the CLSC, a larger profile has been created for them. In many ways the CLSC is the closest representation of institutional care in the community as a variety of services, such as

social work assistance, general practitioners, home care services and psychotherapy are all available in the same dwelling.

This is not to say that the CLSC does not experience the effects of shortages of funding, for Ms. Humber explains that she would like to implement more creative arts therapies modalities in the treatment program at Ensemble, but as of yet has not been able to due to fiscal restraints. However, the CLSC is still unique and fortunate as it is able to nonetheless employ four art therapists.

In both Expression LaSalle and Arbour, there is the sense that the art therapist's professional identity is insecure and not as well established which is quite the opposite experience in the CLSC and Ensemble. As art therapy forms the base of the therapeutic modalities at both these centers, they struggle to promote the creative arts therapies in the community and to educate co-professionals concerning art therapy's unique language of art as a vehicle of communication and self expression for clients and as a therapeutic tool for mental health professionals.

Ms. Olivier, at Expression LaSalle, feels that any growth in the role of art therapy in community-based mental health facilities will depend on art therapy being viewed differently by the mental health care system. Over the last ten years, Ms. Olivier has been in the process of proving to other mental health professionals that art therapists are just as skilled and qualified to work with people with mental illness, yet this recognition has been slow to come. From Ms. Olivier's personal experience at Expression LaSalle, it has been the simple act of doing art therapy which has led to recognition for the Centre and the profession. Ms. Olivier feels that with the continual impact of deinstitutionalized policies in the mental health care system, that more professionals will be entering

community settings. With this influx, comes the responsibility of art therapists to demand and secure the recognition that the profession deserves.

Expression LaSalle has been affected by lack of funding as they have been unable to staff their facility according to the needs created by an increase in the chronically mentally ill population utilizing using their services. Expression LaSalle is known for offering long term care and is caught in a dilemma as waiting lists are mounting and additional staff cannot be hired to fill this need due to fiscal restraints.

The restructuring of the mental health care system (and subsequent effects of, for instances, policy changes, mandates from the government, closing of services and funding) effects the smaller centers more profoundly. Arbour, the smallest of the community-based mental health facilities interviewed, has experienced difficulty with funding and having their services recognized within the community at large. In spite of all Arbour's networking efforts, forming a referral base, and getting contractual work has been difficult. This, in a large part, is related to the fact that they do not have charitable status as a community organization, something that CLSC Lac-Saint-Louis, Ensemble, and Expression LaSalle have. It is hard to obtain government funding but without it the burden of payment for services falls on clients who are often not in a financial situation to afford what Arbour offers. Attempts to overcome this are made by applying for charitable status and by continued public outreach, promotion, and education of the creative arts therapies. Hopefully this will result in more clients and contractual work with organizations.

Additionally, collaboration with colleagues is essential to the growth of any professional field, yet this remains a problem within the field of art therapy. In part, Ms.

Hogg and Ms. Goldberg attribute this to a lack of definition of the creative arts therapies within the profession. This could create frustration and the need to protect one's position, causing a lack of sharing between professionals. Ms. Hogg (June 1999) states, "We are still very much insulated. I think there is a lot that we do to break out of those ranks but at the same time we are very protective of our jobs, of what we have cultivated so far, and don't want to lose it. In order to protect it people tend not to want to share. There is a certain amount of territorialism"(p.152).

2. Conclusion

These three community-based mental health facilities have proven that integration of art therapy in deinstitutionalized settings is possible. They have demonstrated an awareness of the necessary factors required to implement responsible, humane and therapeutic service delivery in their facilities. It is important to note as well, that at this time there are other successful community-based art therapy programs operating in the community (i.e. Le Centre d'Apprentissage Parallel created in 1984) yet due to the delimitations of this paper they have not been investigated. The successes and limitations of the three centers that have been covered can also serve as models to be implemented elsewhere in deinstitutionalized settings.

In conclusion, the author feels that there must be solidification within the profession of art therapy. Once this is achieved, growth in the field of art therapy will increase and the sense of territorialism will perhaps diminish as therapists start to collaborate with greater ease. Randy Vick (1996) in an article called, The dimension of service: An elemental model for the application of art therapy states that:

Over a decade ago, Johnson (1984) challenged the creative arts therapies to focus on three important tasks: “ to articulate our unique contributions... to differentiate a wide range of professional roles [and] to provide the conditions for mature leadership” (p.209).

It appears that even a decade after Johnson’s challenge, these outlined tasks have not been mastered or achieved in their entirety, for the necessity to define the profession still remains. In the three community-based mental health facilities, we have seen how art therapy has played a vital and unique role in filling the vacuum created by the deinstitutionalization movement, yet new issues have arisen as art therapists are out working in the community. Art therapists need to solidify their professional identity as well as to continue to educate co-professionals on art therapy’s unique therapeutic role in treating people with mental illness. Until this is established, such issues pertaining to pay equity, and job opportunities, will be difficult to achieve.

It is important to note that this solidification of the profession takes time. Ms. Olivier states that her experience has been that recognition comes from the simple act of practicing and having the benefits of art therapy reach other professionals via common clients. In the province of Quebec, the population of art therapists is small in comparison to those in other mental health professions, i.e. social work, psychology, and psychiatry and the goals of solidification have to be realistic. Art therapy is in a state of infancy in comparison to the other mental health professions mentioned. This needs to be taken into account.

Research issues are important as well, so that the profession can have more clarity when choosing the appropriate therapy for the individual. With this comes a well founded

sense of art therapy as a complementary profession rather than as a competitive one. A built-in, ongoing, internal assessment mechanism that permits continuous self-monitoring for these community services is necessary with encouragement of service providers to evaluate the program in process. As well, process research needs to be accompanied by outcome research so as to clarify the type of art therapy practices best suited to a particular population. Program evaluation and research should be built into the fabric of ongoing clinical issues. However, as illustrated by the three community-based mental health facilities, funding becomes a factor in the implementation of these mechanisms.

Empirical research on the effectiveness of using art therapy with this population would not only improve the professional identity of art therapists, but also facilitate the promotion of art therapy in the community. Subjective claims from both the experience of clients and clinicians have signaled the power of art therapy. Nevertheless, the time has come for more objective measures to be implemented. The field must show that it is scientifically sound and that means research. Gantt (1998) an American art therapist in Discussion of Art Therapy as a Science states:

And it does not mean just basic research either. Managed care companies are basing their reimbursement policies and their treatment programs on empirical findings that demonstrate the efficacy of specific techniques. As one representative of a major behavioral health care company stated at a recent workshop on managed care, "In God we trust, all others must provide outcome data." (p. 3)

Generally, outcome research in the field of art therapy is lacking and this may be due to the problem that some art therapists have with the employment of this type of

methodology. Gantt (1998) makes a strong suggestion that art therapy is and must be “a strong blend of both art and science if the field is to develop further or have a standing among other professions or scholarly disciplines” (p.3). Outcome studies need to be accompanied by qualitative research as well. Art must attempt to coordinate research efforts so quantitative and qualitative researchers can work together to produce research reports that have the hard data that granting agencies seek, as well as to take into account what in particular art therapy can potentially contribute to the quality of life of the client. Additionally, as many comparative outcome studies of psychotherapies suggest there is not a large difference in effectiveness between them; with this it is up to art therapists to demonstrate the unique qualities that the use of art therapy has on the client. Lastly, the involvement of consumers of therapy as co-researchers is an area of research to attend to as well. These studies could incorporate quality accounts of persons who have benefited from art therapy, for example, the particular ways that this has occurred, the aspects that have worked well and not as well and the reasons for this, and lastly suggestions of how services could be improved from their perspective.

The combination of both quantitative and qualitative research in the field of art therapy will implicitly affect, in the long run, the financial funding of community-based mental health. Governments respond to objective measures of efficacy. With increased funding, art therapy will become more visible in the community and thus, be better able to promote its specialty, gaining recognition as a viable therapeutic modality. As art therapists begin to be seen *en par* with other mental health professionals, financial recognition will come. With better recognition of the field of art therapy, interagency

connection will develop and hopefully increase the entryway for smaller organizations like Arbour, or art therapists in private practice, into the mental health care system.

Footnotes

¹ The holistic approach highlights the role of the patient as an active and responsible participant in the healing process. Martha Foster (1989) states that, The patient is no longer the passive victim of a disease or the passive recipient of a cure. What is unique about this approach is its insistence that individuals have both the responsibility and the ability to influence the course of their illness towards health. The patient is encouraged to explore his own illness and the factors which affect his recovery and relapse.

² For the purposes of this paper, the factors leading up to the deinstitutionalization movement are briefly summarized. However, the author suggests for further research, A historical overview of art therapy since the advent of deinstitutionalization by Foster (1989), for an in depth investigation of both the definition deinstitutionalization and the factors that led up to its implementation.

³ For a more comprehensive inquiry into the third wave of deinstitutionalization and issues surrounding how to implement better service delivery, the author suggests reading, Bachrach, L. L. (1997) Lessons from the American Experience in Providing Community-Based Services. In J. Leff (Ed.). Care in the community: Illusion or reality? Chicester, UK: John Wiley & Sons.

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Appendix A

Sample question list from interview with Julia Olivier at Expression LaSalle

- 1. How was Expression LaSalle's art therapy program established or how did it come about that an art therapy program was introduced through Expression LaSalle?**
- 2. Have the services provided by Expression LaSalle changed over the years (i.e. addition of services, deletion of services)?**
- 3. Could you tell me about Expression LaSalle's mandate or philosophy? Essentially, what is your model of care?**
- 4. How many art therapists are there on staff? Are the art therapists on staff working primarily as art therapists or do their responsibilities overlap into other areas?**
- 5. What is the range of art therapy services that are provided (i.e. art as therapy vs. art as psychotherapy; individual, group and family sessions)?**
- 6. What population do you serve? In your opinion, is there a population that could benefit from art therapy but as of yet, has not been adequately served?**
- 7. How are client's referred to this community center? Essentially, what is your referral base?**
- 8. Is there a maximum time limit a client can participate in the services? Is it continual or is there a cut off?**
- 9. What have you found to be the average length of therapy per client?**
- 10. How are clients involved in their treatment objectives? Are their families consulted? Generally, what are the overall objectives of clients engaged in art therapy?**
- 11. Do you feel that your services are sensitive and relevant to the different cultures that you may serve?**
- 12. How you feel that the community uses the services of art therapy at large?**
- 13. Are clients who participate in the art therapy programs also, involved in other services at Expression LaSalle as well, or at different community centers entirely?**
- 14. How do you identify the needs in the community?**

15. Does the community view it's own needs differently? Does your mandate include outreach? How is that conducted?
16. How is this center funded?
17. How have changes in funding affected your program?
18. Why do you think that there has been a cut back in community mental health services? Where do you feel that the money is going? What can the community do to increase funding? What are your opinions and suggestions?
19. Who do you feel is your client (referred to in the broader context, i.e., the government, and the community, Board of Directors)? Who are you really responsible too?
20. What do you see as the strengths and limitations within this center as it is presently operating? Essentially, what aspects of your service do you feel works well? In addition, what aspects do you feel work less well? What suggestions for improvements can you offer?
21. If a person needs more intensive care (i.e. because medication management fails or a crisis occurs in the client's life that causes a relapse, or when a client is dangerous or threatening to self or others) how does Expression LaSalle refer this client? Where do you refer them? Does this happen often? Do you feel that many individuals are out in the community who really should be hospitalized?
22. What percentage of your work is administrative versus clinical contact?
23. Case management? What are your views? Do you feel that your service planning is individualized and tailored to the needs of specific individuals?
24. Does Expression LaSalle engage in internal or external 'quality control' evaluations of their services?
25. What kinds of files do you keep?
26. How do clients pay for services? Does the government fund art therapy services?
27. What unique qualities do you perceive that art therapy brings to the client? To the team structure? To the community at large?
28. How do you perceive art therapy functioning in relation to your clients, in an adjunctive capacity and complemented with a community-based model of mental health?

29. How do you think clients in art therapy feel about the art therapy services?
30. How do you feel clients see the role of the art therapist versus the more traditional verbal psychotherapist/psychiatrist?
31. What are the overall objectives for clients engaged in art therapy? Essentially, what is the aim; to emphasize i.e. independence, self-reliance, and a sense of support?
32. In your opinion, what do you identify as the gaps in the mental health care system?
33. How do you feel that treatment in the community compares with treatment in the psychiatric hospitals?
34. What is your understanding of how art therapy has been implemented in community-based facilities after deinstitutionalization? Is the community equipped to care for its clients?
35. What is your future vision for of art therapy in community-based mental health facilities? What is your future vision for community-based mental health facilities in terms of service planning?
36. Lastly, do you feel that there are any pertinent questions that have failed to be asked and that you would like to address?

Appendix B

CONSENT FORM TO PARTICIPATE IN RESEARCH

This is to state that I voluntarily agree to participate in a program of research being conducted by Adrienne Durst of the Creative Arts Therapies Department at Concordia University under the supervision of Leland Peterson.

A. PURPOSE

I have been informed that the purpose of this research is to investigate different models of community organizations in which art therapy has been implemented. I have been informed that this material will be used in a research project in accordance with course requirements for the Creative Arts Therapies Department at Concordia University.

B. PROCEDURE

Procedure consists of a semi-structured questionnaire that is issued in a personal interview with participant. The interview time may last for a maximum of 1.5 hours and participants may be called on again for additional interviews. The interview format will include specific questions related to the subject area of research paper, with instructions that the questions will be used only as guidelines and could be answered directly, be modified or disregarded.

The questions used will be given to participants in advance to actual interview, with adequate preparation time for the participant. The interview will be audio taped and will be used in verbatim form in research paper. The subjectivity of the claims made and based upon the information derived from the participants will be acknowledged. This procedure does not involve any deception or coercion.

C. CONDITIONS OF PARTICIPATION

A) I understand that I am free to withdraw my consent and discontinue at any time without any negative consequences.

B) I understand that the results of this study will appear in a published format as a Master's research paper of Concordia University and that I have the right to contact the Creative Arts Therapies Department at Concordia University for the research findings.

C) I understand that my identity will not be confidential and that my name will be used in the research paper and that I have the right to request a copy of the portion of the verbatim used in the research paper prior to publication for the purpose of verification and approval.

D) I understand the purpose of the study and know that there is no hidden motive of which I have not been informed.

I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT. I FREELY CONSENT AND AGREE TO PARTICIPATE IN THIS STUDY.

NAME _____

SIGNATURE _____

DATE _____

Appendix C

Interview with Nancy Humber took place at CLSC Lac-Saint-Louis on June 4, 1999.

AD: Adrienne Durst (interviewer)

NH: Nancy Humber (interviewee)

AD: Could you commence with an introduction of yourself and the position you hold here at Ensemble and at the CLSC, as well as giving some of your background.

NH: I'll start a little bit with the background; my own training in art therapy is relevant in terms of what you are doing here. I trained in the States in art therapy and I have a Master's degree in Art Therapy. Before that, I had been a teacher, so I have a background in education, and I also have a Master's degree in Philosophy of Education. I'm just finishing a Doctorate degree in Psychology, so my background is diverse. I also have training in psychoanalytic psychodynamic psychotherapy. I have worked in lots of different areas and all my training comes together.

For the last eleven years, I have been in charge of what would loosely be described as mental health services at CLSC Lac-Saint-Louis in Pointe Claire. Initially, we basically gave services of a very short duration to what one would call clientele "having normal life difficulties." We originally hired someone who had a background in art therapy, a Master's degree in Art Therapy, plus a degree in social work. The position wasn't an art therapy position. Rather, it was a Human Relations Agent position, but we felt that we needed somebody who was really diverse, who could be very creative, because we had a very limited service to offer. The person had to be able to work with an enormous range of clients, from teenagers up to the aged, people who could come in and say they had ordinary life difficulties. In some instances, they needed a social worker approach and in some instances, it was much more of a straight art therapy approach. Very often, it was somewhere in between, and it was just this approach that the professional we hired developed. Somebody might be talking about an issue but she'd say "let's have a look at that, let's look at that in pictures." So that was the first art therapist working here. Subsequent to that, we did hire an art therapist who works with children in the CLSC. She has a specific mandate to work on prevention programs in terms of mental health issues. So that mainly means that she is working with children who are at risk of developing mental health problems themselves, either because of particular conditions that they suffer or because they have parents who have severe mental illness.

My other role is as director of a psychiatric day center called Ensemble. Ensemble was created, also at the beginning of the CLSC, about eleven years ago. It was created out of the willingness of the department of psychiatry at our local hospital, the interest of the CLSC and the needs of community psychiatric groups. There were four partners at that time who created this new program called Ensemble.

Each of the partners continues to run their own agencies and in addition furnishes employees to be the workers in Ensemble to work with clients who have severe mental illness. Most of these clients have been hospitalized, sometimes for rather long periods of time. Some of them were people who were “deinstitutionalized” in the 1980’s. Ensemble was established with the new policies that were instituted by the then Health and Social Services Minister, Therese Lavoie-Roux. If you are looking at the development of programs in the community that was really the turning point. Her policies in the late eighties was the catalyst and that was how Ensemble got developed.

AD: Eleven years ago.

NH: Yes.

AD: In terms of services provided by both Ensemble and the CLSC can you tell me about how they have changed over the years. Whether there has been an addition of services or a deletion of services.

NH: Well, as I mentioned in terms of the CLSC, it was an exciting thing when a few years ago we were able to hire an art therapist. She is here three days full time, to work with children doing preventive work. That is extremely important. We don’t wait now until we see children who actually develop mental disorders. We try to intervene where we know, for a variety of reasons, that there are risk factors. So, I think that was one of the exciting recognitions in the development of the role of the art therapist in the CLSC.

In terms of the adult treatment center, while it was created with a wonderful willingness and great excitement and funding which was terrific eleven years ago, because of the subsequent policies of the government there’s been no additional funding. We would really love to move more into a range of creative art therapies not to just have art therapy, but can’t. We’ve managed occasionally to hire a music therapist on a contract basis and we once had a drama therapy student who volunteered and we put on a production. But, you know we haven’t been able to go further; the funding has not permitted us.

We have been committed to the development of student art therapists through a funding program that the federal government has for summer positions and we have managed almost every year for the last eleven years to secure the grant. It’s not always an easy process because we don’t find out until quite late in the year if it’s come our way. This is one of the creative ways that we’ve tried to give students a chance to develop a little bit more of the professional side of themselves in the workplace. It also enables us to expand the program that we give to the clients. But I wouldn’t say that there has been an addition of staff. I think it’s more that the staff, the various art therapists in the jobs that they do themselves, have grown as professionals, their viewpoints, their ways of delivering the services have grown and expanded and their expertise has become

more profound. They are able to reach a broader range of clientele with more capacities but that's perhaps located more in their own professional development than in the program that houses them.

AD: You mentioned that the original art therapist that was hired on at the CLSC works in art therapy but also in social work. Do the other art therapists on staff primarily work solely as art therapists or do they have other responsibilities?

NH: I think that's a really good question because the development of a service, whether one is an art therapist or any other psychosocial worker, is not developed based on an individual's personal professional profile. In the public realm, we hire a professional who is the best able because of the kind of training they have to meet the identified needs of the clientele. So when you are hiring people, as an employer, you are not concerned with preserving the identity of the worker. That's simply not the thinking.

So in the initial hiring, the very first time we had an art therapist, she wasn't really hired specifically because she was an art therapist. We had a particular program going. We had a listening and referral service run by volunteers. In her training, this person had done a lot of work with people who came in off the street to get some psychiatric following. As well, the place that she worked also had a listening and referral service not too dissimilar to ours. So she had, prior experience that was very related to this particular service that we were setting up. When we interviewed people, we weren't specifically looking for an art therapist. We were looking for a professional. It could have been a social worker, an art therapist, a psychologist who had the kind of experience, the kind of personality, the kind of creativity, the kind of skills to manage the job that we were hiring for. So we were hiring what is called a 'Human Relations Agent.' We were hiring someone who had to be clinically trained, who had one of a certain number of degrees. The fact that the person who came to us had a degree in communications, had a degree in social work and had a Master's degree in Art Therapy was an extremely attractive package.

You know, art therapists are really creative people and if they are applying for a job where creativity, not only art therapy but generally creativity is a sought after commodity, they usually come up really high on the interview scale in that area. So, if I would generalize from that, art therapists have had a certain advantage when things are in a developmental stage, when programs are just starting. Art therapists, because of both the professional therapy part and the creativity part, present themselves in a very interesting and exciting way to potential employers because when something is being developed you need that kind of...

AD: Pioneering?

NH: That's right. You need that kind of thing. The other side of it or in addition to that, is that in the public system like the CLSC, people do have to meet certain

very pre-established criteria in order to get a job. So we are not simply at liberty to just say, "Well, I think I'm going to create a new job and it's going to be in an art therapy position." So when we first hired in the Human Relations Agent category, which is a unionized category, the category was intended for people who had a degree in sexology, psychology, social work, or criminology. The definition according to the union did not include art therapy, so it was the willingness of our own personnel department to say we will put a Master's degree in art therapy into that same category. We will consider it as equivalent in terms of the kinds of learning experiences that have made up that professional experience. In other words, the person knows how to do intake, how to do an admission into a program, how to do an evaluation of general client needs, how to work interdisciplinarily, has done a clinical internship, has been supervised and knows how to do the kinds of things that are a part of the job. I think I've gone away from your question. You're question had to do with?

AD: Whether art therapists work primarily as, art therapists or whether their responsibilities overlap into other areas.

NH: O.K. Well just by way of that example, you can see that this person did not do art therapy every day, all day long. It's very important in the professional development of art therapists that there is a realization that the training that you do, for instance in group or individual art therapy work, will only be a part of a job definition. It's your discipline. A job definition, a job description however never stipulates that you just open your door, see a client and then the client leaves- that's what you do in private practice. When you work in an agency, probably sixty percent of your time is spent actually working with the clients. The other forty percent is spent doing a variety of things that have to do with the administration of the place you work in. You are almost always on a multidisciplinary or inter disciplinary team so there are many things that you are doing in conjunction with others. You may be on committees for the development of the psychosocial work within an agency. You maybe on a committee that has to do with organizing special events.

There's a great example of something that was done here a while ago in terms of a project. One of the other art therapists was involved in it, with all of the staff's children. It was a day, "kind of a mom and dad go to work day" and the kids came and did drawings which were subsequently laminated and put up in our waiting room, so that there is a sense of the personal in our waiting room. It's not just a decoration on the wall; it very much was a project that was appropriate to the art therapist.

Another major project that the CLSC does is a community forum. We are out there in the community, once a year, with some kind of major day-long or two-day long event that involves the community. Last year we were involved in the production of a mural that now hangs in the CLSC. It involved literally hundreds of people in the community in being produced and so forth. It was a major thing

and again it was not simply that the art therapist was responsible for getting a decoration on the wall. It was the culmination of an enormous community spirit and community effort. So projects like that are also part of what an art therapist might do in a community-based agency.

One of the art therapists was a major member of a team which produced an extremely important document on the role and common work of the psychosocial worker in the CLSC. Here, psychosocial workers included art therapists, social workers, psychologists, intake workers and community workers. Now they are about to write a philosophy and rationale for what actually constitutes a psychosocial evaluation of a client whether it's done by an art therapist, psychologist or any other psychosocial worker.

At the training level, students receive a very specific training for the actual clinical service delivery with the client or with the group, but the role of the art therapist in the work place is much larger than that. I think what is exciting here in the CLSC is that the art therapists on staff have become very implicated in the on-going work of the CLSC and that's really been where their profile becomes much higher. People see them not as just clinicians but as a whole part of the social fabric, and of the fabric of the institution itself. They have a role in shaping the vision of the institution.

AD: For the record in terms of the range of art therapy services that are provided, are you using art as therapy or art as psychotherapy. Art is used in what manner?

NH: Well, O.K.

AD: Is that a straightforward question?

NH: It's a straightforward question, Adrienne, and it's one that's been asked since I was a student. And, I think it's a false question. I'm glad you asked it because I think it's really important. I'm an art therapist and there are three other people here who are art therapists and I would find it impossible to squeeze myself or them into any one of those boxes.

I will say that I don't think that a Master's degree in Art Therapy makes someone a psychotherapist. Psychotherapy training is very specific, and very particular and very involved, and it's in addition to art therapy training. I think of art therapy as a psychotherapeutic discipline but if I'm talking about psychotherapy, as such, I think art therapists who do training in psychotherapy become art psychotherapists if they want to. They go back and forth in any session between, perhaps using exclusively the verbal mode or integrating art with it. I would hope and expect that that person, however, who added that training on, or perhaps family therapy training, is still an art therapist but one who can do family therapy or psychotherapy as well. People who "add on" don't lose where they came from, so it would be impossible for me to imagine that myself or any one of the three

other art therapists who work here wouldn't, if it were the right thing for the client, immerse the client in a very involved and engaged artistic process. So the same art therapist who may be using almost primarily words with someone, with images just somehow adjunctive to the words, could with the next client, or with the next group immerse people very significantly in an art process, where in fact there is a significant product arising, whether it's a painting, a sculpture, or a group mural or any other artistic activity.

So, I believe that the approach closest to the heart of the practicing art therapist often depends on what art therapy program she studied in. Some programs are much more emphatic of understanding psychological processes and some are much more emphatic of the creative processes that people go through. I think you start with what you've got, and that's why I said earlier that the development of art therapy in an institution is very dependent on the professional growth and development of every individual who gives that service. So for instance, in Ensemble, the person who is the art therapist there has done an additional training in psychodynamic group psychotherapy. She has pushed the limits of possibility in group work because that's her interest, that's her professional development beyond her art therapy degree. She's done fantastic things with developing her groups. Sometimes her groups are quite analytically oriented; sometimes her groups are very creativity based. Her groups have sometimes been groups for people who are highly symptomatic, who have just been discharged from the hospital. They are very immersed in a very gentle holding creative process with little or no analysis of the material, but it's an experientially based, creativity based therapeutic process.

So I think it's exciting and I would like to underscore that I really think that the development of the art therapist has to start where they have been trained, whatever the emphasis is. But they must, if they are going to be in the workplace realize that's just the beginning. It's a wonderful springboard and they have to follow their own lead. I mean if they are more interested in creativity-based or more interested in psychotherapeutically based work then they will move in that direction. In the public domain, I know that I couldn't hire somebody who was not able to work within a broad range. I could not because we have a range of clientele to serve and art therapists as professionals have to meet the range of clientele, just the way any other professional does. You can't come in and say "I'm a social worker who only does systemic family therapy." If you are serving private individuals you can say in my private practice, "I do this," and you can refuse all the rest. But you can't in a public setting, so it goes back again, I think, to the creativity of the individual worker. If you are interested, you learn from other professionals. You take courses and build on your knowledge and your professional development keeps on growing.

I have to say it's interesting as I hadn't thought of this earlier, but as we were talking about it, the four art therapists here, myself included, have all had professional backgrounds in addition to art therapy as their training when they

were hired. All had other professional domains, but they all were hired to do art therapy.

AD: That's very interesting.

NH: Yes, it is and I just realized that as we were talking, that that is the profile. And I don't think that there is any other CLSC which has art therapists on staff like this. I think it's quite unusual.

AD: The Guy Metro CLSC I know had an art therapy program I believe, but it closed.

NH: Yes, but that was one person for a short period, and I'm saying we've got four permanent people who have art therapy backgrounds.

AD: You have already given an overview of the type of population that you serve in art therapy but in your opinion, is there a population that you feel could benefit from art therapy and for whatever reason has not been adequately served in that respect or has been neglected or hasn't been approached?

NH: Well, in terms of this institution I can imagine lots of possibilities. We have a very large home care population. It's a responsibility of every CLSC to have a comprehensive home care service. We also do the aftercare for people who have been hospitalized for any kind of surgery or treatment. The home care team serve quite a range of people and they've got a multidisciplinary team and they do very exciting work in people's homes. But they don't have an art therapist. There was a program at a CLSC in Montreal years ago; again it was a pilot project that didn't become a permanent program. I think it might have even been an art therapy student from Concordia who did it but I'm not certain. The art therapist went to the homes of homebound people who were being seen by their CLSC. I think that would be a wonderful thing for us to be able to do because I think that it is very difficult for many clients, in terms of emotional expression and the loss of autonomy that they are experiencing, along with the truly painful and difficult effects of their illnesses and what that creates for the person. It's fun to think that over the coming years maybe as more and more home care services are being emphasized by the Minister of Health and Social Services, that maybe art therapy could be included in some way. I think that would be a very interesting thing for young people in the field to think of developing actually.

AD: How are clients referred to you? Can you talk about your referral base and how that works?

NH: O.K. First, I'm going to talk about Ensemble.

AD: All right.

NH: It's interesting to see the range. In the Ensemble treatment center, about eighty five percent of clients are referred directly from the hospital; these are people who have been hospitalized in psychiatry. They are not referred expressly for art therapy, but for the comprehensive day treatment program. When the referral arrives, the client comes in for an individual interview with an intake worker who assesses what their needs are. It's a long, very focussed, semi-structured interview. The client's level of functioning is also scored on a standardized scoring measure. A self-evaluation is included. It takes several hours. The person who does the assessment intake interview presents it to the multidisciplinary team on which the art therapist sits. The intake assessment person presents what she or he thinks the treatment plan should be. It may mean that there could be five or six different workers each giving a particular specialty. The client may be seeing many different workers all at once. Art therapy may be a part of what has been assessed as a need. If there is the sense that some kind of therapy, whether a verbal group or art therapy group, is recommended for the client, then the art therapist or one of the other therapists does a further evaluation for therapy. This helps to determine whether it would be better if it was art therapy, a verbal group or individual therapy. So that's how that referral comes in.

AD: So, directly from the hospitals.

NH: Directly from the hospitals through an intake worker and starting with a general overall assessment. If the person is in either individual or group art therapy it's because a very specific evaluation has been made and it's been determined that's the treatment modality that would be best for this particular client.

On the other hand, in the CLSC there are two very different ways that clients may end up in art therapy. The person who works with children accepts referrals from social workers in the CLSC who are already working with families in difficulty. If the problem is seen to be not simply the result of family dynamics and structure but that the child is actually personally in need of an individual or group following, the social workers will refer the child to the art therapist. The art therapist will usually do a subsequent interview with the family and child to see if the child could function either in a group or in individual art therapy. However, the general public now knows that we've got this service and now they call us directly as well. Sometimes it doesn't go through the social worker first, it's actually a parent calling in and saying, "I understand you have art therapy there and my child has been seen by a psychologist in the community privately or my child has been seen at the Children's Hospital and they've said she is depressed or she's having behavior problems and they think that art therapy would be helpful." So sometimes it's parents asking and requesting directly because they feel that this would be good for their child.

AD: And then do they have to go through a social worker here?

NH: Then they do have to meet with the social worker who does a family evaluation because sometimes people will say, "I want this for my child," but there are a lot of family problems as well. We have to make sure that we are not treating a child whose symptoms are mainly reflective of the family's problems. Sometimes, the child comes in alone and sometimes the family is getting a service at the same time as the child.

So that's a little bit different. For the other art therapist, the person who works with teenagers and adults, although she treats more adults than teenagers, there's another process. There are people who call the CLSC and say "I have this or that problem and I really need to see somebody." The general CLSC intake worker will tell the client that we have counselors, who can help and will refer the client on to one of the front line psychosocial workers.

The intake worker tries to see, dependent on what the client has asked for, whether the client would be someone who might find art therapy useful. If the client is assigned to the art therapist, the art therapist doesn't start with the premise necessarily that she is doing art therapy with the client. The office is set up so that people come in, they present the problem that they wanted to have help with and she discusses with them what she can do or can't do or what would be the suggested plan that she would have to work with them. Dependent upon her professional judgment she may suggest that the person use images. Then she'll say, "I'm an art therapist as well as a social worker." She also has a very thorough training in marital and family therapy. She will use her professional judgment of what's being presented, to decide or suggest that people move in a certain direction. By and large, most of the people who came in that route have no idea what art therapy is. It's not even something in their heads, and if she suggests moving over to the table where the art materials are always openly displayed in a very inviting and attractive way, almost everyone moves with ease. Almost everyone says, "Oh, this is unbelievable, I don't know how to draw." You know they go through the usual resistance or fears but very quickly, they adapt to that. She will use it with couples too and, dependent upon on the presenting problem and the way that the client or clients are using it may end up using art therapy as the major avenue to working with them. Other times it's used very adjunctively, and for some people it's not used at all because it's not going to help much with what they are coming here to work on. For example, if someone comes in saying that she or he has a very specific, very direct real life concrete problem and needs help to be linked up to a psychiatrist, or to develop a certain structure in terms of how they are going to handle something with their boss at work, or they've got to get legal papers done, you know art therapy isn't the modality that would be applicable.

Some people in fact, it's kind of interesting actually, just simply notice the art materials and say, "What are those and what's that for," and when the art therapist says a bit about what it is for they say, "I would really like to do that." So in her practice, art therapy is a very gentle and inviting thing, which is just very present

and becomes in a way for many, a kind of natural move. So we've got very differing ways for clients to actually end up in art therapy.

AD: Is there a maximum time limit a client can be in art therapy. Is there a cut off? Can it be continual for these two different programs?

NH: In CLSCs in general, the mandate is not to do long term work and that's because CLSCs are meant to be what is called, front line services. Front line service means basically, the first place you go. It's not that shorter term services are always the best services that anyone could have but it's that services should be matched to the needs of the clients. So very often the CLSC is the first place that a family comes with a problem, it's the first place a couple comes with a problem, it's the first place that someone might come if they lost their job and they are having a really hard time getting adjusted to it. So the service that we give in the context of that tends to be about three months.

However, we are very flexible in this particular CLSC because if we say that three months is the average, then we obviously have some people less then, and some people more then, three months. Some people come in and see someone three times and for them that's enough. Their problem isn't a deep a profound one, and they just needed someone to help them reorient them. So, depending on the need of the client, we can make arrangements. The mental health mandate for CLSCs tends to be about six months, rather than three and that average range applies again because some people don't need six months and don't use it. So even there, there are people who come in for three months and some people who come for a year. That's our range.

In the children's program, we know that there has to be consistency and continuity. The program generally starts in September or the beginning of October once the kids are back in school, and goes until the end of the school year. So that's a bit longer for those kids. And then we have a special program, which is an eight-week program in the summer, for some of those kids and for other children as well; it can be new ones that we haven't seen over the winter.

In the psychiatric day treatment center, the mandate is six months to a year for clients to be in the general program which means that they could be in art therapy for the whole time. But also because the treatment is very individualized it's certainly possible sometimes that a client stays in therapy, could continue in therapy for another year. So the clients there range in terms of length of time in therapy, from six months at the least, that's the minimum that people are in the center, to possibly up to two years.

AD: And they are engaged in different activities as well as art therapy? Can you tell me a little about what the other programs are?

NH: Sure, for instance, they could be in family therapy at the same time. They could be in a particular group approach which is run by a psychiatric nurse which focuses on health management issues, a whole range of health management issues, from actually managing the symptoms of whatever particular illness they have, as to how they are handling sexuality, how they are eating; just an entire range. They could be in a stress management group or a relaxation therapy group. Many of the people are in many of these things concurrently. They could be in a group, which is designed to increase their motivation. They could be in a group where they are learning assertiveness skills. They could be in a group which, once a week, goes out on a kind of challenge outdoor outing where they cook food outside in the winter and go canoeing, a lot of challenge outdoor activities. They could be in a nutrition group where they are cooking meals for themselves once a week. We have a community kitchen which people can be in who have neither the personal motivation or the funding to be eating very well, and that's a group of about six people who meet and cook meals jointly and prepare them for a month ahead. A community worker goes places with them in the community and helps them for instance to the 'Y' or join the library. They could also be in a networking group in the community.

AD: So they have a lot of options.

NH: And they could be in a whole other range of skill based groups which are not therapy oriented at all, skill based things run by a core of volunteers. They could be in computer training, arts and crafts, pottery, woodworking, and a variety of such activities. Art therapy is one component, in the treatment plan for our clients. So it has a place along with a lot of other things.

AD: Would you say that along with being involved in different services within the CLSC and Ensemble as well as art therapy that often these clients may participate in other community organizations as well?

NH: Yes. The clients in Ensemble are encouraged to be involved in a range of other things for while they are in a very intense treatment program they also have lives outside the center. I think the whole community-based thinking is a really interesting one. I think the move to community-based services, while initially more humane than the institutional approaches, also had it's own dehumanizing aspect. At the start instead of people with psychiatric disorders living in an institution, they were off somewhere in the community, in another type of housing still with walls around them that keep them all together in one place.

That was a move, it was a positive move we said, "Great people are out in the community and they are getting supportive housing and they've got workers who help them integrate into the community." The terminology we used was social rehabilitation and social reinsertion. However, there was a bit of fallacy there because if you truly are talking about changing the myths of mental illness, if you truly are talking about integration or reintegration into a community, if you are

truly saying that psychiatric illnesses are just one illness among many that anybody could have, then people ought not be housed in another institution. They shouldn't ultimately be housed in a community-based institution either.

One of the things that became important for us at Ensemble was to say, "When people are finishing their treatment, if they truly are being integrated in the community, they shouldn't only be involved in other psychiatric agencies in the community." They ought to be joining the "Y" and they ought to be going to the library, they ought to be in the pottery club and they ought to be in the art classes that are run by the community center. So one of the aims of the treatment center is not only to help people adjust to their illness and learn how to manage and develop their social relationships and coping strategies, abilities and skills but also to demythologize both on the part of the client who often has not felt safe except in a psychiatric milieu even though it is out in the community and on the part of the community itself. To get beyond this, to say your illness is just like any other illness and you have a place in the community. So there is work on both sides, for the community to not see you as someone who is different from everyone else and there is work with the client for them not to see themselves as different from everyone else. So that's one of the important aspects that the community has to work on.

Another one of the ways that we were involved was a project we had many years ago where we brought practicing artists into the center. It was a wonderful summer program and we had practicing artists come for a day. It was to engage clients in something that they probably never thought of; for instance someone came in and made paper. It was just a lovely, wonderful experience. The staff and the clients all made paper for a day with someone who was an expert paper maker. And somebody whose area was pottery came in. On the one hand, that opened up something within the center but also the artists who came in also went back out there. It attracted a few clients to actually go and visit them in their studios. Several of those clients subsequently enrolled in various arts programs in the community.

Our goal is not for clients to stay in art therapy. They don't all have a particular interest in art but for the ones who do, then they go beyond the art therapy and into the world of art, as such. For such a client, the art therapy process has opened up, activated, or renewed the artistic process going on in the client. Then we really want to ensure that they are out there in the range of wonderful artistic activities that take place in the various communities here. We want to help the client make the shift so they feel comfortable, and that they don't keep thinking "I'm someone with a psychiatric disorder, I really didn't belong in that art class." We've got to work with both the community and with the client to help that happen. That's another area that I think would be really exciting. We can only develop that minimally here because we have the staff that we have and we have our limitations of budget and time. But I think projects like that would be just

wonderful for new art therapists to be involved in. To go beyond the psychiatric profile in the community. Develop it.

AD: Do you feel that the services you provide are sensitive and relevant to the different cultures that you may serve?

NH: The different cultural communities and so forth?

AD: Yes.

NH: You know comfort and knowledge and understanding of cultural communities is something that is a process and we're committed to it here in the work we do. We have set up cultural committees, we've adopted a philosophy that says we are not going to give people facile training in knowing twelve different cultures because that's impossible. I mean nobody can just do this quick overview of all people who come from a certain country or nationality or race. People are as individual in their beings as individuals are anywhere. So, we have adopted an approach where we participate in inter cultural things by sharing food, art and cultural artifacts. We have a day a year where everyone in building participates in a very joyful celebration of diversity. That's where we started. We wanted people to first get involved in the joyful celebration of diversity and develop a positive and open attitude. We are working on attitudes rather than content of knowledge.

What we then have moved into was working much more sensitively, often times with translators, because many people who have moved into this area are moving in with really very little English or French. I think among our CLSC staff there are seventeen different languages that people speak. We often use our own staff to serve as translators and not just translators of the language but as translators of the culture. When you are working with somebody it's not just that you get someone else to say the words in English or in French for them, but it's to truly understand what the meaning is for that person in the context of their own cultural heritage. So we moved into that, and then also secured translators from outside whenever we need that. We don't only use the translator when someone can't speak the language; we also use the translator when we need to have a better sense of the cultural context for it.

It's a very touchy issue because if you try to reduce the understanding of a particular ethnicity to ten pages in a book you really risk being very stereotypical. So partly, it's learning from the client and partly it's learning from the material that's already presented. We've had quite a few reflection days and staff discussion periods on issues of multiculturalism and I guess the first thing is that the worker, him or herself has to become comfortable. It's an attitudinal thing in a sense more than anything else is. Even if someone comes from the same racial or national background that you do, when you are there you have to be extremely attentive and open to the person's personal and cultural family history and try not

to see it through your own eyes and try not to project your own background onto that client, even if that client seems to somewhat like you in some ways. So when you have a feeling or a sense that the client is not like you, I think it's the same basic skill but it's got to be extended.

We've worked consistently and openly in that direction. This is not a territory that has a high percentage of ethnic minorities but it's certainly growing. It's changed from something like seven percent when we first started to about fifteen percent, I think. It's growing and it's certainly an area we intend to develop and work on. On occasion, cultural communities in our territory have sometimes presented things to us. For example, for example black history month, a group of people who are very involved in black studies have come and put up a display. We're moving but we don't have a very pointed aim at multiculturalism. We adopted a philosophy to say we want to work at it from another angle.

There were some agencies, which have over the years had a particular specific training that every worker had to go to. People whose attitudes were open, loved it and people who would be perhaps the ones who would be finding it the most difficult, did not like it at all. So the people it was aimed at addressing didn't really benefit. So we decided to do it a bit differently.

AD: I guess the next couple of questions I'm interested in, is in funding, in terms of how the CLSC and how Ensemble are funded? How have changes in funding effected your program?

NH: Well, the Ensemble treatment center is funded as are all psychiatric outpatient services (meaning things that are not in the hospitals) by funding from the Regional Council in Montreal which is the health authority which channels funding from the Minister of Health and Social Services. Community groups are funded on what's called a non-recurrent basis; in other words, they'll have funding that covers them for three years usually. They will be told at the beginning of the budget year or three year period, here's your budget for the next three years.

AD: Whereas Ensemble is more consistent?

NH: Ensemble is more consistent. Ensemble, because it's a partnership of what's called establishment - meaning hospitals, CLSC and community groups, which are two community-based non-profit organizations, receives a special kind of funding which is on a recurrent basis. So there is no danger that in two years or three years that the funding would be withdrawn.

However, the funding is still determined very centrally and that's the way our whole health care system works. The Regional Council for our territory, the island of Montreal, region six, determines what CLSCs get and what non-profit community groups get. They do their studies every year and they determine who

gets what funding. So funding is not something that you have very much control over. Occasionally the Regional Council as an outgrowth of some kind of Ministerial Directive, will say, "O.K. we're going to put more emphasis on the next so many years on youth or on the aged or home care," and they will say to certain agencies, "Fine, you now have to also do also this service and that service and here's the money for it and you have to do it." Or they may say to a territory, let's say to our territory in the West Island, "We've got an extra one hundred thousand dollars available for special projects. Any of the agencies who are giving psychiatric services can apply for it, it's a contest." Or they may say, "We've got twenty thousand dollars left over from last years budget in the youth sector so anybody who can write a good proposal, could get the twenty thousand dollars up for grabs."

But the funding is very centrally controlled. There is not much leeway at all over how funding gets distributed or who gets to get funding. There is more leeway within the community groups. If they have a budget of two hundred thousand dollars, they can decide that they are going to do a certain kind of a program. In the CLSC, it's much more centralized. The CLSCs because they are given mandates, serve people who have just had operations and who are at home, and provide all the social services for children in schools. So in the establishments there is not very much leeway as to how funding can be directed. It's quite delimited.

AD: Could you tell me a little about how Ensemble and the CLSC engage or whether they engage in internal and external quality control evaluations of the services.

NH: Yes it does, both of them do. You know I think that that is really a good question that you are posing there because I think it's not something that automatically comes to people's minds. Students don't usually think of the fact, that when they have a job in an institution they will be part of some kind of quality service assessment and ongoing concern with that.

In Ensemble, there's a policy of sending out to an anonymously picked group of clients every six months a survey on their satisfaction with the services that they have received. The clients send that back without their names and nobody knows which clients have actually received the surveys. The CLSC has a similar policy; there is an ongoing client survey process. Now that tells us one thing, that tells us client satisfaction, it tells us what sorts of services the client is satisfied with, and not, and perhaps something about why. It doesn't necessarily tell us anything about efficacy.

So there are other kinds of things that are important. In Ensemble, for example, when clients finish a group, they are also asked to give feedback on what they got out of the group. When they are actually discharged from the program, there is another form that they complete. The main worker plus the client examine what

the clients feel they got out of it, what they liked what they didn't like, what helped and why. So that's a lot of canvassing of the client to get their perspective on it and it's really important. However, as I said, it doesn't really tell you something significant necessarily changed. You have the subjective objective and the viewpoint of the clinician.

Professionals are supposed to be able to assess their clients and to see if there are changes, so I won't say that the subjective view as a clinician, is "merely" subjective. A professional has to use good judgment about the discipline that they deliver, so it is important what the clinician says about the progress of the client, that's a factor. At Ensemble, we've just started to move into doing some actual outcome research. Outcome research is very hard to do (i.e. you do something pre and post around the administration of a particular service). It's unyielding. It takes an enormous amount of time and the tools and the instruments are not very precise. However, we are trying and we are moving into doing some of that.

We've also done a piece of research that we are just in the process of pulling together on the global scale of functionality of the client, what level they come in and go out with. That's an objective measure. The team has all been trained and they have achieved valid inter-rater agreement on it. So we use several things to try to say something about what has actually happened. We've had three different times where we have had people from the outside come in and do a combination of program evaluation, whether it's interviewing staff, looking at the structures that we have, meeting with people in the community, other agencies in the community and also clients. There have been three different evaluations done by someone from outside.

The CLSC has recently engaged in a very large survey that was one by an outside agency. I think they polled almost one thousand people in the community to see if they know what the services are and how they are perceived. Ensemble along with the CLSC, two and a half years ago, was given accreditation and went through an entire accreditation process. There is an independent accrediting board for public service agencies. The CLSC and Ensemble both passed that accreditation process which was quite thorough and quite investigative. The CLSC also very much engages in an analysis every year, statistical analysis, of the services that have been done and how many people have been serviced and in what way. So, there is a lot. There are a lot of avenues for trying to understand what is done and as I said, the most difficult is the outcome research. We are just trying to put our feet into that water and move into that a bit.

AD: Thank you. In terms of the type of files that you do keep on the clients, can you tell me a bit about that?

NH: The law has changed over the last many years about what constitutes a client dossier. The client has a right to have one dossier about him in an agency. It used to be that, if you went to a hospital or a CLSC or wherever, that one worker saw

you and she had a file, another worker saw you and he had a file, another worker saw you he had a file etc. They were kept in a locked drawer; a locked cabinet but they were the worker's files. The law says, no this is the way it is, it's the client's file. So you have a right if you are in an agency, to have one file on you. So there is one file in the hospital and everybody who sees you, every discipline, every specialty has to all be in that same file. The same thing here at the CLSC, and the same thing in Ensemble. These are multidisciplinary, in terms of many different people write in them. Every intervention made with a client, this is by law, has to be recorded in the dossier. Dossiers used to be organized by section and there are advantages to that. We have adopted a chronological way of doing the dossiers rather than by section. The only thing that would be in a separate section would be tests, whether they are physical or psychological in a particular section of the dossier reserved for tests. But other than that, one person writes after the other person, writes after the other person etc.

AD: So it's very open for everybody to read as well.

NH: Well, it's a communication tool for the professionals who work with the client but it also makes sense. Instead of one thing in one place and another being somewhere else, all you have to do is just flip back and forth on the pages. It is a confidential dossier. No one is allowed to read it or look into it who isn't working with the client. It is preserved in archives and you have to request it. You have to write down who you are and there is a track kept of every worker who ever asks to see a dossier. So, if let's say for some reason, the client said somewhere along the way, "I think that my neighbor's sister who works there is looking into my dossier and she has no business doing it." This can be verified. We know exactly who has access to every dossier. So if someone went and asked for a dossier and they weren't professionally entitled to work on it they wouldn't be given it to read. So it's only the people who work with the client. It's kept confidential. The law states how long it has to be kept and then it has to be destroyed after a certain period of time. There are a lot of laws and regulations on what kind of things can be written and what can't, who can have access to it. Someone who is fourteen and over has the right to confidentiality in their dossier. That means they can say, "No, I don't want the parent to see it." The client has a right to a copy of his dossier. The client has the right to see what is in his dossier. You can't mention hearsay things from other people in a dossier and so on. There are a lot of regulations, but that's all prescribed by the law; it's not something we invented. It's something we have to follow.

AD: O.K. In terms of how clients pay for services, is it all covered by Medicare?

NH: It's all free. It depends on how you think about Medicare. You don't have to do it with a Medicare card. It's only doctors, who go click, click, but yes it's all public funds.

AD: If a person needs more intensive care because medication management fails or a life crisis occurs etc., what is the process to refer the client back to a hospital or another organization? As well, what I'm asking is whether you feel there are many individuals who are out in the community who really should be hospitalized, instead of the back and forth between community and institution?

NH: Well, I think there has been a huge change. If you had asked me the question eleven years ago I would have said yes, but you are asking me the question now. I think the evolution of community-based services is just fantastic. I mean, in this area of the island, we have fantastic collaboration among the community agencies. We've worked very hard, through some very difficult times, to be clear about each of our own mandates so that we aren't stepping on each others toes but that we aren't having any client fall between the cracks. So we have an intensive PACT team out in the hospital now. I don't know if you know about that. They follow clients in the community who would be just simply not clients for any other kind of service. These are clients who must be seen in their homes. So the nurse, the psychiatrist, the social workers all go to people's homes. They do medication administration daily if needed. I mean it's a very intensive community following.

We have another kind of community agency that does once-a-week following with people who are needing it but not needing quite that intensity. We have our outpatient department clinic at the hospital. We've got occupational therapy and job search programs specifically for people who have had psychiatric disorders and are having trouble with that. We've got a couple of drop in agencies in the community where clients can go any day, everyday for as little or as much as, they want. One of them is also extremely involved in getting food for clients who are having trouble with that. We've got Ensemble as a treatment center, which is really geared for clients who want to make very significant change. I mean it's an intensive program geared towards change and social, functional, job related, personal, you know on all levels, the whole gamut.

We've got the CLSCs, which is like the entry way for people who probably aren't at that level of need, significant, but not at that level of need. We've got a wonderful system of church supported apartments for people who have psychiatric disorders. There are nine apartments out here; each one of them is supported by a different church. They have each three clients with psychiatric disorders living there, who definitely would have been living in some kind of much more institutionalized care. They have a whole group of volunteers at the churches who are actually advocates for each of these clients who go and help them organize things, their banking, their grocery shopping. As a result, a lot of these clients are back either in the work force, going back to school or are doing volunteer work, instead of living in something that looked pretty institutionalized in terms of care because they need ongoing support. There are some people who will always need ongoing support. The fact that you are in the community doesn't

mean you don't need ongoing support; however with ongoing support sometimes it's pretty amazing what people can do.

Are there groups of people who perhaps will always need a very closed kind of care? I'm sure there are. I mean there are some people who live in institutions and I think there is probably a small percentage of the population that does need that kind of very enclosed care. There are people whose capacity to function is very limited because their illness is so prevalent, usually it's a psychotic illness, and it's so florid. These are people who have to be cared for, looked after with enormous compassion. So I think at the other end, for the people who need that we really should be looking into how we provide appropriate compassionate care for people who need that kind of being looked after. I think that that's a reality, that there are some people who do.

I don't see the same revolving door syndrome. It's certainly changed within the last eleven years; there is no question. That has changed to a great extent. At Ensemble we keep track of how many clients go back to hospitals and for how long, and the return rate to hospital will run from seven to ten percent over any year, over the last ten years. So that's a small percentage given that the average hospital stay, prior to Ensemble is four which means that some people have eight, twelve, twenty-two hospital admissions. So I think what we are talking about is less use of the hospital. We have a wonderful crisis center, which has emergency beds, and it keeps people out also. They have a crisis mobile team that can see people twenty four hours a day. They can go out to them in the community, help diffuse a situation that would have potentially have sent someone to emergency. So I think that there are a lot of services and there are a lot of different services to meet various kinds of things. There is no one way in the community. There has to be a lot of ways. I think it is working.

AD: What do you see that still needs to be addressed further? Do you see any gaps?

NH: There probably is a need for more housing. And again I like the model that we have with these apartments, which are in ordinary apartment buildings. They also have one large apartment building that was built to be a place for people with psychiatric disorders; there are ten in there. We have some group homes and some foster homes, but I like the normalization model, where there is an apartment in a "normal" apartment building. Where the people in there are getting some extra support according to their specific needs. The system had intended originally to create smaller institutions outside the big ones but it is still ghettoizing people. But, I think we are moving more and more away from that, especially this PACT model where you go to the people where they are and give them help where they are. And if they need help with their depanneur owner at the corner, you help them with that as well. You help on the grounds that people need help with.

I think we have moved into it. I think there is much more to be done in terms of the attitude of people. People are still not comfortable a lot of times to say that a family member has a major mental illness. The person is not necessarily comfortable themselves. Employers still are prejudicial to some extent. You know we have a lot to do in society.

AD: And does that apply here at the CLSC and Ensemble in terms of limitations or weaknesses that you would like to build upon even within this structure.

NH: Well, it's a process of education. Again, if you work in a big agency, a big institution there will always be some people who don't understand whatever the issue, it's not just this issue. There are always going to be some people who are the leaders and some people who are the followers. And the followers take a little longer to catch on to whatever it is that they are being exposed to. I'm very confident that things are moving in a very healthy direction. For instance we adopted a policy in this CLSC that says, "O.K., no matter where you work, you can be working in child and family services, you could be a school nurse, you could be a home care worker with the aged. It doesn't matter. You are going to meet clients with mental health problems just in the ordinary run of the work." Now, do we make a policy that says, "Someone's got a mental health disorder, we are going to send them over to the mental health team?" Or do we say "This is a family that has an ordinary family problem except one of the members of the family has a mental illness." We are not treating the family for mental illness; we are treating the family because they are having trouble in family relationships. So what do we do? Do we send the client to a specialist in mental illness or do we make the family worker more sensitive and more knowledgeable about mental illness and expect them to work with this family as they would work with another family. The latter is the policy we adopted. We are trying to train all of our workers in the CLSC who do front line work whether they are nurses or social workers or people who wouldn't necessarily have had mental health training. We are trying to give everyone basic training in mental health. The Regional Council has just made a five day training program and we are trying to send lots of people to it because our sense is that everybody should be at least sensitized to it and not to split this off as some kind of odd thing that some clients have. So I think that within our own culture, our philosophy has been one of inclusion rather than of separation.

AD: Case management, what are your views?

NH: Well, I have a lot of mixed views about case management. Traditionally the case management model arose from the social work model in the 1940's. As the name implies, people had cases and they had to manage them. So it had a lot to do with welfare, a lot to do with social work, a lot to do with making sure people followed the rules to get their social welfare checks and so forth. That's the foundation for it and there is a reason for that and it makes sense. Society is paying people to be assisted, and it's giving assistance, and it therefore has some

expectations that the people who are getting the assistance comply with certain of society's structures.

However, that model has come to be adopted in some ways well and in some ways not so well, I think, with the clients in the community. Very interestingly at Ensemble, a couple of years ago in a discussion with staff and with clients, in an open group where clients can talk about the agency and what they think works, etc, one client said, " Well, first of all I'm not a case and you are not my manager." I thought that was exquisitely worded. I know that if I have need of a service somewhere, let's say, I have to have my appendix out, I don't like the idea that I'm thought of as a case. I like that I'm thought of as a person. I'm not just bed number sixty-six with appendix on Tuesday. I'm more than that. So, as we talk about clients being in the community we have to find a way to support them, to bring together their needs for multiple services. They do have to have a service provider who is somehow the person among many whom they can depend on the most for having the overview of their needs. Otherwise, you have people getting their needs met like a buffet dinner or a shopping center where you get this and you get that. That has something missing too, its not a very human thing. So the case manager in a sense is meant to be the pivotal person, the human person who brings together the client's needs, the services and who advocates for the client. I appreciate the need for some clients to have that, but not everybody needs that by any means.

We just haven't gotten past the term case manager, however. We've done some work here on the West Island with all the agencies together in developing a case management model, which we have been presenting at conferences. The government is very impressed with the model that we have developed because what we've said is that the person who is the case manager should be the key person, and key person should be identified by the client. So it should not be necessarily the social worker who checks up on the paycheck or the social worker who does the family therapy or whatever. I'm not trying to target social workers here; it's just that they often have been given this job. So in our model that we developed, it could be the parent of someone with a mental illness, it could be a friend. So what we do now is include the client and the key person identified and everyone else who is included, in giving service delivery to that person. Again, as I said, this isn't for everyone who's got a psychiatric disorder. Lots of people don't need a person to do that for them; they are capable of doing it for themselves. So this has to be a voluntarily engaged thing. The client has to say, "I can't do it for me." So even in the process of working out who that should be, the client has a choice. All of the people who are involved in giving services are sometimes involved in supporting the case manager because if it's a friend who is not a professional, the agencies who are involved must be willing to work with that person so that person knows more about the services and how to access them. So in most cases, the client does end up picking a professional, someone they feel good about and want to have that contact. And that person is also the one who receives the necessary information.

One of our agencies, the Crisis Center, has been determined to be the place that will keep records on the case management. It's also extremely touchy in terms of confidentiality. It's very hazy in some places, how many people know how much about someone and I think it's basically not good. I think it's not good, for too many people to have too much information. So we've got a simpler model and we've been trying it out. The policy is basically that you don't do case management without the implication of the client and the client being involved as much as is possible. So I have mixed views as I said I want us to come up with another word. I really, really dislike the term case management.

AD: Any suggestions?

NH: I don't. I was in England and they talked about a key worker. It sounded a little bit better. I really don't know. I suspect we're stuck on the word because there is something conceptually that we haven't quite gotten our heads around yet. If we conceptualize it differently maybe, the words will come. So that's really a process of development and we'll see where that one goes.

AD: I guess going back to art therapy now. If you could maybe talk about some of the unique qualities that, you perceive that art therapy brings to the client, to the team structure to the community at large?

NH: I think you are probably aware of this in the work that you have done but we're still at a time in the development of art therapy as a profession where clients and other professionals will sometimes diminish what the potential is. You can't blame them because they don't have a clue. But, they kind of say, "Just art, how can art be helpful." We are in a society where art doesn't play a great role in the lives of a lot of people. If we would go back two hundred and fifty years ago, whether it was high art for a certain social strata or decorative arts for people of another social strata, art in some way was very much a part of the lives of almost everybody. Music was a part of the lives of the richest and the poorest. The arts were more in everyone's life every day. I think one of the things that the art therapist carries is not just how art can be therapeutic but the whole bigger issue of where does engagement with art either as a doer or as an observer and enjoyer of it, where does that even fit into people's lives?

A lot of the people, who come for individual requests for therapy at the CLSC, seem to experience a lot of emptiness. That didn't use to be the case when people went to therapy. There's this sort of a feeling of "I don't have much meaning." So I think that one of the special qualities that the art therapy process has, is perhaps to at least touch or awaken or enliven a place in people where the importance of the symbolic, the importance of the nonverbal gets touched. And that doesn't necessarily mean always working through every issue the way that you do in the therapeutic process, but having people realize that there is something else out there. That is extremely important.

Many people are very alienated in their jobs. The more computerized we are, the more people are not in touch with people. The more people do e-mail and don't even have telephone conversations the more separate they are. There is no emotional affect in e-mail. So people are getting great at exchanging dialogue with each other, they are speedier and faster because they don't have to deal with emotional affect that's underlying every conversation. You know overtime we say something to each other, and there are emotional undertones and overtones that we are replying to. It's washed out of e-mail so we've become super efficient; we move fast and then when people have to be in situations where they really are with other people, there are lots of skills that have not been developed. The more kids do computers in school, the less that part of it is going to be developed. I think that there is a role for art therapy, for almost a "societal therapy," if you want. If I see the role of art therapy growing, it is that art therapists don't divide up into this kind of therapist or that kind of therapist, but realize that they've got a role to play in healing, if you want, society. We've got to get art into people's lives from a preventative level. I could see workshops in art being done in businesses, in the communities; I see art therapists having a role. Again, we ought not to divide up our art therapists into camps, so that some say, "You are doing real art therapy and you are not." I think the whole thing is a range, just the way you could be a social psychologist who doesn't do individual psychotherapy at all and you are still a psychologist. Art therapists went into this discipline in the first place because we believed in the power of art to change, and that change can be on an individual basis, it can be on an agency basis, it could be on a community basis. So I think we are people who believe in that quality of art and we develop our expertise to apply that in any one of a wide range of things. That's my belief, in any case.

AD: Does that tie into what your future vision for art therapy in the community would be?

NH: I think so. I think that art therapists have to use all their creativity and again not to feel boxed in by the institutional model. Interestingly, we've moved the client out of it, let's move the therapist out of it too. There are therapists who will work in the institutions with the closed walls, in the more front lines of the CLSCs and the more treatment oriented centers, but there should be a place for art in a variety of other ways of giving services. I think there are more young art therapists who are doing all kinds of different things. I hear from time to time that people have ideas to move out and do street art. I think there is whole range and the profession has to be sophisticated enough now to say that's truly all art therapy.

Appendix D

Interview with Julia Olivier on June 1, 1999 and June 11, 1999

AD: Adrienne Durst (interviewer)

JO: Julia Olivier (interviewee)

AD: If you could start with an introduction of yourself and the position you hold here at Expression LaSalle.

JO: I'm Julia Olivier. I'm an art therapist. I graduated from Concordia University in 1992 and I received my ATR in 1994 from the American Art Therapy Association. I am currently employed full time at Expression LaSalle. I've been at Expression LaSalle since 1993.

I first came to work here as an art therapist on a six-month employment grant (Article 25 with the Federal Human Resources Office). When my grant ran out, the then coordinator who was an art therapist, Coleen Gold, was leaving to move to another city in Canada. She recommended me to the Board of Directors and I was hired on an interim basis to fill her position. It was almost like a test run because, they knew her and they didn't know me, so I worked on a contract for a three month period. At the end of that three month period, I was hired as the permanent coordinator. At that time in 1994, I was working three days a week basically running the Centre. It then increased to four days a week in 1996 and then to the full time position in 1997. I've been employed full time for two and a half years now. My job here is still as coordinator and basically I administer and do program development. I'm the one who hires the therapists but first of all, I establish the program of activities. The programming is based on what I believe the member's needs are what they have voiced. The members voice their opinions formally and informally in meetings.

When I first came here, the Centre was called Expression LaSalle because it was based on the philosophy that people expressing themselves, their needs, their experiences and their emotions was considered to be a therapeutic tool or of therapeutic benefit. Self expression in all forms whether it be through art, movement, drawing, music, or verbal expression is therapeutic. That's why it is called *Expression LaSalle*.

AD: Thank you. I'll go onto one of the other questions now. Do you know when Expression LaSalle was established? When was the art therapy program established?

JO: Well, the art therapy program was here from day one. When the government proceeded towards the second wave of deinstitutionalization, there was a lot of criticism that there were not enough resources to support people in the community. So with the second wave the government developed new resources and consolidated existing ones that were under funded. As well, the government

did more marketing surveys. They would set up an advisory committee who would hire an "*organisateur or organisatrice communautaire*" who would do a survey of what was in place and what the needs of the community were based on the users themselves or the people who were working with the users.

AD: When you talk about the second wave of deinstitutionalization, are you referring to the 1980's? What time frame are you referring to?

JO: I'm talking about the mid to the end of the 1980's and the beginning of the 1990's. For example, the advisory committee for this resource was put into place in 1989 and the community worker was hired in 1989. Coleen Gold did a survey of the partners; the partners being the existing community resources in mental health and the hospital services available on an outpatient basis. One of the outcomes of the survey in the Southwest region was that there were no resources in mental health west of Verdun. Most people had to go to Verdun or take a bus elsewhere since the LaSalle territory did not have any walk-in type services. Since Coleen Gold was an art therapist, she obviously had an agenda to implement art therapy, which she didn't hide from the people that were employing her, and they were O.K. with that.

So some of the first groups at the Centre were art therapy based, along with others that was self-help types. The Centre began as a self help one which was called, *Expression LaSalle centre d'entre aide*. It was self help, based on the fact that there was not enough money to hire therapists to run the groups because the budget was very small. The funding came from two sources: the coordinator's salary came Ville Marie Social Services and the Regie Regional provided a sum of about five thousand dollars to rent a room, get a phone and for office supplies. In the first year, there were four groups and two of them were art therapy groups run by Coleen Gold, one in French and one in English, and then there were specific discussion groups, for example, there was an Italian discussion group.

Part of the mandate of the coordinator besides program development is to look for additional funding. The coordinator would look for grants, but she also realized that there was a pool of human resources that wasn't too far away. She decided to contact the universities, like Mc Gill, Universite de Montreal, and Concordia and have students come to do their practicums at the Centre. So, art therapy students came and did practicums, as well as occupational therapy and social work students. We still maintain that practice and every year receive students from different disciplines. Students were the primary way that the Centre staffed the place. So art therapy was right there at the beginning. Now art therapy are the groups that are most developed here and we are known mostly for them. I think it's because the first coordinator was an art therapist, if it had been a movement therapist or a music therapist, I suspect that it might have gone that way.

AD: So, what other kinds of groups or services do you provide here?

JO: Well, when I came in we just had the art therapy, discussion groups, and relaxation groups. One of my visions for the Centre, with increased funding, was to develop all of the creative arts therapies services, such as music, dance/movement and drama therapy. I hired a drama therapist (trained in England) on contract even before the drama therapy department was established at Concordia University, although she moved to another part of Canada too. So, that's been my vision of the Centre and one that the Board of Directors endorses. So new funding that we had coming in went towards developing services in the creative arts therapies. However, because our art therapy services are so well known, the waiting lists for them are the longest. Since they have been around for almost ten years the public knows about them more than they do music or the dance/movement therapy, which have been in place for three.

AD: Alright. I guess you are already answered this, but in case you want to add something more, in terms of the services provided, how have they changed over the years? Have there been additions? I guess it would be additions more than deletions of services than anything else. Is that correct to say?

JO: Yes, additions would be more the term, and modifications in the duration of services. In the beginning, many of the services were short term based (six months or three months) and based on student practicums. So, a group would run from September until the end of their practicum. The lack of funding limited us in terms of how long a group could be run. However, the coordinator and volunteer group animators could offer longer term groups and therapy. So there were ongoing long term therapies that we could offer to a heavier population in psychiatry that couldn't afford therapy per se, and which the local hospitals weren't providing long term support in the community. The recurrent funding from the provincial government has always been to provide long term support to people who are living in the community and who are more fragile because of their psychological background or their illness. We all go through life crisis's, life passages, for example, death, divorce. We, meaning you and I, are healthy and perhaps more resilient going through them. Whereas, someone with a mental illness may not be as resilient and will need to have greater support to get through it. So, our groups are here to help chronically mentally ill people on a long term basis.

So, what's developed naturally over the years is that we have provided groups to people for three, four years or longer. I know people who have been here in groups for five years and you know, it becomes problematic. We have people on waiting lists who want to participate but they can't because we have people using the services on a long term basis. We've thought of putting time limits for our services, but we are suppose to provide long term support in the community to the mentally ill. It's not like managed care like in the United States, where therapy is terminated based on a term, like two years. We encourage people to stay if they need it and they want it. They are the ones to determine what they want and for how long. People do leave after one, two or three years. There is a small

percentage of people who really need it long term, and probably will be involved for a long time. In the beginning years when there was a lot of turn over in the personnel, one member said the Centre was the opposite of the hospitals. Patients go in and out of the hospital and its personnel that are the stable ones. At the Centre, it was the members who were the stable ones. The group therapists and animators were the ones going in and out all the time. So they dealt with a lot of loss and separation anxiety and that was part and parcel of it. Now we have a mixture, and are able to give long term care for people who need it and we provide shorter term types of groups too. Overall, we have been able to expand our long term therapy services.

AD: So, it's pretty continual care then?

JO: Yes.

AD: So, could you even say what the average length of therapy is per client?

JO: I think for people suffering with chronic types of mental illness, there isn't really an average length. We have people who come for a long time. Then there are other people who use our services on a long term basis, but who step away for periods of time. Either because they feel better or not and need to be hospitalized. We will not see them for maybe six months, a year, maybe two and all of a sudden they will resurface and will want to participate once again.

AD: And do they then have to go back on the waiting list?

JO: Yes, and of course when they decide to leave we tell them this fact. They are reminded of our first come first serve policy.

AD: And when you talk about a waiting list, what kind of time period are we talking about, six months?

JO: Well, our waiting lists are a gestalt of the Centre. They are never stagnant, they are very dynamic and changing. If you look at the structure of employees, we have permanent employees who are here long term and then we have short term staff that is hired on contract and they leave. We have had a couple of psychologists on staff as well as a few social workers that have come and gone. And then we have the students that come and leave on a regular basis. Our groups work similarly. Usually a group has a core membership which is parallel to the permanent staff. The permanent core members of the group stay together for quite a long period of time. Then there are members who use the service for shorter periods of time. So there is always a continual in and out movement in the groups, depending on the needs of the members. Some people come for only a couple of months and others come for a couple of years. Therefore, the waiting lists are always in movement because we are calling people to join groups when spaces become available.

The only waiting list that is more sluggish, that doesn't go as fast is, in the sexual abuse area. We have become known for offering services in the area of sexual abuse. I think part of it is due to the fact that we offer the nonverbal therapies. I think people who have had childhood sexual abuse or abuse that's been suppressed or even repressed have great trouble putting words to their experiences. When they newly remember things and/or are ready to deal with it as adults, there are not a lot of services offered to them. It's harder for them to trust people and to put words to express what has happened. I think sexual abuse is a severe trauma on the emotional development of a human being, as well as on the psychological development. It impacts on interpersonal relationships and everything. So, we get a lot of people who are living out of our sector that request our services. We are suppose to be servicing the Southwest sector of Montreal which is, well, I can give you documentation on that. However, we get people from Laval, Longueuil, and Chateauguay. We don't restrict their access because they can't get the services in the creative arts therapies for sexual abuse elsewhere. As well, a lot of our groups are coed, so a lot of men who have been abused or have a history of it can come here too. There exist many other resources exclusively for women. We have specific groups that address sexual abuse, but we've noticed that in a lot of our groups, a third of the membership will have had a history of some form of sexual abuse. We have never really sat down and said that it is because they know that here they can deal with it, or whether it is just inherent in psychiatry. That it is an element. A study in itself could look at that, maybe it's been done, I don't know. Sexual abuse healing is certainly something that we have been drawing and specializing in.

As well, sexual abuse healing encompasses a greater length of time. Sometimes it will take a person a year to feel comfortable with the therapist and with the people in the group in order for them to actually open up about the abuse. Also, in a lot of cases there is a backlog of traumas and of losses, which people can deal with only one at a time. So it can be many, many years. Certainly, if we see somebody can financially afford a therapy, then we will orient them towards a long term therapy in private practice. But, like I said before, a lot of people can't work, are on welfare, or on disability and it's just not accessible to them.

AD: In terms of art therapists, how many are there on staff right now?

JO: Well, the recurrent funding from the provincial government at this time allows for myself full-time and another art therapist part-time. Anne-Marie Levesque has been with the Centre for many years on contract and now is a permanent part time employee, working two days a week. However, because of our waiting lists whenever we have non-recurrent grants we frequently hire art therapists, which can be for six months and up to a year. Sometimes in the summer time I will hire art therapy students but on a permanent basis, there are two of us.

AD: And the art therapists that are on staff are they working primarily in art therapy or do their responsibilities overlap into other areas?

JO: I would say that the art therapists beside myself are just doing art therapy. I'm doing budget, program development, supervision and I represent the Centre outside in the community but I always represent myself as being the coordinator and an art therapist in order to sensitize people about art therapy. I do a lot of education and promotion of what the creative arts therapies are because it is the vocation of the Centre to develop those programs. We have psychologists; we have social workers doing verbal therapies here which is a complement to the arts therapies.

AD: It really is the core.

JO: The creative arts therapies are the core. These are the requested therapies that come across when we have calls.

AD: The way you use art therapy, either as art as therapy or art as psychotherapy, can you...

JO: In this setting, it's art as psychotherapy that we are doing. We do not have what you would call a studio model, where people can come in and work on a project. We have tried to have groups where people are learning basic art techniques for example, how to do contour drawing or techniques like mask making. Essentially, more like art education, but its art as therapy and the therapeutic goal of the group are to reap the benefits of immersing ones self in an art activity. These art as therapy groups haven't been solicited by the members as much and we have had trouble getting them off the ground because people are really looking for the psychotherapy. Members would approach the group thinking this isn't a studio model, so they would make something and then want to talk about how it relates to their emotions and experiences. If the model of the group is based on art as therapy then we would discourage the personal exploration and the verbal stuff that is happening and channel it more towards the art making process. However, within the regular groups themselves, we really do encourage the expression of art and we buy quality art materials, quality paper. We allow for a whole hour for investment in the art making process and then an hour for discussion. During the hour of the art making process, we try to cut down on the verbalization. Most of us, the others and myself included don't put on background music. We encourage the members to get into the art making process, to have the experience of what it is to create an art product and experience a kind of fusion with the object and a disconnection with the time and space.

In the same line of thought, we don't exhibit the art work that people make. It's usually made within a confidential setting, it stays within the therapeutic frame, and it's confidential to the group. We do ask for permission from our members to share case material or any productions made within the setting, during our

multidisciplinary staff meetings, because we are a learning institution, we have many students. Moreover, we as professionals have to learn and develop, we aren't gods, we are human beings, and we don't know everything, so we seek support from peers. We have team meetings once a week so that when we have issues with a member or a specific situation we consult our team members. On the Centre's membership application form we ask for informed consent from the clients so that we can share information about them within the team for their benefit, to help us better serve them and better understand them. When art is photographed or used in any other way, we get their informed written consent as well.

We've tried to have exhibitions and it's been usually something that our members shy away from as well. They adhere more to the psychotherapeutic model that the art is confidential to the therapeutic holding environment. At the end of therapy, they are free to take the artwork home with them and most do. However, we do have an archive cabinet where I hold artwork for five years that has been left, sometimes consciously or other times unconsciously. Sometimes people abandon the therapy and their artwork. We call them, we tell them we can hold it, but that after five years we are going to have to destroy it because we don't have the space to hold onto it and that they are free to come get the art if they want to within that time frame. We label the art and it is kept under lock and key.

AD: Do you provide individual sessions as well?

JO: Yes, we do offer individuals sessions but we offer them on a short term basis, twenty sessions. We offer twenty sessions to people and if they feel they need to have another twenty sessions, their name can be put back on the waiting list. We only provide three rotations, so it is sixty sessions in all. We are not in the business of providing free individual psychotherapy to people.

The individual therapy service came about in two ways; one was to meet the requirements of students that were coming in to do their practicums and who needed to do both group and individual work. So most of the individual services that are offered are done by students who are supervised. The second reason why the individual services were developed was because some members weren't ready for group work or they needed to deal with a specific issue and the group wasn't meeting their needs. So, if we had somebody on staff to see them individually, we would orient them to individual work. However, the group therapist can not see them in individual and in group. That is a rule we have and also if a therapist is offering three groups a member can't attend all three groups. The member has to chose one group. They can be seen only once with that therapist, but they can see other therapists in other groups.

AD: What population specifically do you serve?

JO: Well, when we first came on the map, nine years ago, the initial mandate was to service the community. It was a very large community and the goal was to fill the void between the structured activities of the psychiatric hospital services and the more popular activities, like social and in the educational sphere. So there were discussion groups around a theme like stress that came into being. We were not actually asked to target a population, it was a very open kind of thing. Then in 1993 no, it was actually 1991, we were asked to work within the community of psychiatry. But then again, it was an open thing. We could take people who were mildly depressed or going through a divorce. It wasn't specific to persons with chronic and severe mental illness. Yet, with the increased funding we received over the years; there was more of that mandate being placed on us from the Regional Board. So we have taken the attitude that we would take whoever called the Centre. People who were dealing with trauma from childhood who were functional to some degree, some not and needing long term therapy; people who suffered a job loss or a burnout and would need our services for a year or six months as they would reintegrate back into their community; or like from the beginning, people who have much more severe and chronic mental illness for example, schizophrenics, manic depressives, people with anxiety disorders, mood disorders - that kind of population. We've had more of the latter recently, within the last three years, and I think it has a lot to do with the closing of services in the hospital, the restructuring in the hospitals, and the channeling of people towards the community for psychological services and support.

I think that the services we offer like art therapy, music therapy, and the drama therapy really suits this clientele. It really provides them with a privileged space and tools to explore how it is to live with the anxieties and preoccupations they have because of their mental illness. It's like we are not in the game to cure them, we are in the game to help them with it, to help them accept themselves, and to tolerate what is happening to them. We see people in a lot of different situations. For example, we've seen people whom have known about their mental illness for a long time and received a diagnosis and have had numerous hospitalizations. Then we have people who are new to it all. There are different levels of self-awareness and of acceptance of what's happening. For example, many have to let go of prospects of going back to school or of dreams that they had before they got ill. So we do a lot of work around loss. It's a major component of healing in mental illness; for once the person gets the diagnosis or has had the hospitalization, or made the suicide attempt - what happens afterwards becomes very important.

They have had a major traumatic event happen in their life, it changes their interactions with their family, their friends, and how they see themselves. Moreover, in the psychiatric community, psychiatrists are continually pushed by the pharmacological companies to encourage their patients to try the newest drugs. So we see the patients change their medications and come in and say, "Well, I'm more anxious." You see changing medications is not that simple. Sometimes it takes weeks for the drug to integrate into their system so until it gets

integrated, patients go through all sorts of mood swings, fears, anxieties, instabilities in their appetite and sleeping patterns. And then if it doesn't work, it's too much, they are over medicated, they are sleepy, they have to start over again. All these side effects can happen just because the psychiatrist says, "Try this, try something new, this is the newest thing out." Or sometimes members become depressed or anxious because of something happening in their lives so they take more medication which can have unwanted side effects. The population we have been asked to work with more and more are individuals presenting with severe and chronic mental health problems that need medication. And every medication has its side effects...weight gain, loss of sexual drive, water retention, etc.

AD: Is there a population that you feel could benefit from art therapy but for some reason has not been adequately served in this community center?

JO: I think that there is a population that has been identified by colleagues of mine in the community. There is a population that has been deinstitutionalized, who when they were living in the hospital setting had all the services within their reach. Then, with the government reforms and the transfers of these patients into the community, into foster homes, group homes or in rare cases into independent living settings, things weren't so easy. All of a sudden in order to participate in a group therapy at a community resource they have to take a city bus or walk a few blocks. We have witnessed that they not motivated and inspired to do it. So there is a whole network of people who are living in foster care or residential settings that we know are sitting there medicated, watching TV, eating and could really benefit from our groups, but who are just not coming to the Centre. There are some caregivers in these resources that will make the outreach and will accompany their clients to their appointments, at least in the initial stages, but not all of them do. I think that there could be some sort of linking made between our services and the residential care network.

AD: Is this where case management comes in?

JO: Well, I think that that is one solution that exists. However, I personally feel that the larger problem lies with changing the habits and mentality of the Douglas Hospital workers. The hospital services are being asked to come outside of its walls and into the community. Mental health treatment is no longer only available in a hospital setting. I think hospital workers are having a hard time with this. It's easier and more costly to have all services under one roof. But, that's all changing now and workers and patients are having to change. We have noticed that when hospital workers physically accompany patients out into the community and to resources like ours that people that we thought would never stay, stay when this is done and they come back. It's making that initial link. When hospitals, like the Reddy Memorial or the Queen Elizabeth were closing, the staff was forced to take their patients out into the community and make those links. The ones who did come with the psychiatric nurse or psychiatrist stayed because there was that physical accompaniment. Someone took the time to walk them through it and

discuss the impact. Plus there was follow-up with us, the making of the link to who ... like we would say, "Yes, they are coming, they are attending." I think sometimes that's missing.

AD: How are clients referred to you? What is your referral base and...

JO: We get referrals I would say generally, through outpatient clinics at the Douglas Hospital, the CLSC network, and other community resources. But it's really due to our flyers out there. We have a schedule of all the groups that we run and it's sent out seasonally. We have a mailing list of two hundred and fifty resources: social services, psychiatric resources, occupational departments, inpatient and outpatient day centers in hospitals. Now with the new model of the sector teams we are also sending out our flyers to them so that they have an idea of what our groups are. We encourage people themselves to phone us and to inform themselves as much as possible because you know, they're the ones that are ultimately coming here in minus thirty below weather in February or in the sweltering heat of the summer. Most of our referrals are from the psychiatric and mental health community.

AD: So links between community centers and the institutions...

JO: Yes and some general practitioners. We have tried to get our pamphlets out to the clinics as well, even to the police stations. We have put flyers out in the Lions Club and the other community resources that are not even linked with mental health because there are people who might have mental health issues in these settings as well.

AD: Going back to treatment objectives for clients, can you tell me how involved clients are in their own treatment objectives? If the clients identify what they would like to work on and how they would...

JO: Well, when somebody calls, our receptionist who is quite astute by now, she's not a clinician by far but she can ask the appropriate questions to see what kind of issues somebody is wanting to work on. Then she will direct them towards specific services in the center because we do have limited resources. For example, we might have a music therapy group that is being given in English and the people who are attending are dealing with depression. We would not encourage someone to integrate into that group who has an anxiety disorder or who has a borderline personality. We know our groups and who is attending them at any given time, and when this changes. Some groups may have a lot of schizophrenics in them and other groups may have a lot of depressed woman, working on loss and panic attacks. So we would do a mini intake evaluation over the phone. We will ask them key questions about who has referred them, which right away gives us a big clue. If it's their general practitioner, it might be less serious, than somebody at the Douglas. There will be times where they will be vague and noncommittal about what they want to talk about, what they want to

deal with, so a more qualified clinician will call them back. Sometimes we will invite them and will say you come and try to integrate into a group for a couple of sessions and see if you fit. It's really based on their needs. There have been times when we thought that the person would never stay and they stayed and they fit. Then there are other times where we would say we would put our hand in fire, certain that they will stay, but they don't. It depends on who is in the group. It's always whatever they want to talk about and it is based on their readiness.

AD: So, it's very individualized then.

JO: Yes, but it's also very based on the needs of the group because we practice mostly group therapy here. I've seen a case where a person wanted to process a loss of her partner who committed suicide. She was very depressed and she wanted to work on this but the rest of the group was in a much more manic phase. They had already gone through a depressive phase and they weren't at that place. They were not able to be there and accompany her through that, with no fault of their own. That's where that group was at that time. So one of my interventions with her was to extract her from the group, sharing with the group that I thought that it would be beneficial for everyone, so that her needs could be addressed elsewhere, maybe in individual or in another group - which is what she did. She went to a writing workshop at the Centre instead and was able to work through the issue. But it was only in the course of working with her in the group that we could understand what her needs were. It became much more evident what her needs were.

AD: What about families are they ever consulted at all, maybe in the preliminary stages

JO: Very little, and again it's all with member's informed consent. If members want us to talk to their psychiatrists or their family, we discuss it with them first and why they want us to do so. Sometimes, we've had psychiatrists ask to see the art images of a member and so we ascertain whether the member wants it, whether they see it as a benefit, why they would see it as a benefit for their treatment and then we make the contact outside. There have been times when we've seen that it's not been beneficial so we have encouraged the person not to do so, or supported a member who didn't want to. Our intentions are always based on people's pace and where they are at psychosocially. Even though we think they may need to work on an issue, if they are not ready to, we're not going to force them. If they leave the therapy prematurely we don't guilt trip them either. Maybe they weren't ready. They can always come back later, the door is open and you know of course, the waiting list is there, but we always have to deal with that reality right!

AD: Well, we're moving along nicely. The next question I will pose pertains to how you feel that your services, or whether you feel that your services are,

sensitive and relevant to the different cultures that you may serve. If you could talk about that a little bit...

JO: Hummm, well, I think that to be honest with you, I think that in the Southwest region there are a lot of visible minority groups, for there are a lot of Jamaicans, there's a small Indian population, there's also an Italian population. We do have individuals from those minorities that come to the Centre but not a lot.

AD: O.K.

JO: And to tell you why that is, I think it could be twofold. I think that it is culturally based. We are offering a westernized kind of therapy, coming to tell a stranger about your problems or coming to tell other strangers in a group about your problems. In some cultures it's not viewed as a thing to do. Moreover, I think to be honest, eighty percent to ninety percent of the staff here are young women or women between thirty to fifty years of age. We have one male psychotherapist on staff. Most of us are Caucasian and we are not visual minorities and it wasn't planned that way, meaning, that's who has come for the jobs. The psychologist we have on staff is Chilean but when you look at her, you wouldn't think that, for she doesn't have a dark complexion, however she does speak Spanish and is sensitive to the cultural issues. It's not a major preoccupation, we are not really working with a large visual minority population, and we don't advertise ourselves that way either. I can imagine somebody who is Jamaican walking in the door and seeing all these white therapists might not feel totally at ease. They may turn around and say, "I don't feel like talking to a white woman or a white man, I would like to talk to a black therapist." I can really empathize with that. It is something that has been brought to my attention by a social work student. Unfortunately, it's one of our weaknesses. It's not within our mandate or within our reach right now based on the people I've employed.

AD: Right. In terms of clients participating in different community centers, like CLSCs, outpatient care programs, is that fairly common?

JO: I think so. My experience has been that people who want help are quite resourceful. They will shop around and will use different resources but they will still be committed and have an allegiance to one or two, which they will favor. They will present themselves as being more of a member of one specific resource. But that will not stop them from going and shopping around and using other resources in the community. And we as a matter of fact, encourage it because we don't want to become the sole providers of support for individuals. We have quite close networking relationships with other resources, like the crisis center and other types of resources, in order to help refer people. We can't meet all the needs.

AD: As a center how do you identify the needs in the community? How is that done? At the beginning you were discussing how Expression LaSalle came about through surveys which assessed the needs of the population, is that done on a continual basis? Versus, how do you think the community might view it's own needs?

JO: I think it's a time of confusion, any way it is for us in this sector. The primary reason is related to the fact that the Douglas Hospital has been undergoing a major restructuring internally so, there has been a lot of shuffling of services and people. The government is forcing them to cut services (i.e. money) in order for that money to be reinvested in the community. The CLSCs have within the last two years received money to create mental health teams. Some of those mental health teams have been composed of people who came from the hospital closings; human resources that were redirected into the community, like psychiatrists, social workers and psychologists are now working in the CLSCs. That's a whole new thing for the CLSCs. They never had a mental health mandate before. I think there is only one in our region that took on that mandate in the Saint Henri and Saint Charles area. Other than that, the LaSalle and Verdun CLSC, never had a mental health team because they didn't have the resources, but the CLSCs in LaSalle and Lachine are developing these. So they are also in a process of restructuring themselves and defining their mandates.

A lot of the community mental health resources like ourselves have within the last few years seen their budgets triple and quadruple. I mean like in 1994, our recurrent budget was forty thousands dollars from the Regional Health Board and now we are up to one hundred and thirty thousand dollars a year. So that's meant that we have undergone major restructuring as well. We have been trying to define ourselves as to where we are going to put the money and how are we going to develop the services. But, as with any development there are positives and negatives, you know, there are growing pains. So the entire network has been restructuring. I think that it is natural at this time that there has been a lot of confusion about what are the communities needs. It's really hard to identify what the community's needs are because, the government's policies are dictating so much change. Plus, how can we evaluate the benefits or the outcomes of the changes in services if there hasn't been enough time for the benefits to have actually been put into place properly and allowed to help people? That was something that I was saying recently at a regional committee, as I noticed that there was a lot of research projects coming out of the Douglas Hospital, which are trying to assess how the *Le Virage Ambulatoire* has affected the population of clients, the community resources and us as workers. I think it's a bit premature to be assessing this. I think what a lot of these studies are going to say is that, "Boy, its all messed up right now." Maybe other things will come out of it, who knows. But the needs are being dictated by the financing and what the government is deciding as to what they are reinvesting in the community. I think a lot of the needs are being dictated by what the government is putting back in. I mean they are cutting millions out of the hospitals but...

AD: So, they are putting money back into the community?

JO: Two or five percent is coming back into the community.

AD: But you said that your budget...

JO: We benefited to a certain degree but to really run Expression LaSalle as it should be run, it's not a hundred and thirty thousand dollars that is going to respond to the needs. We have a budget to rent this place, but the facilities, if you look at them closely aren't adequate. The group room that we use for movement therapy is very small and the ventilation is poor in it. The two small rooms that we use for individual counseling frequently overheat and both windows give onto Newman Boulevard, where there is continuous traffic, so we can't open the windows. We have a little room for the staff, it's like a cupboard. We can't afford anything better. We already looked and better facilities are out of our reach.

Concerning the funding of the Centre, it was the Regional Board that put us on the map. The recurrent funding that they give us is part of the network of health and social services that the government is supposed to promise the people. They provide that chunk of money. They don't penalize us if we get money from other government departments, foundations or other agencies, like Centraide. So we can do fundraising and receive donations through private corporations and things like that. We are a registered charity. We can receive donations, for example, this year we received a donation of six thousand dollars worth of office furniture and we provided a charity receipt for that. We even received a computer one time too. So the registered charity status helps.

However, the funding itself, like going from forty thousand to one hundred and thirty thousand a year, marginally responds to the needs of the community. If you look at the type of clientele that we see, they are increasingly more fragile and chronically ill and require fully trained professionals to work with them. Whenever I hire, I'm always trying to find qualified people who are trained, have degrees and clinical experience.

Psychologists, social workers, and even therapists in the field of creative arts therapies have committed many years to their education, as well as money into their training. I think that the education we receive in the creative arts therapies is better than in social work and occupational therapy and we are *en par* with the field of psychology. Community Mental Health Workers want to be paid like professional in the hospitals or the CLSCs. Unfortunately, I can't pay that. I don't have the financial resources to pay people what they actually deserve. I think that community resources suffer the syndrome of being the "poor cousin."

Historically, when community resources first came on the map, they were staffed with volunteers or people who were willing to work for eight or ten dollars an hour. I can't find people to work for that today. Even in the field of the creative arts therapies, people are expecting to earn twenty or more dollars an hour. When

you consider the serious nature of the work that we are doing, and the very fragile people, who are sometimes suicidal and who have major difficulties in judging between their inner and outer reality, it only makes sense. There is a lot of testing of boundaries and ethical issues that come up. It's a major responsibility to commit to working with people like that. It's hard work and workers want to be paid what they are worth, as well as for the difficulty of the job.

Unfortunately, I've lost good people to better paying jobs. Or they left because I wasn't able to give them what they felt they really deserved. Honestly, half of my staff are employed people with benefits like sick days and employer contributions into the Quebec pension. However, the other half are all on contract, that are working independently. I would love to be able to have them as employees who can benefit from statutory holidays and have paid vacation. But it is impossible with the current funding that we receive from the Regional Board. Thus, we constantly have to address issues related to employee status. The inequalities, the feelings of envy and jealousy that it creates and the messages that it sends - that one is more important than the other. Unfortunately, that is the way the hiring structure has evolved and through no fault of anybody. But when we compare ourselves as community workers, vis a vis, the CLSC workers, or the workers in the hospitals settings, our salaries and our benefits can't be compared to what they receive. They are unionized most of the time. It's just night and day.

The government outlined in their Quebec Mental Health Policy recently, their intentions to divide all mental health care resources into a sixty/fifty ratio. They want sixty percent of the budget that they allocate for mental health services to be provided in the community (ambulatory services) and fifty percent to be spent in hospitalizations where they provide ultra specialized and more acute care services. If we are to assume an important role in their ambulatory health care services, then we also have to be recognized financially for what we are contributing. Frankly, I was very happy that we received an increase in our recurrent funding, however it certainly doesn't measure up to what we need. I need twice that amount to run this Centre, in order to pay all my staff in an equal fashion and to have good facilities to work in. We can't afford better facilities or else I would have to cut in to the staff budget.

AD: Do you also apply for grants on top of the recurrent funding?

JO: Yes, and that's another nightmare, if I can permit myself to say that. Funding agencies give grants but they have all sorts of restrictive criteria, the major one being that the money has to be spent within a certain amount of time. Usually it is in short spans of time like, ten weeks or six months and it's intensive full-time work. That's not really how I would like to be able to use that money. The typical grant obliges me to provide work for somebody on a full time basis for a short period of time. Whereas, I would prefer to employ a person part-time over a longer period of time, which would enable the Centre to provide more different type of services to the members, which is what they want. Our members have

repeatedly said that they don't want short term interventions, nor do they care to deal with more loss when the therapist has to leave. The other thing with non-recurrent funding is that I constantly have to be reapplying for it. Then there are periods of uncertainty while a committee is studying the dossier or application. For example, this year I was able to hire two people, an art therapist, and a psychosocial worker for a year. Towards the end of the year, I applied for an extension that I was eligible to receive. I left plenty of time before the end of the grant because I knew the importance of termination work for our members. After all, many members would have been in therapy for almost one year. However, what happened was the funding body left us in limbo for three months and couldn't clarify whether we would be getting the extra funding or not. So when we were actually supposed to be closing down the services and terminating with members, the funding body still had not made up its mind about the extension. I had to do a lot of pressuring to get either an affirmative answer or in the case of the negative answer a one month extension in order to do proper termination.

AD: This doesn't sound terribly therapeutic..

JO: Yes, it's horrible. For us, but more importantly for the members! The members became extremely agitated and full of anxiety, they experienced sleep disorders, and some people even abandoned and dropped the therapy completely because they could not deal with the high level of the unknown. So a lot of the non-recurrent funding is not conducive to the therapeutic type of work that we are doing here. It's frustrating, but that's life! We still continue to apply for the funding because at least it's something that we can offer to our members.

AD: And I imagine how time consuming that application process must be.

JO: Yes, grant writing is very time consuming and in Quebec, it has to be in French if you want to be considered.

AD: So obviously, I know who your members are but who would you say your client is in the broader sense. Is it essentially the government, the community, the Board of Directors? Who are you really responsible to?

JO: Well, I think there are many levels, but primarily two: the members and the Regional Board. I think we are responsible to the members because it is their needs that determine the mandate of the Centre and which groups are offered. Until now it has always been therapeutic work that has been requested. I don't know if you know, but in community mental health, the Board of Directors of the Centre is supposed to have a majority of users sitting on it. So for us, we have nine places on the Board and five of them are reserved for the users of the services that we provide, and four of them can be for people who are either working in the social services sector or who are citizens of LaSalle and who are concerned with or interested in promoting mental health issues. Usually we have representatives

from the local CLSC and other community resources. But the members are in majority and have a continuous opportunity to give their input and evaluate the types of services offered and needed. Like at one time, we discontinued to offer purely art as therapy groups due to the lack of response. Another request from members that we looked at recently was to incorporate yoga based exercises into our meditation groups. I meet with the Board of Directors frequently, like every six weeks, and the membership once a year at our Annual General Meeting. However, the members are welcome to come to me with their comments and suggestions throughout the year.

As far as the Regional Board is concerned, or the government, you know we have to submit an audited report that comprises an activity report, statistics, and an audited financial report. But they haven't come in and said to us that they think based on our statistics that we should be serving more people in the Saint Henri area. We haven't had this kind of close scrutiny or evaluation from the outside or from the Regional Board.

AD: I guess this leads into how do you as a community center evaluate your own services, whether it be by internal or external quality control?

JO: Well, I would say that evaluation of our services has been only internally undertaken until now. We have never hired an outside evaluator to talk with the members about the services and about the workers. There exist formal mechanisms, but we have never been able to afford them. As I mentioned just previously, my office door has always been open to our members, I would say that one, or two times a year, I receive complaints. Members are usually dissatisfied with the service: either the length of the service or they disagree with the therapist's point of view. Sometimes a member feels that the therapist isn't doing their job right. There have been times where it has been beneficial to have the Board of Directors address these complaints, because the Board of Directors is made up of their peers. Some of the complaints have also gone to the Regional Board and an external mediator has stepped in to assess the problem from our perspective, as well as the member's. We've always been able to resolve the issue. I believe that we've been open to receiving feedback from the community, like other resources. For example, we used to place a schedule of our groups outside the door of our offices. One of our members complained to a worker in another resource that our flyer identified that there was a sexual abuse group happening at a certain time and day. It bothered this member, but she didn't want to pursue it and asked the worker to talk to us instead. It was drawn to our attention how the schedule placed outside our offices was a breach of confidentiality, because the people coming and going at that hour at our Centre could be...

AD: Identified.

JO: Yes, so it helped us to reevaluate how we advertise our services and to make it more respectful of member's right to anonymity. We modified this and now we keep our flyers inside our offices, not outside. More general information is displayed outside now. So there have been things like that, where we have been very open to feedback. As far as evaluating the clinical work that goes on inside the Centre, we have weekly staff meetings where we examine among peers what we do and try to understand the motivation behind it, whether it be in policy making, our interactions with members or between ourselves. We have become a close knit team over the years and have developed means to talk to each other which are honest and supportive. Our goal is to give constructive comments whereby no one feels humiliated. We don't have a "formal mechanism" of assessing the efficacy of our services, but I could see it happening in the future.

AD: Do you keep files on your members?

JO: No, we don't keep hospital type dossiers or written records on members here. In the beginning, it was because the Centre was based on a self-help model and there were members (or users) on the Board of Directors who had access to all the files. The president of the Board of Directors had as much access to the files as the coordinator. But with time we adhere to a more alternative philosophy and viewed Expression LaSalle as a "community" resource. We wanted people to feel accepted as they were and comfortable to disclose what they want to. For example, someone new might not want us to know about previous suicide attempts which she has resolved. She may want to be addressed as who she is today and how she is coping now. She doesn't want it to be biased. Additionally, a lot of people come to our Centre with negative perceptions of psychiatry. They do not want to take medication and feel that psychiatrists don't take the time to understand them. Psychiatrists are frequently perceived as dictating to them what they should do. We on the other hand try to endorse an approach to treatment that puts the control into the person's hands. Members choose which groups they want to attend, what they want to deal with at any given time and how long they need a particular group.

As professionals, we do keep files ourselves, which we need to do ethically. Each therapist and student keeps their notes under lock and key at the Centre, however they are not accessible to other therapists. Although we verbally exchange information among ourselves about members, we respect each other's files. Moreover, when we verbally exchange information about members it is on a need to know basis.

AD: Which is very different from the institutions.

JO: Yes. For instance, if somebody was in my group and she is now in another group, I'll never ask the other therapist how she is doing. I don't need to know that. I wouldn't say either that I saw them at Zellers during a staff meeting unless

it had relevancy, otherwise that has nothing to do with what we are doing at the Centre.

AD: So I'm sure, the clients definitely pick up on that. One of my questions I was going to ask, is how do the clients perceive the staff here versus the institutional care they have received?

JO: I think they perceive us as being a treatment team, like in a hospital, and presume that every member of the staff is aware of their case. I have had a member in my art therapy group say to me, "Oh you probably know what I've been doing in music therapy," and they are quite surprised when I say no. I'll explain that we only talk about certain members or groups when we need to and it's not systematic. A lot of times we don't know and they want us to know, so I'll say "Well, what would you like us to know, why don't you tell this group what is going on in music therapy." They are surprised at the amount of boundaries and confidentiality that we maintain. If a member is having difficulty with let's say, the art therapy group we'll definitely encourage that the resolution of any conflict happens in the art therapy group and not in another group. Members are instructed to go back to the group where the difficulty originated. Sometimes, a member will leave a group flustered and go and sit in the waiting room and try to talk to the secretary/receptionist instead. The receptionist will say, "You know, I'm not a psychologist, I'm not an art therapist, and the best place for you is to go back into the group."

AD: O.K. How do clients see the role of the art therapist versus the more traditional verbal psychotherapist or psychiatrist? Do they make comparisons? What do they see as the gains, the differences between the two?

JO: Well, I think that in art therapy there is obviously the art medium and the art process is the center piece of a group therapy. I guess the privilege of that is having a concrete element. From a team point of view, we see when the music therapist talks about her group, unless she actually records what the groups has done, she is verbally talking about it, and there is kind of a bit of an interpretation of it. Whereas, when we bring in an art object, it's very pure. Each member of the team can project onto it and see it differently, however it is still more of a pure product or expression of the person. We also have the benefit of having a visual record over time with the art. We can do a review, we can bring in for example, ten weeks of art work that somebody did. We can show it and have a visual display of a person's process in the product. Whereas, it's much more difficult to see that in movement therapy or even in drama therapy. The drama therapist can explain it and unless she has videotape, there is something lost. Anyways, whenever we translate whatever we do in the therapeutic space there's ultimately, I would say eighty percent of it is lost. There is so much that transpires in a therapy: there are feelings, sounds, visual gestures, and verbal exchange of conversation. Even when we take notes after a session it's impossible to get everything. So, I would say that in a sense, the art is something that is extra

special. It can stand on it's own and it's permanent. There's a permanent record there. It's quite astounding to see when somebody hasn't done a review of their artwork and the first time they approach it, the impact they have. Like when you see a piece of art every week and you come back to it and when you see it all laid out and are able to look at some sort of evolution that's happened or a change or no change that's happened. It's awe inspiring. It can be very overwhelming for a client. I think it's very empowering because it's a huge validation of who they are. It's like holding a big mirror up to themselves. I think the art sometimes creates envy within the team because the art therapist has all these big juicy pictures and lots of concrete examples. Whereas, in the other therapies they don't. I don't mean to say that they aren't doing just as good work but they don't have this extra. Although, I think sometimes we are forced to deal with the feeding, the mother stuff also you know. We get a lot of dependency that maybe some don't get the same type of transference.

AD: What do you see as the strengths and weaknesses at Expression LaSalle as it is presently operating? Essentially, what aspects of your service do you feel work well and what aspects do you feel work less well. Are there suggestions for improvements that you can offer, future visions etc..?

JO: Well, I've seen Expression LaSalle mature, going on now six years. I've seen the Centre grow from the point of view of economics; from being relatively under funded to being better funded, however I still feel that we are under funded. I think that combining a model of being a community mental health center with a clinical model of psychotherapy is a strength. I think that it is a new thing to be offering. However, I think that it presents us with a lot of challenges and greater conflict of interest situations. By definition, a community mental health center is governed by a Board of Directors whose membership majority are the users. So if we look at it in a clinical sense the patients are running the show! When you have the Centre being run by patients, the good side is that you know that the money is being spent on services that they want. Their needs are heard directly in the Board of Director's meetings and at the Annual General Assembly. Objectives are constantly being modified according to the needs of the people using the resource. In that sense, it is very positive, it is very grassroots which is exactly what a community mental health center should be.

However, when you bring in a clinical model to it, things become more complicated. If you look at the Centre's administration from a psychodynamic framework, it's potentially incestuous. I have a lot of roles and I interact with the members, personnel, students, and the Board of Directors. There are a lot more boundary issues to be handled, as well as ethical ones in a psychodynamic model. For example, I frequently supervise employees or students who are providing therapy to a Board member who is my boss. If ever an issue or a conflict arises, I may not be in a position to be objective if it relates to an issue concerning their therapist. We've set some very distinct definition of roles and responsibilities for the people on the Board. For example, members on the Board are not supposed to

be in therapy with myself, and if they have, it is best that it has been a few years ago. The distinction between my role as an administrator and as a therapist at the Centre is made clear to them. We are always careful to avoid conflict of interest situations as much as possible. Since there is a limitation in the funding the members, the personal and myself ultimately find ourselves in challenging situations.

I could name a few situations that we have encountered over the years, but we don't have the time to go into it. What is important to identify here is that we have had difficulties applying a clinical model in our community mental health resource. One of the primary mandates of community mental health resources is to promote the empowerment of members, their decision-making practices, and their inclusion in the running of the place. Many resources do this by allowing its members to volunteer in the day-to-day functioning of the place (i.e. answering phones, running programs, etc.). Yet, since we have the strong clinical and psychotherapeutic component in our resource, we can not have a member doing volunteer work because that person would be exposed to names, addresses and telephone numbers of other members who might want to have their confidentiality protected. Professional workers and students adhere to a Code of Ethics that clearly outline rules of ethical behavior in the mental health field, but this is not the same for members. It's an uneasy relationship and we are continuously dealing with boundary issues and ethical issues all the time. So it's a strength, but it's also a weakness.

The fact that a predominance of our services are in the creative arts therapies is a major strength and uniqueness. We are not offering just pure verbal psychotherapy. The fact that we are a functioning center with all the creative arts therapy modalities is a precedent that people are drawn to.

Another positive element about our services is that they are free to members. This is an important aspect because many of our members are on disability or welfare and would not be able to afford the services in a private practice milieu or setting. It's not like we have access to Medicare reimbursements from the government ... there is none of that here, like in a CLSC when people see a nurse, a doctor or a social worker. So, until now, we've had the policy that people don't pay for the services. However, beginning this fall we shall be requiring that our members pay an annual fee of ten dollars for their membership card in order to participate in the activities. It is a small fee, but we believe very symbolic.

As the Centre has grown over the years, our waiting lists have become really, really, long. I think one of the things we might have to envision changing in the future is the duration of the services. Right now members can participate for as long as they like or as long as a service is offered. We might set a two-year limit on participation for instance. The growing waiting lists raise moral issues: How can we offer somebody five years of therapy if there is a waiting list of 73 people? We have kept statistics on our waiting list over the last two years, and like I

described earlier, they are constantly changing. We are constantly calling on new people since people leave the Centre on a regular basis. However, we have noticed recently that the waiting lists seem to be slowly growing. Inching up slowly, so, that term limits might be something we need to address. I don't think we can add more people to the groups in order to form larger groups for it would be too anxiety provoking to have bigger groups.

We have put into place some strict rules and regulations about attendance and absenteeism. If somebody misses more than three times in a row without a serious and valid reason like a hospitalization, a sickness or a death in the family, we inform the member that their place is going to be given to someone who is on the waiting list. We question their motivation and investment, especially if they just abandoned a service without telephoning to explain.

We are trying to respond to the needs of the community and adjust to the financial realities of what the government is transferring "budget wise" to us. As I mentioned previously, the new plan of the government is to make available to the population, sixty percent of the services in mental health in the community and have forty percent for hospitalizations in institutions. When you look at the cutbacks in the hospital settings and the transfer of services and budgets into the community, we've noticed a big change over the last three years in the type of clientele that we are seeing. They are more psychologically fragile, and present with more severer and chronic mental health problems. These are the types of people who need long term care and support. Moreover, they have a great deal of difficulty with change. The Douglas Hospital recently undertook a research project that examined the follow-up care that individuals who had a major crisis and hospitalization received. One of the results of this study identifies how patients are subjected to a mental health network that is continuously changing. Patients complained about how often they were forced to change workers and to tell their story over repeatedly. Worker stability and service stability was identified, as a very high need for this type of clientele. I think that some of our service responds to the needs for longer term support. Some members have come to our groups for five or six years. We are managing to meet that need, but then there are the growing waiting lists. Who is going to respond to the other people on the waiting lists that need the longer term care and support too? That's something we are struggling with as workers in the community mental health system.

I believe though that our services in the creative arts therapies are popular because they are so appropriate to this clientele. The majority of our members have difficulty coping with and managing their emotions, as well as expressing them. They tend to isolate themselves, and have problems with their communication and social skills. Group art therapy responds to many of their needs and is non-threatening in many cases. It provides a social and creative activity which assists in breaking their isolation and creating links with people with whom they can share concerns and get support. Many of our members feel isolated because they can't work, as well as stigmatized since they don't have the energy or capacity to

even do volunteer work. We see a lot of people suffering a great emptiness in their lives because they feel that they aren't contributing to their families and community. Psychiatric medications can dull the pain, but it certainly can't provide meaning and self-fulfillment in a person's life. That's where the creative arts therapies step in. Our groups help reconnect with life and emotions. They stimulate, energize, and bring purpose through creativity.

AD: In terms of gaps in the mental health care system would you say as you mentioned previously, in terms of continuity of care, that a person is not experiencing that stable support? Is that one of the gaps that you would identify?

JO: At one time, the hospital had the primary vocation of offering mental health services. Now they are in a period of restructuring. Many people, who were living in and receiving services in hospital settings, are now being integrated into their communities. Because of that shift we are going to have a whole work force that's going to have to be retrained. If you are going to close a bed, you aren't going to have work for the person who cleans the room, does the laundry, or who administers the medication. Most of those workers are unionized and have guaranteed jobs. Something has to give. This work force, formerly in hospitals, is going to have to either retire or be retrained and come into the community and be implicated.

AD: Is that happening at all?

JO: Well, I think that in some areas like nursing, social work, psychiatry, and psychology, it is happening. Workers are being transferred into the CLSCs and towards the creation of mental health teams in CLSCs. Then, in the Southwest region of Montreal the Douglas Hospital has adopted a model of community care which is comprised of Sector Teams. Each CLSC sector (five in all) now has a "Sector Team", who is headed by a psychiatrist and provides case management and community follow-up for individuals who need it and have a revolving door syndrome tendency at hospitals. One of the problems right now is that the hospital has limited qualified people to work on these teams and an abundance of people that have to be retrained because they are not skilled to work outside the hospital walls. I'm glad, I'm not the head of the Douglas Hospital right now. Then of course, a minority of former hospital workers are applying for jobs in community resources.

So, at this time, the partners in mental health are trying to create a new network of services that include the community resources, the CLSCs, and the hospitals working together in partnership. A three party partnership. Currently, I sit on a committee which brings all three partners together, COPASM: Comité des partenaires en santé mentale du Sud-ouest. We are slowly building a new network, but we have to work through lots of misconceptions about each other. Opening lines of communication and working complementarily is a main goal. I think that community resources have had to really work at being perceived as serious and

qualified to work with the clientele that is deinstitutionalized. The hospital isn't the expert anymore. It's like a change of mentality that the entire community is being asked to do because the government doesn't have the money to keep people in hospitals. The funny thing about it is that I think a lot of community resources believe that it is healthier to have a person living in the community- rather than in an asylum. Isn't it more normal for people with mental illness to be part of the community and have the community assume the responsibility for them? It's a small percentage of the population, but it is a big burden.

AD: Maybe you can speak about your understanding of how art therapy has been implemented after or since deinstitutionalization. Do you have an evaluation of where we are since the early eighties? What needs have been met? What changes have occurred?

JO: In the last ten to twenty years art therapy has come to be practiced in a wide variety of settings in the community. While art therapists have been quietly working, they have been in a process of proving to other mental health professionals that we are skilled and qualified to work with people with serious mental health problems. We provide assessments and treatment interventions like psychologists or social workers, but we have an added tool- the art and creativity. From my experience working at Expression LaSalle for the last six years, the best proof that art therapy deserves its place in the new network of services are the results. Many of our clients are followed by psychiatrists or psychiatric nurses. Our members give them personal testimonies of how art therapy in our community center has helped sustain them, combat a crisis, prevented them from being rehospitalized, helped them cope better with their emotions, helped them with their interpersonal skills, and helped them better accept themselves. We have been winning validation and receiving recognition through individual and small successes with our clients. Now when I go to a meeting in the community or at the Douglas Hospital, people respond to me, "Oh, you're from Expression LaSalle, that art therapy stuff is great...it has helped countless numbers of my patients." I come out feeling great because we are getting validation now and only because of the concrete work. I would never have received that validation or recognition years ago. They didn't know what art therapy was and there was no proof of how it benefits our clients. So I think the more that we are involved in the community and implicated, the more we will be taken seriously by other professionals. When we will be seen *en par* with them, hopefully then the financial recognition will come. Art therapy will be perceived as a viable option and not seen as a frivolous thing that should get axed first.

AD: What is your vision for art therapy in the community?

JO: Well, right now the way Expression LaSalle is funded, it doesn't permit us to put into place the full scale of all the different types of therapies that could be offered. For example, right now we can't afford to hire a drama therapist. Moreover, my music therapist and dance therapist are independently contracted.

My vision for the Centre would be to permanently employ a part-time art therapist, a part-time music therapist, and a part-time drama therapist and dance/movement therapist. So that they are actually employees that have full benefits, statutory holidays, plus a sense of permanency and seniority could develop. Around this core staff, we could still have professionals on contract coming to give other specialized groups and have students as well. In a sense, currently, we are providing as many services as possible, but like I said before, there is an inequality in the pay scale and the benefit structure. In reality, somebody who does come to work in this setting really has to feel strongly that it is what they want to do because they will have to make some concessions. You know, they will have to let go of certain things like health care or pension plans. We can't afford that, we can't offer it at the present time. It would be nice if we could be financially recognized like other mental health workers. I still think community centers are perceived as the "poor cousin" and a lot of times the government expects the place to be run by volunteers. There is going to be more and more creative arts therapy professionals coming into the community resources and it will be up to us to demand the recognition that we deserve. Thank you.

Appendix E

Interview took place at Arbour with Alice Hogg and Laura Goldberg on June 11, 1999

AD: Adrienne Durst (interviewer)

AH: Alice Hogg (interviewee)

LG: Laura Goldberg (interviewee)

AH: I'm Alice Hogg and I'm a co-director here at Arbour. Originally, we were three but now there are two of us at the helm. I did my graduate degree at Vermont. I did my practicum here in Montreal at Shawbridge, so I worked up North with youth and children. I stayed at Shawbridge for a few years and did a lot of community-based work after that.

I come from an art background as well, so I focus a lot on the artwork with the kids and the art process. I also have done a lot of work with elderly people in chronic care. All this has pretty much brought me to Arbour. There isn't really that much more background. There are a lot of little things that have brought Laura and I together. It's like six degrees of separation.

LG: I'm Laura Goldberg, the other co-director. I have my undergraduate degree in art education from Concordia and I graduated from the art therapy program in 1985 from Concordia. I've worked at Batshaw, which was then Youth Horizons for about nine years upon graduating. After that I got a job as the first art therapist at Maimondes geriatric center. I worked at the Douglas Hospital in children services for one year and after that I formed my own company called Creative Sparks with a music therapist. As partners we designed programs that combined art and music. We ran them both in elementary schools and alternative high schools. Three years ago, roughly speaking, Alice and Stuart called me up and asked me if I wanted to be a part of Arbour.

AD: So Arbour started three years ago. Can you tell me about how it was established?

AH: I think really it was that our backgrounds were the seeds for the idea and the name that we chose: Arbour. We really wanted a place that was very much for growth and development. A place to feel safe and protected as well as to be able to develop ourselves. We didn't want to limit it just to art therapy because there are a lot of other expressive arts therapies. With Laura's background in being able to work with a music therapist as well as Stuart's and mine, we were very interested in diversifying ourselves with other people. So it became a good place to do a lot of things in the community.

LG: I also heard just through speaking with Leland Peterson prior to getting together with Alice and Stuart, that he was thinking at the time of opening up the art therapy program to include drama therapy. We agreed it was the way to go.

AH: It was very telling that it would be great for us to work together; we all had similar experiences even though we had come from different orientations. Stuart had also worked at Shawbridge. I had been at Shawbridge and Laura had worked at Youth Horizons. The whole package is now Batshaw. We had never crossed paths while we were there and in fact I had met Laura through the Quebec Art Therapy Association because we both served on the Board of Directors.

LG: I hired Alice to teach my programs at Creative Sparks and I really liked her work and collaborating with her. Then I trained Stuart to take over as Treasurer for the Quebec Art Therapy Association, so we all kind of knew each other.

AH: The whole thing started officially on paper in 1997 but we started the Christmas of 1996.

AD: Here in this building?

AH: Well this is our second office. Our first office was in another part of the Complex. We were in another space and that was the location where we defined what we wanted Arbour to be. Then we decided to move, and that's when we felt that our ideas were a bit more put together. We had a better sense of what we wanted.

LG: Our move coincided with Stuart leaving. Stuart got a job out West but he remains on our Board of Directors. Once Alice and I were left running the show, we decided we were going to shift a bit and move to this space. I think we solidified our goals, our visions on what we wanted to do. It's very different with two people than with three, a different dynamic. However, we knew from the beginning that we wanted this to be a place that was more than a shared private practice. We wanted to support other therapists in the community.

We became non-profit so that we could access funding. If other therapists wanted to rent space and apply for funding, they could do it through Arbour instead of just struggling on their own. We also wanted to collaborate with other kinds of therapists so that we could have all these different things to offer.

AD: If another art therapist rents space from you, is it in this building?

LG: It's right here. It's this room.

AD: So you all share the same room and work on a time schedule?

AH: Yes.

AD: The next question addresses the range of art therapy services that you provide, whether you use the art or music as art as therapy or as art as psychotherapy. Where do you fall? Do you even buy that split?

AH: I think we all pretty much work in a variety of ways depending on the clients that we have. There are two camps and most people fall in between somewhere that art is the therapy and that art can be used as a psychotherapeutic process. I am of the opinion, that art and psychotherapy are very much connected. But it all depends on the clients, some don't want something very and there are some that are really just not ready for that. So we work at the pace of the clients.

AD: So clients are quite involved in their own treatment objectives?

AH: Yes. Some people call not knowing what kind of therapy they want, so we give them an idea of what it is we can offer them. If they are looking for something that we don't have, then we will network among people that we know to find out who does have that kind of background and training in order for us to either refer them or bring the therapist on board so we can help the client.

LG: I think as Alice said we all have enough experience and we are all flexible enough to meet individuals' needs. We've all been running groups or trying to run groups. One of our members runs a group to help people explore their creativity and explore their personal issues through their creativity. So when people call and say, "Well, I really don't want therapy but I want something that has to do with painting," we think of this particular member.

I work with a very young child who uses play, the art supports the play. I've been running groups for diabetics and they're support groups. We do a lot of talking but we always have an art activity to focus on a certain issue. The clients say, "The art is great because it really got us to break the ice and get into very painful things that we just wouldn't be able to leap into."

AD: So you offer group sessions. Do you ever run groups together?

AH: We haven't yet. There was a project that got put on the back burner with Stuart and I doing something for an eating disorders clinic. It was advertised but with a lot of groups, it was very hard to get going. The climate right now for anything like the expressive arts therapies or anything considered alternative or not quite the standard norm and with the health care and social services in such a flux, it is a pretty big issue. All of this to say, that that particular group didn't really quite get itself going. However, we did get a few other things going with other organizations that are around us. There was the Miriam Home, I think Stuart did something with that.

LG: He ran a group for intellectually challenged adults at Miriam Home. He also got a contract for a summer camp at the Fluency Center for very young kids as the art therapy specialist.

AH: And that was all through Arbour, they got to know the organization, they got to know Stuart and it did some nice networking for us too.

AD: You had mentioned a few minutes ago that it is hard to put a group together especially because the expressive art therapists may be viewed as more alternative. Have you seen a shift in the last couple of years in terms of art therapy being more embraced by the community? Can you speak to that?

AH: I don't now if I would say shift. I think the interest has been there for a long time but we live in a province, a country, which really supports health care for very little cost. They are doing so many cutbacks everywhere that I still think that people find the concept of free health care very hard to let go of. None of the expressive arts therapies have ever really been considered mainstream, so you always had to pay for those. I think for some people that's a deterrent but it seems to me that more and more people are calling and asking questions. But what it really ends up boiling down to is the cost.

LG: I think that the shift has been really slow in coming. When I graduated in 1985 we were told we were going to be pioneers.

AD: They're still saying that!

LG: They're still saying, "It's up to you to get out there and create jobs and educate people." I can tell you I do quite a bit of presentations and guest lectures at McGill, Concordia and Dawson and I always bring flyers and pamphlets. People express appreciation for the lecture but I find over all that people really don't now much about art therapy.

AH: After fifteen years!

LG: As far as I'm concerned, I think the profession is still at that level of being pioneers and trying to educate people and have it accepted. Those of us who practice art therapy and for the few that actually come and take art therapy all know how great it is. We all know how well it works, that there is nothing in the world like it. But to let people know exactly what it can do, how deep it goes and what it brings out, that process is difficult. I don't think it has shifted very much.

AD: Do you have any outside funding, for example from the government?

AH: Not yet. One of the difficulties with that is because like most every other art therapists and probably music and dance therapists out there, we haven't been able to do full-time work here. Most therapists have to have another job as well in order to supplement what they do. Full-time work elsewhere means that you have less time to dedicate to something like this. So there really hasn't been a lot of time. We have spent pretty much all of our extra personal energy making sure that business floats, but up until now we really haven't had time to be here on a regular full time basis.

LG: Our top priority, beside paying the rent, has been trying to get clients, trying to get other people to come here, to get the word out and let people know that we are here. And similar to Alice, I have another part-time job and these two part time jobs do not equate one full-time job. So it's really been a struggle. The other part-time job is draining and work here with whatever extra energy that is left. We find it hard to do everything. It was a little different with Stuart here but he also had a job that was very draining. So it's been rough.

AH: I think part of that is also because that's where more of our energy has to go.

LG: And I think as well, the way the system goes is, that it's hard to get funding when you are only non-profit. You really have to have charitable status. So that is our next step, but it all takes a lot of money, time and energy. It's expensive to get charitable status and it's not easy.

AH: One of the difficulties for us has been to sort out our structure here. There are so many hats that we wear and one of the things about a non-profit organization or organization period, is that you have a Board of Directors. You have an executive, officers, treasurers, secretaries and we happen to be all these things rolled up into one. So on the one hand we are the Board, the secretary, the treasurer, and the whole bit and then we are also members. All the members are free to use the space and run their own private practice, it just happens to be the two of us who do all the other things that make it an organization.

AD: Can you give a broad overview of the type of population that you serve. I guess where my interest lies in whether CLSCs and smaller community centers are supporting psychiatric patients in the community and whether that fits into the type of population that you serve?

LG: We don't have any psychiatric patients. There is a psychiatrist next door who has a steady stream of patients and as far as I know they come in to get medication adjusted. I saw him the other day and he said, "I almost had a referral for you," I asked "What happened?" He said, "Well she changed her mind." Overall, we tend to get parents calling about kids who are having difficulties in school. I've worked with a couple of people who have survived sexual abuse as children. I tend to get people who are having difficulties in relationships or expressing a lot of anxieties, and need to connect with the source of their pain and heal it.

AH: We have had a few that have called. I was supposed to meet with someone last week who happens to live with a psychiatric disorder, but that was not necessarily her reason for calling or for wanting therapy. It's never been specifically included in our mandate, but we would never refuse.

LG: Our mandate is wide open to anyone we feel we can help. We now have four members so between the six of us we have extensive experience with

different populations. But just to address that question, I work part-time at the Douglas hospital. I was there for one year as an art therapist now I work as an educator. They had an art therapy room for the adults in the Newman Pavilion for many years. I thought it was a wonderful oasis in the hospital. It looked like such a wonderful place to work. But, they forced this art therapist into early retirement and closed the position. So I think it's pretty safe to say that there is a need. This modality is something that works so well with psychiatric patients but it's being cut. Hospitals are suffering huge cutbacks. I know that the Douglas is in a transition where units are being closed and people are getting bumped. Services such as art therapy are among the first to go.

AD: I was speaking with Julia Olivier today and she was saying that the government's goal is to have forty percent of the resources directed into the institutions and sixty percent into the community. I have a feeling that may not be happening, in terms of making that shift monetarily. What are your views?

AH: I think we will probably see a lot more people make the shift than the actual pennies. One of the government's goals has been to cut down on beds in the hospitals. Theoretically, the upswing of that is that people don't have to feel glued to the hospital but that they can be out in the community and live relatively normal lives. But that's not actually happening. A lot of people are out on the street looking for something to do, something that makes them feel useful and contributing but the services have not been established yet. That is among the things we would like to do, to be there for that. But all of it is a very slow transition and just when people are starting to get used to that idea, we end up with more cutbacks, which means people are going to have to choose, are they going to pay for therapy, pay for their pills or pay their rent and buy their food.

LG: As for foster homes too, I think that this is probably where the money is going to go. As another example, one population that needs help are diabetics who do not get the support they need. I networked and I went to all the major clinics, hospitals, eye clinics, centers and pharmacies and met with the doctors and nurses who specialize in working with diabetics in order to get referrals.

I ran two groups, one which had four people, and the other had five people. I gave out questionnaires at the end of each group to assess and evaluate what they got from the experience, what they wanted that they didn't get. I got very positive feedback. Everyone said, "It's something that is hidden, that diabetics live with alone, that must be cared for every single day. There is a huge emotional component to taking care of diabetes." What you learn in the hospitals from the doctor is how to take insulin, how to balance that with diet, and it's all the technical aspects. My clients all said that this can easily be learned, but it's the fears of complications and of living with something that's hidden which is difficult. Having to manage and stick to the protocol, every day takes discipline. It's not possible for many to be that strict and a lot of them slide; there is a lot of denial and rebellion. I had someone in the group who had been diabetic for

sixteen years and she said, "I'm still really angry." One of the members said, "After sixteen years, you are still angry?" and she said that she was stuck in that anger. She stated that this group was an oasis because there is no where else that she can talk about these things, she felt that no one understands it. So I know there is a need for this kind of work. Most doctors are reluctant to refer their patients. I've gone to the open houses at the Royal Victoria and the Jewish General hospitals at the diabetes clinics, to show what my work has consisted of and to meet the doctors and nurses; it's been slow to get going.

AH: Because it's not present where they work every single day it's one of those things, out of sight out of mind. People don't necessarily think of art therapy first. There are so many other tried and true methods that have been around for decades, even centuries. We are pretty much still in infancy compared to a lot of the other social services that people run to first and foremost. I think that's one of the reasons it's been so slow going.

LG: And another problem, which was brought up by one of our members, has to do with the lack of art therapy as a recognized profession. She was talking about an occupational therapist she knew who took one or two courses and then said, "I can do art therapy." I was at a geriatric centre and when I began as their first art therapist I was introduced to the staff. A woman came up and said to me, "Oh, I didn't know that they were hiring another art therapist; I do art therapy". I said, "You do? What's your educational background?" She replied, "I'm a teacher but what I do is therapeutic". She basically used to set up a still life for the residents and drew the outline for them and they would color it in. The Head of Rehabilitation called us both in for a meeting to set the record straight: "This is what you do, this is what Laura does, and you are not an art therapist". But the centre knew and loved her work because it was visible, framed, and hung everywhere.

AH: I think there is still a misconception of what art therapy is and what constitutes therapy as oppose to something that is therapeutic.

AD: What needs to be done in your opinion in terms of helping this situation?

AH: Marketing is a big deal. However, the problem with that, I think, is that, and I say this a lot, I feel like I'm preaching to the converted. I'm telling people all about art therapy who say, "Yes, yes it's so wonderful," and I know we talk about art therapy because we are art therapists but I'm quite positive that any music therapist, dance therapist would probably say the same thing. The people we've spoken to are pretty much in alignment of where we are at too. Marketing is wonderful but it only takes you so far. We are still very much insulated. I think there is a lot that we do to try to break out of those ranks but at the same time we are very protective of our jobs, of what we have cultivated so far because we don't want to lose it. In order to protect it people tend not to want to share. There is a certain amount of territorialism. It's not always very negative but sometimes

it is and that can be a detriment. I think marketing is a big one but there are other things that go along with it.

LG: First of all, who goes to art therapy conferences ? Other art therapists. And it's hard to reach the public. It seems that when the public hears art therapy they either think, "But I can't draw, I can't do art. Or they think, "Oh, I knit that relaxes me so I don't really need art therapy," and we know it goes as deep as you can go but it's a well-kept secret.

AH: I think that's a big part of it. Other therapists have to get together and network. And as much as we really want to do that, I think that there are other people who say, "Well if I do someone else is going to steal my idea."

We had a woman who wanted to rent space. She was a very interesting woman, but she was not a therapist. We were a bit reluctant, now I'm not sure if we would be quite as reluctant because I think her program would have been interesting, she came with the same kind of mentality that a lot of therapists have (and probably would never admit to in a hundred years) which is, "I developed this technique, this is mine, this is my thing that I do and nobody else can do it." There is some truth in this: without proper training you can't be an art therapist, you can be a therapeutic art person, but people still don't get it. We are also not that willing to get out there and share it with all those other people and at least teach them how to be advocates for art therapy without getting really mixed up about the differences between what we are doing and what they are doing. There is a really fine line.

LG: Also, if you ask ten art therapists what art therapy is, you are probably going to get ten different answers. I have heard the way people promote art therapy and some of them make me cringe.

AH: Everyone's interest brings them to a different understanding of what they are doing. We are not a profession that's as clearly defined as "A is art therapy and B is not." How many times has the article crossed my desk when I was doing all my studies (called Art therapy: What it is and what it is not). It's a great article but it's pretty telling of where we are: We still don't know what we are.

LG: What we have started is quite unique. There really is nothing else like Arbour. When we presented at a conference a woman came up to us and said that there are only two centers like ours, one in Canada and one in the States. When I got in touch with her a bit after that in order to network with them and discuss our experiences, she said, 'They don't exist anymore, they've closed!'

AD: Why do you think they closed?

AH: Funding, as it is also our biggest struggle. Another element for us is that we really needed to work on for ourselves, was that we all had different ideas and

visions for what we wanted and then reworked all into one concept, that could make us all happy. You are automatically going to get a brand new thing in the middle that incorporates as much of each of us as possible. Those kinds of dynamics determine what comes out of it at the end. Maybe this is one of the reasons that the other groups didn't survive. It's part of, "What are we? Who are we going to serve? Who is going to come and use our services? How much time and energy can we put into this so that we are serving the people that we want to serve and at the same time able to still pay our rent?" These are concerns that we have .

LG: And referrals, as previously mentioned. Where do we get our referrals? With all the networking that we've done, we don't really get a whole lot. We've gotten quite a few calls every time an article appears in the newspaper. People have said, "I've seen your article and I'm really interested."

AH: I think that most of my clients have come from previous contacts. I'm now working with a client from Shawbridge. I haven't worked there in years but every once in a while they still want services. That's another place that might be interesting for you to talk to at some point. They have been doing a lot of work with kids that would have been sent to the Douglas.

LG: They have a psychiatric unit at Batshaw don't they?

AH: It's not specifically psychiatric. But most kids that would have ended up at the Douglas in a particular ward can't go there because the ward doesn't exist anymore. So they either act out looking for help or trying to find someplace to be and they end up in a place like Shawbridge. There are a lot of kids out there that need mental health services and I think that's a growing concern for them especially with really young kids, and that's where we come in.

AD: What do you perceive as completely unique at Arbour? What's different about Arbour compared to other community-based centers?

AH: The spirit of collaboration.

LG: I think there is a great potential that has yet to be realized.

AH: One of the primary things we wanted was a place for clients to come and get services and for therapists to come and apply their trade and to not be so isolated. No matter where you go any private practitioner will tell you, that they feel alone. They say, "I have no one to compare notes with, and I don't have anyone to meet and join with." We were really hoping that therapists would be able to come here and do that with each other. But because everything else has been slow going, that's also been slow going.

LG: Something that has been a great strength of ours is the lack of politics. Even though Arbour is still quite young, we don't have a clash of egos here. We are

three therapists who are in business, trying to run an organization. We have never had a problem with power trips or politics. It's very cooperative and we collaborate extremely well.

AH: For sure, that was a goal we all wanted for Arbour. Laura's main goal originally was to work in a team setting and I think that no matter how many people do or don't use the space here, that's here. Let's say we have somebody who calls who wants this and this doesn't interest me. We will call so-and-so to see if she or he is interested. Whatever it is, we try and do our best to make sure that the person is served and it's with somebody who has similar goals as we do and who can do it here.

LG: We support each other, we have peer supervision. We consult each other on a regular basis. There's real heart here.