EXPLORING INDIVIDUALS' EXPERIENCES OF TIME-SENSITIVE PRACTICE IN

RURAL NEWFOUNDLAND AND LABRADOR

A QUALITATIVE STUDY

by

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ABSTRACT

Rural residents of NL face some of the most complex and challenging mental health issues including depression, schizophrenia, and risk of suicide with inadequate and hard to access treatment services. Due to the increasing demands for mental health services, government officials have been emphasizing the need for more responsive and person-centered services to meet client needs. Time-sensitive counselling, an alternative approach to long-term counselling, provides more timely and focused interventions. Mental Health services in Bonavista, a rural community in NL, recently began offering time-sensitive counselling services to its residents, entitled the "Change Clinic." This phenomenological qualitative research study explored individuals' experiences of time-sensitive counselling services as offered by mental health services in Bonavista. The results of this research study are detailed and suggest that time-sensitive counselling services can assist in meeting the service needs of rural residents of NL.

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CHAPTER ONE: INTRODUCTION

National research pertaining to the mental health needs of individuals residing in rural or remote communities in Canada identify these areas of the country as facing some of the most complex and challenging mental health issues including depression, schizophrenia, and risk of suicide with inadequate and hard to access treatment services (Kirby & Keon, 2006; Kulig & William, 2011; Mental Health Commission of Canada 2012). Rural areas or communities have unique features and values which makes defining a common identity very difficult (Canada Rural Revitalization Foundation, 2015; Herbert, 2007; Statistics Canada, 2011). Statistics Canada (2001) recommends one definition as a benchmark for understanding Canada's rural population. In this definition, "rural' is defined as "a population living in towns and municipalities outside the commuting zone of larger urban centres (Statistics Canada, 2001, p.1). The Canadian Institute of Health Information (CIHI) (2006) reports that "95% of Canada's land mass is rural with 22.1 % of Canadians occupying that mass" (p.7). Although half of Canada's rural land mass is occupied by Canada's northern territory, 30 % of Canadian population resides in rural communities (Canadian Institute of Health Information, 2006).

Within rural areas, mental health services, specifically counselling services, are less available than in urban centers. Many individuals residing in rural areas are often confronted with geographic disparities and travel related barriers associated with accessing services in more populated areas (Kirby & Keon, 2006; Ministerial Advisory Council on Rural Health, 2002; Public Health Agency of Canada, 2012). If services are available locally, they are often not appropriate, and long wait-times deter individuals from accessing service (Dyck & Hardy, 2013; Talmon, 1990). The lack of appropriate and accessible mental health services for rural areas are associated with significant

adverse effects for individuals, such as chronic and persistent mental health problems, completed suicides, and homelessness (Kirby & Keon, 2006; Kulig & William, 2011).

Newfoundland and Labrador (NL) is the easternmost province of Canada with a population of approximately 527, 756 (Government of Newfoundland and Labrador, 2015; Statistics Canada, 2015). 51% of the residents of NL reside in rural areas (Newfoundland and Labrador Center for Health Information, 2015). For residents of NL, specifically rural residents, the lack of appropriate and accessible mental health services is a harsh reality. Individuals in need of mental health services often face significant obstacles associated with obtaining services. For example, in 2005-2006 the CIHI collected data from mental health facilities throughout the country. They found that NL had the highest percentage of individuals waiting longer than a year to receive mental health services. On average, individuals in NL have to wait 26 weeks or longer to receive services. This is in comparison to all other provinces where the majority of services are available in approximately 13 weeks (Canadian Institute for Health Information, 2006; Newfoundland & Labrador Medical Association, n.d.). The CIHI also found that NL had the longest wait-times in Canada for psychotherapy, cognitive-behavioural therapy, and couple/marital therapy, which far exceeded the wait times recommended by mental health professionals throughout the country (Canadian Institute for Health Information, 2006; Newfoundland & Labrador Medical Association, n.d.).

Given the significant population of rural residents in NL, the considerable cost of services, and current difficulties associated with meeting mental health needs, provincial experts are strongly advocating for preventative and early interventions, reduced wait-lists, and timely and appropriate mental health services for all areas of the province

(Canadian Mental Health Association of Newfoundland and Labrador (CMHA-NL), 2015; Department of Health and Community Services, 2014; Government of Newfoundland and Labrador, 2005). In response to this need, improved access to services became priority of provincial and regional 2011-2014 strategic plans that have yet to be fulfilled. It is therefore timely for the province to consider and implement alternative and innovative counselling services (Eastern Health, 2015; Department of Health and Community Service, 2014; Government of Newfoundland and Labrador, 2005).

At present, there is limited literature and education on time-sensitive practice within the social work profession (Gibbons & Plath, 2012). Nevertheless, time-sensitive practice is relevant to social work given its emphasis on enhancing the relationship between individuals and their natural supports, resources, and communities. Time-sensitive practice acknowledges the urgency felt by individuals in their attempts to access service and provides social workers with a service delivery approach that is responsive to client needs (Gibbon & Plath, 2012).

Time-sensitive practice is also very relevant and important for rural populations. Within rural NL, residents often have no choice with regard to service options as most mental health facilities only offer long-term counselling services (Tilley, personal communication, November 4, 2015). Individuals who would prefer time-sensitive services are therefore unable to obtain such services. As a result, many individuals wait extensively for service or terminate service prematurely. The increasing wait-lists and high rates of premature termination in rural areas suggest that the needs of rural residents are not being met and more alternate options for services need to be explored (Tilley, personal communication, November, 4, 2015).

This apparent professional "fit" along with the identified needs of service users of mental health services in NL, prompted the development and implementation in a rural area of the province, of a small time-sensitive counselling project, known as the Change Clinic. My research of the Change Clinic explored the lived experiences of clients who engaged in Change Clinic services in rural NL. In order to obtain information specific to the individual's experiences, my central research question was "What were your experiences with Change Clinic Services?" This study is distinctive given the lack of qualitative research regarding the depth of time-sensitive counselling experiences from rural clients' perspectives (Hymmen, Stalker, & Cait, 2013; Mireau & Inch, 2009; Riebschleger, 2007)

This thesis paper begins with a focused review of the literature that includes an overview of national and provincial mental health issues and a comprehensive review of time-sensitive services. Chapter three presents the methodology, including the data collection procedures and steps used for a phenomenological analysis. Chapter four presents the findings, my reflections, and a discussion of the validity of the composite descriptions. The final chapter provides a discussion of the findings, limitations, and implications for future research and education.

CHAPTER TWO: LITERATURE REVIEW

The Role of Social Work in Mental Health Services

The profession of social work is multifaceted and focused on providing holistic and person-centered services to individuals, couples, families, and communities. Social workers have been employed in mental health services for many years. As the profession evolved, social workers have played a key role in the research, development, and implementation of mental health interventions through government and not for profit organizations (Canadian Association of Social Workers (CASW), n.d.; Horner, 2012; Towns & Schwartz, 2012). Social workers employed in mental health settings provide case management services and direct mental health services to individuals, couples, families, and communities. Within most areas of Canada, social workers are required to have a minimum of a Bachelor of Social Work Degree and be registered with a provincial/territorial regulatory body that establishes standards of practice and monitors employment conditions (Canadian Association of Social Workers, n.d). Within NL, social work is one of the largest health professions, with over 1500 registered social workers practicing throughout the province (Newfoundland and Labrador Association of Social Workers (NLASW), 2015). As one of the largest health professional groups providing mental health services in NL, social workers assist individuals and families on a daily basis who are impacted by mental health problems (NLASW, 2015).

The mental health problems commonly addressed by social workers include emotional distress, depression, anxiety, vocational stressors, addictions, situational occurrences, and family and relationship issues. Mental health problems affect individuals of all socio-economic status, education, geographical location, race, and ethnicity by impacting the way individuals think, feel, or behave (Canadian Association

of Social Workers, n.d.; Corcoran & Walsh, 2009). It is important to note that everyone at some point in their life will be impacted by a mental health problem, either individually or through a family member, friend, colleague (Mental Health Commission of Canada, 2012). The Mental Health Commission of Canada (2012) reports "the onset of most mental health problems occurs during adolescence and young adulthood" (p.12). Mental health problems can greatly impact the overall functioning of any individual, including his/her educational achievement, career opportunities, relationships and physical health. These impacts can occur throughout an individual's entire life (Centre for Addiction and Mental Health (CAMH), 2012; Mental Health Commission of Canada, 2012). Social workers, therefore can assist individuals at every stage of life in addressing mental health problems (Towns & Schwartz, 2012).

Mental Health Issues in Canada

Within Canada, approximately one in five individuals experience a mental health problem (CAMH, 2012). The economic costs associated with mental health problems within the country is staggering, with an estimated cost of $51 billion per year (Mental Health Commission of Canada, 2012). In 2011, $42.3 billion was spent solely on providing treatment and supportive services to individuals with mental health problems. Furthermore, it is estimated that over the next 30 years, the cumulative costs of these services will exceed $2.3 trillion dollars (Mental Health Commission of Canada, 2012; Statistics Canada, 2011).

The impact of mental health problems for Canadians can be specifically felt in the workplace. Approximately, 21.4 % of Canadians who are employed currently experience a mental health problem. This greatly impacts their attendance and productivity.

Unfortunately, due to the ongoing issues associated with accessing timely and appropriate services, many individuals are unable to work. It is estimated that 30% of short-term and long-term disability claims result from mental health problems (Mental Health Commission of Canada, 2012; Parliament of Canada, 2014).

Individuals residing in rural areas experience a greater number of population health risks than their urban counterparts, such as higher rates of unemployment and poverty, and lower levels of self-reported functional health and health status (Bollman & Clemonson, 2008; Kulig & William, 2011; Ministerial Advisory Council on Rural Health, 2002). The CIHI, as cited in Whyte and Havelock (2007), explored the mortality and suicide rates between individuals residing in rural areas versus urban areas of Canada. It was reported that individuals residing in rural areas of the country have higher mortality (death) rates and suicide. The risk of suicide among rural individuals was significantly higher; especially amongst rural youth – girls were six times and boys were four times more likely to commit suicide than their urban counterparts (Whyte & Havelock, 2007).

The rates of suicide is also extremely high for Aboriginal Canadians. Aboriginal peoples include First Nations, Inuit, and Metis. They have a diverse culture and status within Canada; comprising 4.3% of the population. Over half of Aboriginal Canadians reside in rural areas throughout the country (Health Canada, 2012; Newfoundland and Labrador Centre for Health Information, 2014; Statistics Canada, 2011). In comparison to the general population, Aboriginal people have higher rates of suicide and mental health problems (CAMH, 2012; Statistics Canada, 2011). Health Canada (2015) reported that "suicide and self-inflicting injuries are the leading causes of death for Aboriginal youth

and adults up to 44 years of age. Suicide amongst Aboriginal youth is 11 times higher than the national average" (p.1).

As of 2011, the population of Aboriginal people residing within NL was 35, 805. Almost all of the Aboriginal people residing on a reserve within the province live in a rural area. Over half (51.8 percent) of individuals residing off a reserve live in rural area (Government of Canada, 2011). Aboriginal peoples, like other rural residents, experience significant barriers to accessing mental health services. The Government of Newfoundland and Labrador (2005) identified "factors such as treaty negotiations, loss of land to settlers, and the organization of power and governance as having a significant impact on their [Aboriginal peoples'] lives and health" (p.22). Due to the unique culture and experiences of Aboriginal peoples, the need for comprehensive mental health services have been repeatedly emphasized in provincial strategies and reports (Government of Newfoundland and Labrador, 2005). Although time-sensitive practice may not be appropriate for all Aboriginal peoples, it can offer an alternate service option for individuals in need.

Mental health issues in NL. Mental health problems is a significant issue facing the province of Newfoundland and Labrador. NL has reportedly the highest percentage of people diagnosed with schizophrenia, psychotic disorders, and mood disorders, and has the third highest percentage of people with substance abuse disorders in Canada (Newfoundland and Labrador Medical Association, n.d.). Furthermore, suicide is the second leading cause of death after accidents for individuals aged 15 to 24 in NL (Newfoundland and Labrador Medical Association, NL). Given that NL has the longest wait-times in the country for counselling services, the mental health of its residents,

particularly those in rural communities, is significantly compromised (Newfoundland and Labrador Medical Association, n.d).

Within NL, there are has been considerable concerns raised in relation to state of mental health services. In 2000, a judicial inquiry was held in NL following the deaths of two men with mental health problems who were fatally shot by police officers. Judge Donald Luther completed the inquiry which was titled "Report of Inquiries into the sudden deaths of Norman Edward Reid and Darryl Brandon Power" (December, 16, 2003). This inquiry had a significant impact on mental health services in NL, resulting in many recommendations and changes to services. It is important to note that Norman Reid, lived in Little Catalina, a community in the catchment area under study in this thesis (Government of Newfoundland and Labrador. Department of Justice, 2003).

In this inquiry, Judge Donald Luther determined that NL's health care and justice system failed the deceased. From his report and investigations, he made recommendations on how the province can better respond to individuals with mental health problems. Some of the recommendations included developing a new mental health strategy, reforming the Mental Health Care and Treatment Act, enhancing community supportive services, and providing increased training and education on mental health problems to front-line service providers. Throughout the report, Judge Luther made reference to the need for more comprehensive and accessible services to meet client needs, specifically in rural areas (Government of Newfoundland and Labrador. Department of Justice, 2003).

Although some changes have occurred as a result of this inquiry, such as the reforming of the Mental Health Care and Treatment Act, the lack of comprehensive and

assessable services continues to present as a major obstacle for residents of NL. Government officials are therefore challenged with addressing the mental health needs of its residents. There is concern that without increased access to services, more tragedies will occur (Government of Newfoundland and Labrador. Department of Justice, 2003).

Challenges of Current Mental Health Services

Accessing appropriate mental health services remains a challenge for many rural communities, especially Aboriginal communities, due to the limited and often inadequate services and resources available (Dyck & Harding, 2013; Parliament of Canada, 2014). Given the fact that resource allocation in public mental health does not meet the demand for service, long wait times occur (Mireau & Inch, 2009). For example, individuals in NL, on average, have to wait over fifty-two weeks for treatment to commence (Hair, Shortall, & Oldford, 2013). Such waiting-times have considerable negative consequences for both clients and social workers (Mireau & Inch, 2009). Mireau & Inch (2009) report "clients on wait-lists experience more problems and poorer outcomes as their waiting period lengthens (p.63)." Research indicates that a client's motivation begins to decrease two weeks after s/he requests service (Mireau & Inch, 2009; Pekarik, 1991). Social workers who have significant wait-lists for service describe increased stress and anxiety from the pressure associated with meeting these service demands (Corcoran & Walsh, 2009; Mireau & Inch, 2009).

In addition to long wait-lists for service, premature termination is also a significant problem impacting the delivery of community mental health services (Pekarik, 1991). Premature termination refers to clients who end counselling services or 'drop out' before achieving a requisite level of improvement. This is a major issue which often

results in poorer outcomes for the client and hinders the delivery of counselling services for individuals on waiting-lists (Bloom, 1992; Swift & Callahan, 2011; Talmon, 1990). For service providers, premature termination can result in underutilization of their time and resources. According to service providers, premature termination is a common and widespread problem in counselling with approximately 30% to 60% of clients ending counselling prematurely (Swift & Callahan, 2011).

The challenges with current mental health services have been the focus of national and provincial reports and strategies. In 2012, the Mental Health Commission of Canada completed a mental health strategy titled: *Changing Directions, Changing Lives: The Mental Health Strategy of Canada.* This strategy focused on improving the mental health system to meet the needs of all Canadians. Thousands of Canadians impacted by mental health problems were contacted to discuss their presenting concerns with the Canadian mental health system. Recurrent issues reported by Canadians in their attempts to access mental health services included: lack of accessible information regarding how to obtain mental health services, inadequate treatment and lack of sufficient compassion by health care officials, and long wait-times for service. From these reports, the Mental Health Commission of Canada (2012) highlighted that in order to better meet the needs of Canadians, recovery must be made center of the mental health reform. The Mental Health Commission of Canada (2012) identified having timely access to service, responding to reducing disparities and risk factors in accessing services, promoting mental health services, and addressing the needs of diverse communities, specifically Aboriginal communities, as critical components of an effective mental health system.

Within NL, provincial experts have been strongly advocating for improved mental health services to meet the needs of NL residents. Emphasis has been placed on increasing the accessibility of services, particularly for rural residents, so that timely services are available for everyone in need (Eastern Health, 2015; Government of Newfoundland and Labrador, 2005; Provincial Mental Health and Addictions Advisory Council, 2012).

Responding to the Need for an Alternative Mental Health Service Delivery

In attempting to address issues related to waiting-lists and premature termination, research has shown that clients who have short wait-times for service are more likely to attend their first appointment (Mireau & Inch, 2009; Swift, Whipple, Greenberg & Kominiak, 2012; Swift, Callahan, & Levine, 2009; Talmon, 1990). Research also supports how many clients report meeting their goal for service after their initial visit and many others who dropped out of service reported being satisfied with the service they received (Bloom, 2001; Hatchett, & Park, 2003; Swift, Whipple, Greenberg & Kominiak, 2012; Swift et. al., 2009; Silverman & Beech, 1984; Talmon, 1990).

Expectations regarding treatment length is a major factor impacting client outcomes. The dominant view point which social workers have been trained and continued to be trained consider counselling to be a long process, which could last a few months, years, or even lifelong. Social workers are taught that client issues are extremely complex, often rooted in early childhood, and therefore require an extensive amount of time to be resolved (Corcoran & Walsh, 2009; Talmon, 1990; Swift et.al, 2012; Swift et. al., 2012;Weakland, Fisch, Watzlawick, & Bodin, 1974). Silverman & Beech (1984) state "one of the most commonly held assumptions about mental health service delivery is the

equating length of intervention with successful outcome (p.184)." The authors argue it is not the amount of time that a client is involved in counselling that is important but what happens during this time and what the client brings to the session. Pekarik and Finney-Owen (1987) pointed out that a social worker's attitudes and beliefs are extremely important when considering the rates of client drop out. The beliefs held by the social worker can impact the length and outcome of an intervention by affecting the client's behavior, evaluation of client's behavior, or both (Hair et.al., 2013; Hatchett & Park, 2003; Swift et. al., 2012; Swift et. al., 2009; Weakland et. al., 1974).

The length of time that a client expects to be involved in counselling is often much shorter than that of the social worker, this helps explain why clients end counselling services earlier than anticipated by the social worker (Talmon, 1990; Pekarik, 1991; Swift et. al., 2009). Social workers commonly predict that clients need three times more sessions than the client estimated s/he needed (Pekarik & Finney-Owen, 1987). Regardless of the social worker's approach or orientation, research has found that clients seeking counselling services commonly have low duration expectations (Bloom, 2001; Pekarik & Finney-Owen, 1987; Talmon, 1990; Weakland et. al, 1974). Pekarik (1991) reported that 50% of clients expect to attend less than five sessions and 20% expect to attend two sessions or less. He further states that between 30% and 55% of clients are only likely to attend one session. Many clients report feeling discouraged and disempowered as a result of their social worker's belief that they require additional counselling sessions. Given this, clients typically do not attend more sessions than they initially expect and therefore are more likely to be viewed as terminating service prematurely and being classified as a drop-out (Pekarik, 1991; Talmon, 1990).

Conceptual Frameworks for Social Work Practice

Research indicates that the assumptions and beliefs held by social workers about mental health problems and solutions have been developed from an empiricist conceptual framework (Atherton, 1993; Dean & Fenby, 1989). This framework is built upon the belief that "there is one objective reality, that psychosocial phenomena is a part of that reality, and knowledge of psychosocial phenomena must be determined using scientific inquiry" (Lit & Shek, 2002, p.107). Hair and colleagues (2013) demonstrate the influence of empiricism in a sampling of assumptions from traditional psychotherapy practices:

- The *Diagnostic and Statistical Manual IV-TR* (American Psychiatric Association, 2000) provides the "truth" about mental health problems.

- In order to provide effective interventions, the "root" or underlying cause of the client's mental health problem must be identified and addressed. Therefore, initial sessions must be focused on obtaining a comprehensive history of the problem and a biopsychosocial assessment of the client.

- The length of time a client is involved in counselling is (pre) determined by the social worker and is dependent on the severity of his/her disorder and its underlying cause.

The influence of empiricism is further reflected in long-term counselling methods which have focused on completing comprehensive and problem-focused reports, clinical formulations, and treatment plans. As a result of these methods, clients commonly see their social worker for eight or more sessions before the social worker can obtain sufficient information to understand their presenting issue, diagnose their disorder, and complete the prescribed intervention plan (Bloom, 1992; Hair et. al., 2013; Talmon,

1990). From a positivist perspective, if a client terminated service before the intervention plan was completed, s/he was believed by service providers to have individualized issues (e.g. fear of abandonment, transference, separation anxiety, etc.) which lead to his/her termination (Talmon, 1990).

Over time a new practice perspective has surfaced which challenges the beliefs of empirialists. A social constructionist perspective can be seen as "an approach to human inquiry, which encompasses a critical stance toward commonly shared assumptions" (Sahin, 2006, p. 58). This perspective highlights how commonly accepted assumptions strengthen the interest of dominant social groups. Social constructionists posits that the way we understand the world is socially constructed through the history of negotiations and exchanges among groups of people (Sahin, 2006).

A social constructionist perspective, unlike positivism, adopts a relativistic view of reality in which an individual's stories and narratives are flexible and co-constructed between the client and the social worker (Bloom, 1992; Hair et. al, 2013; Lit & Shek, 2002). A unique feature of social constructionism relates to his emphasis on individual differences and the importance of tailoring interventions to meet the specific needs of the clients (Sahin,2006). Language is therefore used by the social worker to construct client realities and emphasize individual reflexivity (Lit & Shek, 2002). Multiple viewpoints and different approaches to knowledge are also considered by the social worker when engaging with any client (Hair et. al., 2013; Houston, 2001; Lit & Shek, 2002; Sahin, 2006).

A social constructionist approach to counseling differs from a traditional approach. Social workers practicing from a social constructionist approach believe that

the acceptance of knowledge and meanings can be multiple and diverse; change can occur during every therapeutic moment; and clients can greatly benefit from a collaborative and co-constructed conversation between the participants (de Shazer, Dolan, Korman, Trepper, McCollum, & Berg; 2007; Hair et. al., 2013; Talmon, 1990).

The Development of Time-Sensitive Practice

Time-sensitive practice derived from particular forms of short-term or brief therapies, all which share a social constructionist approach (Hair et. al., 2013). These brief therapies create a shift from traditional psychotherapy which emphasizes psychopathology and client deficits (Bloom, 1992; de Shazer et. al., 2007; Saleebey, 2002). Initially, brief therapies were used as a strategy to assist large numbers of individuals faced with mental health problems without undermining the position of long-term or traditional therapy (Bloom, 1992). Although some social workers expressed interest in brief therapies, the long-term perspective which focused on problem-formation and problem resolution resulting from a client's individualized issues endured (Bloom, 1992; de Shazer et. al., 2007; Saleebey, 2002).

Over time, there has been increased interest in brief therapies due to the growing dissatisfaction with the lengthening of traditional counselling. As more emphasis was being placed on providing accessible mental health services to everyone in need, social workers and other mental health professionals began changing their view of brief therapies. They started recognizing the potential for brief therapies to effectively and efficiently assist in addressing individuals' presenting problems (Bloom, 1992; Budman & Gurman, & Talmon, 1990; Slive, McElheran, & Hanson, 2008).

Unlike traditional long-term therapy, brief therapies proposes that clients know what is best for them. The practices such as focusing specifically on client's strengths, resiliencies, and resources aim to assist individuals in meeting their identified goal for service. Interventions are prompt and require a high level involvement from the social worker. Time limits are set between the social worker and client which specify the length and time of sessions. The counselling sessions are focused on the establishment of the client's specific goals and a clear focus is maintained throughout the sessions in order to effectively meet his/her goals (Bloom, 1992; de Shazer et. al., 2007; Fisch, 2004; Gibbons & Plath, 2005; Kozel & Schuyler, 2000; Saleebey, 2002).

Drawing on the assumptions familiar to brief therapies a time-sensitive counselling approach is focused on maximizing the effect of each therapeutic encounter with a client to promote the most substantial change (Bloom, 1992; Hoyt, Roseumbaum, & Talmon, 1992; Talmon, 1990). Like brief therapies, time-sensitive practice believes that change is an inevitable part of life and clients only require the assistance of a social worker for a brief period of time to assist them in identifying and utilizing their own resources and strengths to solve their issues (Bloom, 1992; Hoyt et. al, 1992; Talmon, 1990). Time-sensitive counselling interventions also focus on identifying a client's strengths and resources and attending to his/her motivations, individualized goals, and hope and expectations for improvement (Hair et.al, 2013; Pekarik, 1991; Talmon, 1990). Time-sensitive services can be offered as a walk-in service, single-session services, or a time specific service in which clients are offered a specific number of sessions (Bloom, 1992; Talmon, 1990). It is important to note that brief-therapies and time-sensitive practices are not suited for all individuals. Many individuals often prefer and chose to

avail of traditional psychotherapies or long-term interventions from multi-disciplinary teams (Hair et. al., 2013).For example, individuals impacted by severe trauma often choose and/or require more long-term counselling services.

In order for effective time-sensitive practice to occur, Hair and colleagues (2013) argue that a conceptual framework shift is required. This is due to the fact that the assumptions and beliefs held by a social worker are influenced by "a broader conceptual framework, worldview, or epistemology that describes truth and reality and decides what can be known, who can know it, and how it comes to be known" (Hair et. al., 2013, p.18). Although no one model of therapy is used in providing time-sensitive counseling services, research has shown that social workers are informed by strengths-based perspective, solution-focused therapy, narrative therapy, motivation interviewing, and a range of other ideas and practices (Bloom, 2001; Young, Dick, Herring, & Lee, 2008; Talmon,1990).

Within the social work profession, the strengths-based perspective aims to identify and emphasize client strengths (Bliss & Bray, 2009; Graybeal, 2001; Saleebey, 2002). It is based on the belief that individuals have an innate need to recognize their own capabilities, accomplishments, and assets. Emphasis is therefore placed on the client's strengths and resources, rather than his/her problems or symptomatology (Weick, Rapp, Sullivan, & Kisthardt, 2001). From a strengths-based approach, the social worker assists a client in identifying his/her aspirations and capabilities, as well as, developing a positive outlook regarding how s/he can create change. Social workers explore with clients how they have been able to adapt to change in the past and the resources/skills which have previously assisted them (Saleebey, 2002; Weick et.al, 2001). Practicing

from this perspective, social workers are encouraged to suspend their judgement and to accept client's expressed aspirations as sincere. There is no focus on clinical diagnoses as strengths are not viewed as symptoms of pathology (Weick et.al, 2001).

Solution-focused therapy is a strengths-based and future-orientated therapy. It is based on the premise that change is constant and inevitable and people possess the necessary resources to resolve their own issues (Corcoran & Pillai, 2009; Reiter, 2010). In solution-focused therapy, hope and expectancy of change is emphasized. The social worker views the client as the expert and highlights his/her individual strengths, successes, and resources and how they can be applied to the change process (Corcoran & Pillai, 2009). The role of the social worker is to ask questions to the client to uncover evidence of previous solutions and exceptions to the problem; noting times in which the problem did not exist or times in which the client successfully coped or addressed the problem (Bliss & Bray, 2009; Reiter, 2010). From this, the social worker assists the client in raising awareness of his/her strengths and how s/he can mobilize these strengths in creating change (Campell, 2012; Corcoran & Pillai, 2009). Throughout this process, it is important to note that the client is encouraged to identify and utilize solutions that fit with his/her own worldview (Bliss & Bray, 2009).

In narrative therapy, emphasis is placed on client stories and conversations instead of pathology. Through storytelling, clients present an identity of themselves, along with the meanings they associate to their stories (Carr, 1998; Gibson, 2012). The client's problem is viewed as having developed from oppressive stories which have dominated his/her life. Within narrative therapy, the social worker adopts a collaborative co-authoring consultative position with the client. They assist clients in separating

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themselves from their problems, identifying times in which they were not oppressed by the problem, creating alternative self-narratives, and linking their new self-narrative to past and future (Carr, 1998). When social workers take a collaborative and curious approach in this process, they assist clients in acknowledging their insight of their presenting problem and how they can use this knowledge to create change (Gibson, 2012; Young, 2008).

Motivational interviewing is a client-centered and directive counselling method. It is focused on enhancing a client's intrinsic motivation to change by exploring and resolving ambivalence (Miller & Rose, 2009). Social workers assist clients in creating change by creating a supportive environment in which the client can safety explore his/her motivation, readiness, confidence, and ambivalence for change. Social workers view change as a series of stages representing a continuum of motivational readiness. These stages include: precontemplation, contemplation, preparation, action, maintenance, and relapse (Miller & Rollnic, 2002; Miller & Rose, 2009). Social workers use these stages to assess the client's readiness for change and to develop an intervention plan that accurately meets his/her needs (Wahan, 2005)

Time-sensitive practice and the social work profession

Drawing from these counselling approaches, social workers implementing time-sensitive practice use a unique set of psychotherapeutic skills. Rockwell and Pinkerton (1982) point out that success in time-sensitive practice is directly related to the social worker's confidence in his/her ability to provide this service, his/ her belief in the value of time-sensitive practice, and his or her ability to assess a client's motivation for change. (Hoyt et.al, 1992; Cameron, 2007; Talmon, 1990).

Social workers who apply a social constructionist perspective to their therapeutic

sessions with clients are focused on the client's presenting needs. They use language that

is curious and enquiring in order to maximize each therapeutic encounter and promote

hope for change (Hair et. al., 2013). They encourage readiness and motivation for change

by viewing each session as the only potential encounter s/he may have with the client

(Talmon, 1990). Interventions are focused and pragmatic as they strive to provide clear

outcomes and identifiable goals. Hope and a sense of control in the client is seen as

critical components of effecting change (Fisch, 2004). During each session, the social

worker assists the client in identifying his/her presenting problem, exploring potential

solutions, and supporting the development and implementation of new approaches

(Bloom, 1992; Cameron, 2007; Talmon, 1990). Continuous feedback is elicited from the

client to ensure the procedures used by the social worker coincides with the client's own

ideas (Barwick, Urajnik, Sumner, Cohen, Reid, Engel, & Moore, 2013; Talmon, 1990).

The Neoliberal Context and Time-Sensitive Practice

At the national level, the socio-economic-political context of services being

delivered is a major challenge facing social workers, specifically rural social workers.

Due to reduced social funding and globalization of corporate agendas, social workers are

often challenged with meeting client needs within a neoliberal context. Neoliberalism

refers to a

> theory of political economic practices that proposes human well-being can be best
> advanced by liberating individual entrepreneurial freedoms and skills within an
> institutional framework characterized by strong private property rights, free
> markets, and free trades (Harvey, 2010, p.2).

The role of the state is to create and preserve an institutional framework

appropriate to such practices. During the past 30 years, significant changes have occurred

within social services and health organizations throughout Canada and other Western countries, which have resulted in notable cuts to health and social service programs (Baines, 2006; Baines, 2004; & Wallace & Pease, 2011). For example, the health care system in Ontario underwent significant restructuring which resulted in strict procedures and standards of practice reflecting a reductionist approach to service (Suschnigg, 2001). The impact of such changes has had a profound impact for both social workers and clients. Within the current socio-economic-political environment marked by cutbacks and reorganization of services and resources, social workers are pressured to provide more client services with fewer resources. Baines (2004) highlights how there is an increased expectation placed on social workers to demonstrate "efficiency" and "accountability" within their individual practice (Baines, 2004).

The impact of neoliberal agendas and restructuring has many implications for rural social work practice. Social workers practicing in rural areas throughout Canada are not only challenged by limited access to services and resources but also by policies and procedures which assume that only cost-efficient services can be provided and specifically provided in high populated areas. As the population of many rural areas decrease, funding for services and resources are often reduced or eliminated. Social workers are often pressured to assume additional roles within their current position in an attempt to meet client needs (Baines, 2010, Baines, 2006).

Given the direct impact of neoliberalism on social work practice, social workers must make a conscious effort to identify and critically reflect on how they are individually affected. With organizations increasing their emphasis on 'efficiencies" and viewing this as the only way to meet client needs, social workers are often pressured to

conform to this way of thinking. With increasing pressure to respond to organizational demands, there is a concern that social workers may become more focused on meeting the needs of the organization versus the needs of clients. Social workers must therefore be mindful of the power relations resulting from a neoliberal agenda and the ways in which they can mitigate such challenges (Baines, 2004). Resistance to neo-liberalism by social workers is possible. Singh and Cowden (2009) describe how social workers have the power to identify, confront, and resist neoliberalism by utilizing their professional knowledge and skills to work within and against the neoliberal agenda.

For social workers providing time-sensitive counselling services, awareness of the impact of the neoliberal agenda is especially important. Like brief therapy, time-sensitive practice has been criticized as a service developed to address organizational needs (Bloom, 1992; Saleebey, 2002). The "cost-efficient" notions associated with time-sensitive services can often undermine the benefits of this practice approach. Social workers providing time-sensitive services must critically reflect on the impact of the neoliberalism within their employing agency and ensure their services as focused on client needs versus organizational demands. As previously noted, time-sensitive practice is an alternate service options for individuals. It is not appropriate for all client populations. Social workers must therefore resist organizational pressures to provide one service option to all client populations.

Time-Sensitive Services in Canada

In a minimal number of locations in Canada, time-sensitive counselling services are being offered to individuals, couples, and families. My understanding of these services is that they take a time-sensitive approach to each session within a particular agency structure. For example, limiting the number of social worker-client contact to three sessions (Hair et. al., 2013).

Alternatively, agencies have reduced session's expectations further and begun offering walk-in counselling services. Walk-in services are focused on providing timely and accessible counselling that is cost-efficient and confidential. Clients are not required to have a referral or an appointment. Rather, the client presents to the agency when in need of a therapeutic intervention and they have the opportunity to come as often as needed (See Barwick et.al, 2013; Harper-Jacques, Mchelgeran, Slive, & Leahy, 2008; Mireau & Inch, 2009; Young, 2008; Young, Dick, Herring, & Lee, 2008).

Consequently, the region of Eastern Health, NL, developed a program entitled, the Change Clinic which was recently offered to residents of the Bonavista region. This provided an opportunity for research on participants' experiences of time-sensitive counselling services provided by social workers.

Importance of Time-Sensitive Services for Rural Populations

Time-sensitive counselling services informed by a social constructionist perspective provides a practical alternative for rural individuals with mental health problems. Time-sensitive counselling services allows individuals to access service when they are in need and to return for service without facing extensive wait-lists.

For rural individuals having access to responsive and time-sensitive services can assist them in reducing travel costs as they attend a limited number of sessions and return only when needed. Furthermore, time-sensitive services can assist in reducing wait-lists so that individuals in need of more intensive and/or traditional counselling services can access them more efficiently (Hair et. al., 2013).

CHAPTER THREE: METHODOLOGY

A phenomenology research method was chosen for this study. Phenomenology research is a form of qualitative research that is focused on providing thick and rich descriptions of a specific human experience when there is little known about the topic (Marshall & Rossman, 1990; Moustakas, 1990; Polkinghorne, 1989). It attempts to understand the deeper meanings individuals derive from their experiences as it is related to a phenomenon, such as the experience of living with a mental health problem (Boyd, 2001; Creswell, 1998; Creswell, Hanson, Plano, Clarke, & Morales, 2007; Moustakas, 1990; Rossman & Rallis, 2003).

Phenomenological principles emphasize how scientific data is valid when derived from rich descriptions that allow for the understanding of the essence of individuals' experiences (Moustakas, 1994; Moustakas, 1990). Through the use of phenomenological based interviewing, researchers are able to understand the attitudes and meanings of participants. The richness of the information obtained in the interviews provides context for the collective experience of the participants (Seidman, 1998).

The philosophical assumptions of phenomenology research are compatible with social constructionism (Boss, Dahl, & Kaplan, 1996). For example, assumptions of phenomenology research include the belief that knowledge is tentative and incomplete and co-created between individuals and that researchers are not separate from the focus of their inquires (Boss et. al, 1996; Creswell, 1998; Moustakas, 1990; Polkinghorne, 1989).

A phenomenology research method was appropriate for this study given its emphasis on providing a comprehensive account of the participants' lived experiences, along with the meanings they attach to these experiences (Creswell, 1998; Moustakas,

1990). This information provides a critical source of knowledge and understanding about human experiences and the specific phenomenon being studied. Phenomenological research allowed me to enter into the experiences of the participants and understand the meanings they attached. Through the use of in-depth interviewing, I was able to gain additional information about the participants' attitudes and beliefs as related to the phenomenon. By exploring the experiences of the individuals, I was able to obtain information and knowledge about time-sensitive services in rural areas not otherwise possible (Creswell, 1998).

To best fit the objective of this study, the methodological design was developed according to suggestions from Creswell (1998), Moustakas (1990; 1994), and Polkinnghorne (1989). The goal of this inquiry was to explore the lived experiences of individuals who received the Change Clinic service in Bonavista, NL. The research process included self-reflections, selecting the research participants, data collection, and developing steps to interpret the interview data.

Context and Background of the Study

Mental health services in the town of Bonavista, NL are provincially funded and provided by the Eastern Regional Health Authority, which is the largest integrated health organization in the province (Eastern Health, 2014, About Us, para.1). Bonavista has a population of approximately 3685. The town is located on the Discovery Trail Route 230 and is a three and half hour drive from seventy percent of the province's population, residing in the capital city of St. John's and the surrounding area. Bonavista is a local service center for approximately thirty-eight communities, expanding geography over 70

kilometers. This catchment area results in many clients having to travel over 30 kilometers to receive service (Tilley, personal communication, January 15, 2014).

The mental health facility in Bonavista provides counselling services to individuals of all ages, with referrals made directly to the intake social worker within the program. The service receives approximately 500 referrals per year for individuals, couples, and families facing various mental health problems (Tilley, personal communication, January 15, 2014). Wait-times for counselling have been an on-going concern for this region; with the average wait-time for all ages being five to seven months (Tilley, personal communication, January 15, 2014).

The Change Clinic as offered in Bonavista developed from recommendations from the Eastern Regional Health Authority which previously completed a pilot project on time-sensitive counselling services at the Janeway Family Centre in St. John's, NL. Through discussions with the director and program managers of mental health services, time-sensitive practice was identified as a counselling service option that could potentially assist in meeting the service needs of individuals throughout NL (Hair et.al, 2013). The two social workers working at the Boanvista site received training on time-sensitive practice as provided by their employer. This training focused specifically on social constructionist informed assumptions and skills for time-sensitive counselling.

In June 2013, the social workers began offering the Change Clinic service one day per week. Individuals on the pre-existing waiting-list were initially contacted and offered the service. Individuals who had been waiting the longest for service were contacted first. Prior to commencing the Change Clinic service, the longest wait-time for counselling was approximately 12 months (Abbott, personal communication, November 15, 2015).

Individuals who chose to avail of the Change Clinic service were offered up to three counselling sessions. This number was chosen based on the research average (Hoare, Norton, Chisholm, & Parry-Jones, 1996).

I received approval from the director and program manager of mental health services in Bonavista to complete this study (see Appendix A), along with approval from the Interdisciplinary Committee on Ethics in Human Research (ICEHR) (see Appendix B). The two social workers who offered services through the Change Clinic agreed to participate in this study by providing the recruitment material to their clients. I held a telephone conference with the social workers to explain the recruitment process and procedures of my research study and to answer any questions they may have.

The Place of Self-Reflection: Situating Myself with the Topic Before the Interviews Begin

Self-reflection is an important aspect of the phenomenological process which allows the researcher to identify any prejudices or predispositions s/he has that may influence the research findings. Once the prejudices or predispositions are identified, they are written down or *"bracketed"* by the researcher (Moustakas, 1994; Polkinghorne, 1989). This process provides some protection against the potential impact of the researcher's expectations on the study (Creswell, 1998; Creswell & Miller, 2000; Mostakas, 1994; Polkinghorne, 1989).

During the preparatory stages of this research study, I spent time reflecting on and documenting my experience with time-sensitive practice, specifically, my experience with this practice for rural populations. The following are my reflections (with some editing):

Growing up in a rural community in NL provided me with insight into the barriers individuals face in their attempts to access service, such as long waiting-lists and travel times. In 2010, I became employed as a social worker in rural NL. Initially, I was expected to provide long-term counselling services, consisting of formalized assessments and multiple sessions. Clients, on average, would have to wait up to seven months for service and would have to attend at least three to four counselling sessions before their initial assessment was completed. Many clients expressed frustration with the agency's wait-times and emphasis on formalized assessments. As a mental health social worker in this agency, I was challenged in my ability to provide timely and accessible services that were client centered.

My interest in time-sensitive counselling developed from reviewing literature regarding this practice approach. From the literature, I became curious about the potential for this practice approach to meet the needs of rural residents. In 2013, I received training on time-sensitive practice and was involved in the development and implementation of this service within my employing agency. From this involvement, I gained increased insight into my construction of knowledge and meanings and the impact of societal influences. I noticed myself shifting my expectations that were previously influenced from the dominant view point, which emphasized long-term interventions, to those of a social constructionist perspective. For example, I recognized that clients often only attended one session or required counselling for a brief period of time. Therefore, I became focused on making the most out of each therapeutic encounter.

When I began offering time-sensitive services, I initially experienced resistance from some colleagues and professionals as they believed these practices were insufficient

and a condensed form of 'therapy.' However, through the process of peer consultation and feedback from clients, many of the professionals with whom I worked began recognizing the benefits of this practice approach.

From my experiences, I would now describe my overall perspective as a person and social worker predominantly grounded in social constructionism. From this, I have developed ideas of how a social constructionist perspective would provide a conceptual framework for times-sensitive counselling services. For example, I believe every therapeutic encounter with a client, even if it is only one, provides an opportunity for hope and change. I believe clients know what they want to change and as a result obtaining the history of the problem is not always needed to engage in a conversation promoting hope and growth. Furthermore, I believe that in order for social workers to provide effective time-sensitive services they must use language that is curious and exploratory, while also focusing specifically on the client's presenting issue and preferred outcome (Hair et. al, 2013).

My own experiences, beliefs, and knowledge about time-sensitive service have encouraged my wonderings about this practice approach for rural residents. Although some clients provided feedback during their counselling sessions, their responses were often thin and vague. Furthermore, due to the fact that clients commonly provided feedback directly to their social worker, their responses were likely to be influenced by the social worker's presence. Therefore, in order to obtain detailed and rich descriptions, I felt the exploration of rural individuals experience with this service was necessary.

Throughout the course of this research study, I kept a journal describing in detail my impressions of the interviews, as well as my responses to the information received.

This process assisted in bracketing my views and identifying any preconceptions which could have influenced my participation in the interviews and my interpretation of the research results (Moustakas, 1990; Polkinghorne, 1989).

The Participants Selection Criteria

A phenomenological study involves the completion of in-depth interviews with up to 10 individuals (Creswell, 1998; Polkinghorne, 1989). Boyd (2001) notes that research saturation can be attained with 2 to 10 participants. This is further supported by Polkinghorne (1989) and Creswell (2007) who state that research saturation can be achieved with 5 individuals who experienced the phenomenon. Due to the time-constraints of this study, in-depth interviews were completed with five individuals who received time-sensitive counselling services in rural NL. Any adult, aged sixteen years or older, who was capable to self-refer to mental health services in Bonavista, was invited to participate. This was consistent with Eastern Health's policy regarding the age requirement of consent. A convenience sampling method was chosen to complete this study. A convenience sample is a type of non-probability sampling method in which data is collected from participants who are readily available to participate in a study (Creswell, 2007). Given the fact this study was completed in a rural area and under strict time-constraints, a convenience sampling method provided increased access to individuals who were available to participate. For the purpose of this study, a convenience sample allowed me to collect data from individuals who completed the Change Clinic service (Creswell, 2007).

Recruitment

A recruitment letter was used to invite clients to participate in this research study. The recruitment letter was given to clients by their social worker at the end of their first Change Clinic session. The reason why the recruitment material was given at the end of the client's first session was due to the fact clients may choose to attend only one Change Clinic session, even though they are offered up to three sessions each time they request Change Clinic service (See Appendix C).

After receiving the recruitment material, clients were asked to review the letter in the waiting room of the mental health office, place it in the accompanying envelope, seal it, and then return it to their social worker. At the end of each month of data collection, the social workers would mail all envelopes via Eastern Health's internal mail system. After I received the envelopes from internal mail, those interested were contact via telephone from a private and secure location between 4:30 pm and 7:00 pm, Monday to Friday.

Data Collection

During the initial contact with the potential participant, a Phone Invitation to Participate Script (see Appendix D) was used to further introduce the research study. If the person was interested, the Information and Informed Consent Letter was read to them (See Appendix E). If they consented to participate, I confirmed this with a written notation on their consent form. If the participant had completed the Change Clinic service, a mutually agreed upon date for the phone interview was scheduled. Those who were currently receiving service but were interested in the research study were contacted again when s/he anticipated his/her sessions would be completed. During this second

contact, I ensured the sessions were completed and reviewed the Information Letter again. If the individual was still interested in the study, consent was obtained.

In-depth interviews of up to 60 minutes were individually conducted with each of the participants at a mutually agreed upon time. Completing interviews via telephone was important given the geographical challenges of the participants. The participants were asked to choose whether they wanted their interview audio-taped or if they wanted notes taken. All participants chose for me to take notes.

Developing a central question for the interviews was critical as it directly impacted the information obtained. The question I explored was: "What were your experiences with Change Clinic Services?" This question was asked of all participants. A list of probing questions was also used to obtain additional information and guide the experience (see Appendix F). The exact wording of the questions was flexible in order to promote an interactive experience with each participant (Merriam, 1998). It is important to note that further questions unfolded as the interviews progressed. To ensure accuracy, I reread to each participant his/her responses and asked him/her to verify the correctness and clarify any errors or discrepancies. This process ensured that the notes I had taken were an accurate and direct account of the participant's experience.

Addressing Ethical Concerns Regarding Confidentiality and Informed Consent

Every reasonable effort was made to keep the interview data obtained from the participants confidential. The interview notes, consent forms, and contact information was kept in a locked filing cabinet. My thesis supervisor and I were the only people who reviewed the notes. I used coded information by removing all direct identifiers on the notes and replacing them with a number. This interview data was entered into a computer

data base that was password protected and stored in a secure office. Participants were advised they could contact me to obtain a written copy of the aggregated research results.

The data obtained in this research study will be securely retained for a minimum of five years as per Memorial University of Newfoundland's policy on Integrity in Scholarly Research. After the information is no longer needed for additional research, possible journal submissions, and/or presentations, hard copy materials will be shredded, data files will be deleted, and notes will be destroyed.

Data Analysis

In order to interpret the data, the following steps were used as a guide. These steps were developed based on the phenomenological approaches documented by Creswell (1998 & 2007), Moustakas (1990, 1994), and Polkinghorne (1989). Steps 1-5 were completed for each of the interview transcripts.

1. The interview data was read in its entirety by the PI in order ensure the meaning and depth of each interview was understood.

2. The interview data was re-read several times in order to identify significant text segments in relation to how the individual experienced the phenomenon according the research question. This process is known as the *horizonalization* of data, which views all text segments as having equal worth.

3. The identified meanings emerging from the text segments were grouped into *theme clusters* or *meaning units,* which shared commonalities. Repetitive or overlapping text segments were removed. The theme clusters were interpreted and given a heading to describe the meaning.

4. Each of the theme clusters and the associated heading were read in response to the research question. The clusters which did not directly relate to the topic, along with any discrepancies and contradictions were passed over. In order to identify the qualities that were related to the research question, the text segments of each theme cluster were rewritten in the first person. My reflections were critical in this process in order to convert each thematic cluster into a descriptive statement. In order to focus the readings and reflections, two questions were used: (1) what is truly being described? and (2) what is absolutely essential to understand the phenomenon? This process zig zagged back and forth between the theme clusters, the interview data, and the headings until the meaning statements reflected as closely as possible to the essence of the theme clusters (Polkinghorne, 1989).

5. The meaning statements were combined and converted into a written *exhaustive description,* capturing in my words "all possible meanings and divergent perspectives" (Creswell, 1998, p.150). This also included the *textural descriptions* of what was experienced and the *structured description* of how the phenomenon was experienced in response to the research question.

6. Steps 1-5 were repeated for each interview. Before moving on to the next interview, the exhaustive description was compared to the transcript to ensure that the depiction of the experience corresponded with the data.

7. After all of the exhaustive descriptions were completed, a *composite description* is written to uncover the essence of the phenomenon. During this process, discrepancies or inconsistencies did not need to be smoothed out as differences

are an expected part of multiple meanings and constructions (Creswell, 1998;

Moustakas, 1990, 1994).

CHAPTER FOUR: THE FINDINGS

My discussion of the research findings begins with the participants, then the interviews. My documentation of the findings corresponds to my understanding of phenomenology data can be presented (Creswell 1998; Creswell, 2007; Moustakas, 1990; Polkinghorne, 1989). First, I describe my experience of interviewing the participants, followed by my reflections on the interview process. Next, I present my interpretive process and reflections. Thirdly, I review the findings and provide examples from the interview notes to support my understanding of the participants' experiences. I conclude this section with an inquiry into the validity of my composite descriptions.

Participants

There were five participants ranging in age from 19-56 years of age. There were two men and three women. One participant resided in the town of Bonavista. The remaining participants lived in the surrounding rural area up to 30 kilometers away. All participants completed three counselling sessions as offered by the Change Clinic service.

The Interview Process and Reflections

Prior to completing the interviews, I reviewed my journal entries to assist me in identifying any biases or preconceptions I had which could influence the results of the study. Although I had no prior contact with the participants, I did have a previous collegial relationship with the social workers who provided the Change Clinic service. Therefore, I spent time bracketing my preconceived notions in relation to the social workers who provided the service. By setting aside any preconceptions, I ensured my focus was entirely on the research.

Interviews with the participants. It was a pleasure for me to complete the telephone interviews with the participants. Throughout the course of the interviews, I was struck by their interest and eagerness to engage. The five participants were able to offer rich descriptions of their experiences with the Change Clinic service and the meanings they derived from same.

I began each interview by asking the research question, "What were your experiences with the Change Clinic service?" Throughout each interview I attempted to provide questions and comments that encouraged the collaboration of ideas and a co-creative process between myself and the participant. I used a list of probing questions to elicit further information and gain additional insight into the deeper meanings of their experiences (see Appendix E). During conversations with the participants, many of the probing questions flowed out of the conversation. There were times during the interviews when I wanted to share my opinion or comments but intentionally did not as I did not want to impact the participant's responses. At no point during the interviews did the participants inquire about my thoughts or opinions. This helped me remain focused on the participants' experiences.

My reflections. Throughout this research study, I often wondered what difference it would have made if the interviews were conducted face-to-face versus the telephone. Given the fact face-to-face interviews provide synchronous communication, I questioned if the participants would have been more spontaneous in their responses. Furthermore, I wondered what, if any, additional information I could have obtained from observing the participant's body language as they responded during the interviews.

The impact of power in the interview process was another factor I reflected on in relation to the interviews. Given the fact I was the PI of the research study and an employee of Eastern Health, I questioned if I would be perceived as having a greater influence or greater power in the interviews. Initially, I thought my voice would be dominant as I was the one who was asking the questions. I did notice that during some of the interviews, the questions I asked determined the direction of the conversation. However, after completing the interviews, I identified many times when the participant's ideas formed my subsequent questions or comments. Given this, I think there was a general sense of collaboration and co-creation during the interviews.

In order to clarify some of the wondering I had during the interviews, I reread my notes taken from the first interview. This provided me with punctuation points that became present in the other interviews. These punctuation points developed into ideas that appeared meaningful to touch on and also emerged during the conversations. After the interviews, I wondered how much of that flow was due to my desired preferred meanings.

The Interpretation Process and Reflections

The purpose of the interpretative process was to discover and articulate the essence of individuals' experiences with the Change Clinic services in rural NL. This would be accomplished when I could complete in my words a composite description of the experience according the participants. In order to complete this, the following analysis was pursued for each of the five interviews. I have highlighted the process using material from Participant One (P1).

First, in preparation for analysis, I read and re-read the interview notes in their entirety. Immersing myself in the data by repetitiously reading the interview notes was critical step in the completing the analysis (Marshall & Rossman, 2006). Next, I extracted all text segments that I believed described the individual's experience of the topic (see Appendix F).

After the horizonalization was complete, I began my interpretation of each text segment and clustered those segments with shared meanings into theme clusters/meaning units, removing any text that was repetitive or overlapping. I then created a heading, aiming to capture the meanings of each theme cluster (see Appendix G). The headings eventually became the basis for the essential and composite description.

For the fourth step, I reflected on each theme cluster in response to my research question: (1) what was truly being described? And (2) what was absolutely essential to understand the phenomenon? I then passed over clusters that I believed were not relevant. In doing this, I was cognizant not to compromise any unique meanings, and to cluster all possible nuances of meaning. For each participant, I re-wrote the clustered meaning unit into a statement using the first person (see Appendix H). Throughout this part of the interpretation, my process for each interview zigzagged back and forth between the theme clusters, the interview notes, and the headings until the meaning statements reflected as closely as possible the essence of the theme clusters.

Finally, I transformed the descriptive statements into an exhaustive description of the phenomenon in my words (see Appendix I). Before commencing to the next transcript, I checked the exhaustive description with the associated interview notes to assure myself I had captured all possible meanings and experiences of the phenomenon.

For all exhaustive descriptions, I decided to use a limited number of headings as a helpful way to understand the various aspects of the experiences. Once the five exhaustive descriptions were complete, I was struck by the similarities between the participants as captured in the composite description (see Appendix J).

Reporting on the Interpreted Findings

The purpose of this research study was to discover the lived experiences of individuals who received the Change Clinic service in rural NL. In order to accomplish this, the following research question was used: What were your experiences with the Change Clinic service? In the composite description the experience of the participants was captured within four core headings that represented the four conversational themes: These are: (a) experiences with Change Clinic Service, (b) expectations of the Change Clinic sessions, (c) outcomes of the sessions, and (d) service improvements. In the following discussion, I highlight the aspects that make up the essence of the phenomenon (see Appendix J for the complete Composite Description).

Experiences with the Change Clinic Service. In response to the research question: What were your experiences with the Change Clinic service?, all participants described their experience as positive and helpful. They noted the sessions assisted them in creating change by addressing their individual problem(s). Participant One noted, "It [Change Clinic] was a very positive experience. It provided a forum of safety and confidentiality to express my concerns at that time." Participant Two commented: "I found Change Clinic sessions to be very successful and helpful. It invited change into my life and made a positive difference."

The participants described the Change Clinic sessions as focused which assisted them in creating change. Knowing they had a limited number of sessions was described by the participants as helpful in keeping them focused on their individualized goal for service. Participant Two reported "With Change Clinic, I knew I only had three sessions to deal with my issues. I wanted to get the most out of it – so I had to stay focused." Participant Five stated "I think having three sessions helped me to stay focused. Like I had to work harder. But my work paid off."

The potential for Change Clinic sessions to assist in achieving change was emphasized by the participants. Participant One commented "Change clinic invited the potential or option for change and support for change." Participant Four noted: "It [Change Clinic] invited change because we talked about the different tools or methods to cope with anxiety. I was able to scale back my dosage of medication."

The social workers' approach and orientation was identified as a helpful aspect of the Change Clinic sessions. The participants described in detail positive experiences with the social workers providing service. Participant Three noted "talking to the counsellor was like talking to a friend back and forth." Participant Two stated:

> My counsellor, in particular, she kept me on track. She was really helpful and ensured we were talking about the issues I wanted to talk about. She made me feel positive about myself and the situation. She didn't judge me at all. The questions she asked me were really helpful. She didn't put words in my mouth either. She helped me to get to where I wanted to be. The questions she asked and her experience helped me the most I think.

The participants referenced how the social worker helped them to feel relieved after attending the Change Clinic sessions. As Participant One commented,

> I always felt relieved after finishing the session. I felt listened to and heard. When I returned to my home environment the scenario improved. I felt more open and hopeful. More able to communicate and to see things from a different angle.

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Participant Five noted:

> By the counsellor focusing on what was bothering me, I felt so much better when
> I left. Like a weight was lifted off my shoulders…the counsellor also always
> asked if we were talking about the things I needed to talk about. I found that
> really good.

Expectations of the Change Clinic sessions. The participants described not

knowing what to expect prior to attending the Change Clinic sessions. They also

referenced how they received limited information about the service. Participant Three

stated:

> I was on the waiting list for counselling and they [the Eastern Health social
> worker] asked if I was interested. They [the Eastern Health social worker] did not
> explain it well. I really didn't know anything about [Change Clinic]; didn't even
> know it [Change Clinic] existed so I didn't have any expectations.

Participant One noted:

> I didn't know what to expect at first. I didn't know much about it. I got a call
> seeing if I would be interested in Change Clinic but they really didn't explain
> it. I had been waiting for long-term counselling for a long time so I was really
> wanting help. I really didn't know when I was going to get in. I was told I
> would get three sessions for the Change clinic sessions.

The participants described how they were unsure if the three counselling

sessions they were offered would be enough. As Participant Four stated "I was told I

would get three sessions. I wasn't sure if that would be enough, but once I got in there, I

felt I got what I needed."

After attending the first session, the participants noted having a better

understanding of the Change Clinic procedures. As Participant One stated "Initially, I

didn't know what to expect. There was a change from the first session to the next session

as I gained a better understanding of the service and my expectations were always met."

Participant Five noted

After the first session, I was able to prepare myself in advance for the next session as I knew the questions – I knew what was going to be asked of me. I would actually take notes and keep a journal from day to day and then I was able to look at that before I went into an appointment and determine what was the most important issue for me.

The pre-interview questionnaire used by the social worker to help identify the client's presenting issue was identified by the participants as being a helpful process of their Change Clinic experience. They noted the questionnaire helped them to identify what they wanted to discuss during their session and also helped them to stay focused.

Participant Two stated:

The questionnaire she [social worker] gave me in the first session made me actually sit and think about what I wanted to talk about. This helped me a lot going into the session. I kind of knew what I was getting into. The questionnaire kept you on track.

Participant Four noted:

The questionnaire was helpful. Every day I went in, I had to write down what I wanted to talk about. Because of that, I had to figure out what I wanted to talk about. I knew then what I would be facing. Whatever was weighing on my mind, I would talk about it and get it out.

Outcome of Change Clinic sessions. The participants described feeling relieved after completing the Change Clinic sessions. Outcomes were described as achieving a better understanding of themselves and their presenting issues. Participants noted experiencing less stress, increased socialization, less mental health problems, increased confidence, and less reliance on medication. Participant One stated:

There is a lot less stress in my life now from attending Change Clinic. There is more of a calmness- things have settled a lot. There has been positive outcomes for me and my family. My family has noticed changes in me- for the better. I am not down in the dumps, I am more outgoing after attending Change Clinic sessions. I got a better social life now.

Participant Three commented:

Change clinic has helped me deal with the issues so I wouldn't rely on medication. Talking about the different tools and things I could use and situations

that I could use them was the biggest help. It [Change Clinic] taught me tools to help me cope with anxiety. Also, it helped me figure out what was helpful for me.

The potential for Change Clinic sessions to promote hope for the future was referenced by the participants. Participant Five noted "Things were tough. I am glad they are better now. I feel hopeful that things will get better. That I can keep going." The participants highlighted their ability to return to the service as contributing to their sense of hope for the future. Participant Four commented, "I feel better knowing I can go back if I need to, you know. That makes me a little more hopeful and relieved."

Service improvements. The participants identified increased information and publicity, reduced wait-times, and availability of sessions as factors which could improve the Change Clinic service. According to Participant Four:

It [Change Clinic] needs to be made more public. Everyone should be aware of it. There should be something out there to let the public know that this is a service we have. I didn't even know it existed. The only way I found out was because I got a letter in the mail from Eastern Health. I think there should be signs or flyers around, to let people know, promote it, you know.

Participant Five stated:

There wasn't much information about it. Like, I didn't know a lot about it before I went there. I think there should be information out there for the public to see. It's a good service, more people should know about it.

The participants expressed concern with regard to wait-times for services; noting the Change Clinic sessions would be improved if there were decreased wait-times.

Participant 5 stated:

The waiting time is the worst. I was waiting forever before I went to Change Clinic. If they could fix that, things would be better. It is scary how long people have to wait for help.

Participant One commented:

Everyone wants to see shorter wait-times. I know that I can go back if needed. However, if a loved one wanted to get in there is such a long period. What if you really needed to speak with someone? The waiting period is such a shame.

The participants also identified the need for increased session length and availability.

Participant Two stated:

> In terms of what was missing for me, I had to take time off work in order to attend the sessions. The times that were available were limited. I finish work at 2:15 and there were no sessions available after a certain time and there only sessions available on certain days of the week. I wish they had evening hours or offered it more than one day per week. It would have made it easier to get there.

Participant Three noted:

> Missing? It would have been nice if the sessions ran longer. More sessions would have been helpful. The amount of time was good but you only had a limited number. It is hard to know how many you would need because each individual is different.

The Validity of the Composite Descriptions

Within phenomenology research, validity is critical to ensuring participant representation is accurately obtained and described (Marshall & Rossman, 1995; Moustakas, 1994). Given the fact the participants' views are the only justifiable evaluator of the results, the research relies on them for validity. Validity within this research study is determined by how well the composite descriptions of the research portray the participants' experiences (Moustakas, 1994; Polkinghorne, 1989). Creswell (1998) notes that one way to determine validity is through my own scrutiny of the findings. To complete data analysis, I immersed myself in the data obtained in the interviews. I read and re-read the interview notes in order to ensure the participant's voices were accurately depicted in the composite descriptions. I also used thick-rich descriptions to ensure the unique voices of the participants were communicated (Creswell, 1998).

I also utilized member checking to ensure validity of the research findings. To complete member checking, during the telephone interviews I read and reread the notes I took from the participants to them. This process assisted in ensuring clarity and accuracy.

I then asked the participants to confirm if the responses I had detailed, accurately

portrayed their experiences. This process allowed me to check for inconsistencies or

discrepancies and receive further clarification from the participants. It also assisted me in

addressing my own subjectivity and promoting the trustworthiness of my findings

(Moustakas, 1990).

CHAPTER 5: DISCUSSION

This research study used a phenomenological, qualitative research design, to explore individuals' experiences with a time-sensitive counselling service in rural NL. Any adult, aged sixteen years or older, who was capable to self-refer to mental health services in Bonavista, was invited to participate. Recruitment letters were provided to clients of the Change Clinic service by their social worker at the end of their initial session. There were a total of five participants who completed this study. After informed consent was obtained, in-depth interviews were completed via telephone and notes were taken detailing the participants' responses. Data analysis was conducted using the phenomenological approaches of Creswell (1998 & 2007), Moustakas (1990, 1994), and Polkinghorne (1989). The findings from this research study followed the research question, What were your experiences with the Change Clinic Service?, and addressed four conversational themes (a) experiences with Change Clinic Services, (b) expectations of the service, (c) the outcome of the sessions, and (d) service improvements.

This research study developed from my interest in discovering rural individuals' experiences with time-sensitive counselling services as this offers relative insight for researchers, professionals, social workers, clients, and students. My hope is to contribute to the understanding of time-sensitive practice, specifically for rural populations.

Individuals' Experiences with Time-Sensitive Services

The findings of this study correspond to research findings regarding individuals' experiences with time-sensitive counselling services. For example, several studies (Barwick et.al, 2013; Hair et.al, 2013; Harper-Jaceques et. al., 2008; Mireau & Inch, 2009; Young, 2008; Young et. al., 2008) have found that individual's experiences with

this service were positive; highlighting how the sessions assisted the clients in meeting their individualized goals for service. Clients of these studies described how the sessions were effective in providing an opportunity for hope, growth, and change. Furthermore, clients also referred to the counselling sessions as client-centered, which allowed them to stay focused on addressing their presenting issue (Barwick et.al, 2013; Hair et.al, 2013; Harper-Jaceques, Mchelgeran, Slive, & Leahy, 2008; Mireau & Inch, 2009; Young, 2008; Young et. al., 2008). The participants within my research study reported similar experiences. They described the counselling sessions as helpful; noting it assisted them in meeting their identified goals for service.

Hymen and colleagues (2013) completed research on time-sensitive counselling services and noted the helpful aspects of the sessions as reported by clients. These helpful aspects included (a) obtaining information or advice to assist them in addressing their presenting problem, (b) the orientation and approach of the counsellor/social worker, (c) the ability to discuss their presenting problem and feeling supported in completing same, and (d) accessibility of services when needed. The helpful aspects identified in this study correlated with those reported by the participants in my research. The participants within my study identified learning how to manage their current stressors and feeling heard, supported, and accepted. Respondents also identified the importance of the social worker's approach, focus on addressing their presenting problem, and the availability to access this service in the future if necessary as helpful aspects of their Change Clinic experience.

Expectations of the Change Clinic Sessions

Participants within my research study described not knowing what to expect prior to attending the Change Clinic service. They reported receiving limited information regarding the service prior to their arrival. Participants also described feeling uncertain if the three counselling sessions would be sufficient in addressing their presenting problem(s).

Although there is no literature specific to individuals' expectations with time-sensitive counselling service, the research completed on this practice approach emphasizes the importance of clients receiving accurate information regarding the service. Young and colleagues (2008) provided detailed descriptions of time-sensitive counselling services, specifically the policies and procedures guiding the service. In this report, the authors emphasized the importance of providing clients with information regarding the service; noting the importance of reflecting the critical concepts of brief therapies in their explanation of the service. To address feelings of uncertainty, Young et. al., (2008) highlighted the importance of clients being able to avail of time-sensitive services as needed.

Within my research study, the pre-interview questionnaire was described by the participants as helpful in identifying their presenting issue and knowing what to expect during the counselling session. Similarly, Hair and colleagues (2013) described the pre-interview questionnaire as a tool which can guide the counselling session, while also ensuring the client's presenting issue is identified and addressed.

Participants within my research study noted that after they learned more about the Change Clinic service, their expectations of service were met. This correlated with the

research findings on time-sensitive practice in which clients described meeting their individualized goals (Barwick et.al, 2013; Hair et.al, 2013; Harper-Jaceques et. al., 2008; Hymmen et. al., 2013; Mireau & Inch, 2009; Young, 2008; Young et. al., 2008).

Outcome of the Change Clinic Sessions

Harper-Jacques and colleagues (2008) completed research on time-sensitive counselling services in Canada. Participants described being very satisfied with the service and reported improvement in their overall functioning. Additional studies have found that clients expressed decreased mental health problems after completing the time-sensitive counselling sessions (See Barwick et.al, 2013; Hair et.al, 2013; Harper-Jaceques et. al., 2008; Mireau & Inch, 2009; Young, 2008; Young et. al, 2008). The participants in this study also referred to similar outcomes as they described their individualized experience(s). They reported decreased stress, increased socialization, less mental health problems, increased confidence, and less reliance on medication. The participants in my study described feeling relieved and hopeful for the future after availing of the Change Clinic service. They also identified being able to return for future counselling sessions as contributing to their positive outcomes.

Service Improvements

Participants identified increased information and publicity, reduced wait-times, and increased availability of sessions as factors which could improve the Change Clinic service. In comparison to the literature, research completed on time-sensitive practice emphasizes the importance of accessibility; noting how clients must be able to access information regarding the service and appointment times as needed. Short or no-wait-

times and extended hours of operation were also identified by researchers as critical components of time-sensitive practice (Hymmen et. al., 2013; Young et. al., 2008)

Conceptual Frameworks, Assumptions, and Practice

Hair and colleagues (2013) discussed how social constructionism is a compatible conceptual framework for time-sensitive counselling services; noting how assumptions informed by a social constructionist perspective can assist in meeting the needs and preferred outcomes identified by clients. The influence of social constructionism was suggested in this research study. Participants in this study described the counselling sessions as a collaborative process between themselves and the social worker; noting their ability to determine the focus of the conversations. The participants reported feeling hopeful that change was possible; noting their increased sense of control and ability to address their presenting problem(s). Participants referred to the sessions as focused; stating the social worker elicited continuous feedback from them to ensure they were talking about the issues they wished to discuss.

Relevance of Time-Sensitive Practice for Rural Populations

The findings of my research study provide support for time-sensitive practice counselling services for rural populations. The participants of this study described positive experiences with this service; noting it assisted them in meeting their identified goals for service. They reported the limited number of sessions helped them to stay focused on creating change. The participants were thankful that they could return for service when needed and it was available in the rural community in which they reside. The positive experiences described by the participants' highlights the potential for time-sensitive service to assist in meeting the mental health needs of rural residents.

Limitations

The study was limited by the sampling method, small sample size, demographics, participant feedback, and use of bracketing. The convenience sampling method which was used in this study is highly vulnerable to self-selection bias. Self-selection bias refers to how a participant's decision to take part in a study may reflect some inherent bias in the characteristics of the participants (Creswell, 2007). Due to the time constraints of the study and staffing issues at the Eastern Health office in which the participants were recruited, the sample size of this research study is small even for a phenomenological research project. As a result of the small sample size, it is difficult to say if the individuals' experiences are typical of others receiving the service. Furthermore the study sample is limited to a small geographical area. People residing in different geographical areas may have had very different experiences with this service and as a result have a different story to tell. Due to the time constraints of this study, I was unable to provide the participants with a copy of my composite descriptions to ensure it compared with their experiences. Given this, I was unable to ask the participants if any of their experiences had been omitted. Finally, the use of bracketing as part of the phenomenology inquiry has many potential limitations. Bracketing requires the researcher to set aside or "bracket" their beliefs, values, and experiences in order to describe the experiences of the participants. Kosh (1994) describes how the researcher's preunderstanding cannot be completely eliminated or "bracketed". As a result, it is difficult to detect or prevent researcher induced bias. Furthermore, the difficulty associated with ensuring pure bracketing can interfere with the interpretation of the data (Kosh, 1994).

Implications for Future Research and Education

The findings of this study have implications for future research. The phenomenological approach can be used for future studies utilizing a larger and more diverse sample. Increasing the number of participants, specifically participants from diverse populations, would enrich the descriptions and meanings. It would also substantiate the shared experiences for the participants. Additionally, studies exploring the experiences of individuals receiving time-sensitive counselling services in other geographical areas, would add to the transferability of the research results.

Although there are studies which discuss individuals' experiences with time-sensitive counselling services (Barwick et.al, 2013; Hair et.al, 2013; Harper-Jaceques et. al., 2008; Hymmen et. al., 2013; Mireau & Inch, 2009; Young, 2008; Young et. al., 2008), I have not uncovered any studies which explore rural individuals' experience with this service. The lack of research on time-sensitive practice, specifically for rural populations, suggest that extending this type of inquiry could be valuable to mental health services and social work practice. It is my hope that future research could help to ensure the potential for time-sensitive counselling practice to meet the needs of rural residents. Specifically, I am curious to further discover how time-sensitive practice can promote hope, growth, and change for clients.

The findings of this study also have implications for future social work education. One of the most predominant concepts that arose from this research study was the importance of a social constructionist perspective in providing effective time-sensitive counselling services. To facilitate student learning, it is imperative that social workers be provided education and information on social constructionism, specifically the practice

assumptions informed by a social constructionist perspective, as well as, the associated skills. This can be accomplished through education courses provided by instructors or employers. Furthermore, in order to enhance student learning, further exploration of individuals' experiences with time-sensitive counselling services, specifically those in rural areas, is recommended.

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Appendix A

Mental Health & Addictions Program
Mount Pearl Square
760 Topsail Road
Mount Pearl, NL A1N 3J5
CANADA
Telephone: 709-752-4602
Fax: 709-753-4969
Website: www.easternhealth.ca

September 16, 2014

To whom it may concern;

On behalf of the Mental Health & Addictions Program of Eastern Health, I am providing my support for the research project, "*Exploring the Experiences of Individuals Receiving Change Clinic Services in Rural Newfoundland: A Qualitative Study*". This research is to take place at the Mental Health and Addictions Services Office in Bonavista, Newfoundland.

I have reviewed the research project of the Principle Investigator, Jaspen Barker. The results will be interesting and timely for our program. I understand that the research will not take place without the required ethics and organizational approvals.

If you have any questions or require additional information, please feel free to contact me.

Sincerely,

Kim Grant
Regional Director
Community & Addictions Services
Mental Health & Addictions Program

cph

Appendix B

ICEHR Number:	**20150694-SW**
Approval Period:	November 4, 2014 – November 30, 2015
Funding Agency:	N/A
Responsible Faculty:	Dr. Heather Hair School of Social Work
Title of Project:	*Exploring individuals' experiences of time-sensitive counseling services in rural Newfoundland; A qualitative study*
Amendment #:	*01*

Interdisciplinary Committee on Ethics in Human Research (ICEHR)

Research Grant and Contract Services
St. John's, NL Canada A1C 5S7
Tel: 709 864 2561   Fax: 709 864 4612
www.mun.ca/research

April 17, 2015

Mrs. Jaspen Barker
School of Social Work
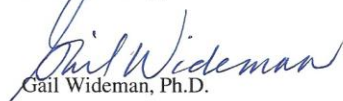Memorial University of Newfoundland

Dear Mrs. Barker:

The Interdisciplinary Committee on Ethics in Human Research (ICEHR) has reviewed the proposed modification for the above referenced project, as outlined in your correspondence dated April 17, 2015, and is pleased to give approval to change the site of your research, as requested, provided all previously approved protocols are followed.

If you need to make any other changes during the conduct of the research that may affect ethical relations with human participants, please forward an amendment request form with a description of these changes to icehr@mun.ca for further review by the Committee.

Your ethics clearance for this project expires November 30, 2015, before which time you must submit an annual update form to ICEHR. If you plan to continue the project, you need to request renewal of your ethics clearance, and include a brief summary on the progress of your research. When the project no longer requires contact with human participants, is completed and/or terminated, you need to provide the annual update form with a final brief summary, and your file will be closed. The annual update form is on the ICEHR website at http://www.mun.ca/research/ethics/humans/icehr/applications/.

The Committee would like to thank you for the update on your proposal and we wish you well with your research.

Yours sincerely,

Gail Wideman, Ph.D.
Vice-Chair, Interdisciplinary Committee on
Ethics in Human Research

GW/lw

copy: Supervisor – Dr. Heather Hair, School of Social Work

Research Grant and Contract Services, Bruneau Centre for Research & Innovation   Page 1 of 1

Appendix C

Exploring Experiences of the Change Clinic Counselling Service

Invitation to Participate

You are invited to participate in a research project developed to explore people's experiences of the Change Clinic offered by the Mental Health and Addictions Services in Bonavista.

This research project is developed by Jaspen Barker, Master of Social Work Student, from the School of Social Work at Memorial University. Dr. Heather J. Hair from Memorial University is the supervisor of the project. This project is not part of Eastern Health and will in no way affect your access to services now or in the future. Your participation involves having a telephone interview with Jaspen Barker that will last approximately one hour.

PLEASE FILL OUT THE FOLLOWING:

☐   **YES, I am interested in hearing more about the research project.**

FIRST NAME:_____

PHONE NUMBER:_____

Please give a number where you can be reached between 4:30pm – 7:00pm.

Jaspen Barker will call you to explain the project and, should you agree to participate, you will be asked to give your consent. A mutually convenient time will be set up for the phone interview.

☐   **NO, I am NOT interested in participating.**

Please put this completed form in the accompanying envelope, seal it, and return to your counsellor.

The forms in its sealed envelope will be given to Jaspen Barker. Your counsellor will not see this form or learn of your decision about the research.

THANK YOU FOR YOUR TIME

Appendix D

Exploring Individuals' Experiences of Time-Sensitive Counselling Services

Information Letter for Potential Participants

You are invited to participate in a research project developed to explore the experiences of the time-sensitive counselling services available at Mental Health and Addictions Services in Bonavista. With your participation, we can learn what works best and how we can be most helpful to clients. The Principal Investigator (PI) of this research project is Jaspen Barker, Master of Social Work Student, from the School of Social Work at Memorial University. Dr. Heather J. Hair is the supervisor of this project. If you would like more detail regarding something mentioned here, or information not included here, you are welcome to ask questions. Please take the time to read this carefully.

It is entirely up to you to decide whether to take part in this research. If you choose not to take part in the research or if you decide to withdraw from the research once it has started, there will be no negative consequences for you now or in the future with Mental Health and Addictions Services or Eastern Health. If you withdraw, you can request that the data collected from you up to the point of your withdrawal will not be used in the study and your data will be destroyed.

Purpose of Study:
To explore individuals' experiences of time-sensitive counselling services in rural Newfoundland.

Possible benefits and Risks:
 This research could help improve counselling services for individuals of Newfoundland and Labrador. There are no foreseeable risks or costs to you for participating.

Procedures:
You will be asked to complete a telephone interview of up to 1 hour following the completion of your Change Clinic sessions. The telephone call will be either be audio-taped or the PI will take notes; the choice will be yours. The interview will consist of open-ended questions to explore your experiences with Change Clinic Services. The interview will take place via telephone during a mutually agreed upon time between you and the PI.

Withdrawal from the study:
Participation in this research study is voluntary. You have the right to withdraw at any time or refuse to participate. Refusal to participate will not influence your assess to Eastern Health Services of the quality of services provided. If you decide to withdraw from the study after your telephone interview, simply contact the PI, or Dr. Heather Hair. If you withdraw from the study before completing the telephone interview your information will not be saved. Information will only be saved once you have completed the telephone interview. You have the right to not respond to any question(s) you choose.

Confidentially and Anonymity:

Every reasonable effort will be made to keep the interview data obtained confidential and to protect your identity. The interview data will be kept in a locked filing cabinet at the MHAS office in Bonavista. The PI and Dr. Hair will be the only individuals who will review the information. The research data will be transported to Dr. Hair's MUN office in a locked brief case and will be stored in a locked filing cabinet in an office. Prior to removal from the MHAS office in Bonavista, the PI will replace the identifying information from the written notes or transcriptions of the telephone interview with a number and remove all identifying information. After the notes or transcription records will be entered into a computer data base which is password protected and stored in a secured office. No participants will be identified in any presentation, publication, or discussion. Participants are welcomed to contact the PI for a copy of their research results.

Compensation:
You will not receive any form of compensation for your participation in this study.

Reporting of Results:
The data collected will be used for the completion of the PI thesis's project, which will be submitted to the Faculty of Graduate Studies and Research in partial fulfillment of her Master of Social Work degree. The results could be used in future presentations, conferences, publications, or reports.

Storage of Data:
After the research is completed, the data will be securely retained for a minimum of five years, as per the Memorial University policy on Integrity in Scholarly Research. Survey responses will be shared collectively. If any of your written responses to open-ended questions are used as sample quotations, all identifying information will be removed. You will not be identified in any presentation, publication, or discussion. You are welcome to contact the PI or Dr. Hair to request a copy of the research results.

Sharing Results with Participants:
Once the thesis project is completed, you are welcomed to ask for a copy of the report. The PI will provide a written copy of the results to the Program Manager of Mental Health and Addiction Services in Bonavista and the Director of Mental Health and Addiction Services. They will also make themselves available to personally present the information to any office that perceives it to be beneficial.

Questions about the Research:
The proposal for this study has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at (709) 864-2861.

If you have questions regarding this study please contact me, Jaspen Barker at g99jjb@mun.ca or by telephone at (709) 427-7563, or PI's thesis supervisor with Memorial University, Dr. Heather Hair, at hhair@mun.ca or by telephone at (709) 864-2562.

Appendix E

Exploring Individuals' Experiences of the Change Clinic Counselling Services

Informed Letter of Consent for Participants

This research study has been developed to explore individuals' experiences with Change Clinic counselling services available at Mental Health and Addiction Services in rural Newfoundland. With your participation, we can demonstrate evidence of informed practice.

Your signature means:

- You have heard or read the Information Letter about the research and have had adequate time to think about what you learned.
- You have been able to ask questions about this study and you are satisfied with the answers.
- You understand what the study is about and what you will be doing.
- You understand the risks and benefits of your participation.
- You agree that the PI can use anonymous quotations from your telephone interview responses.
- You understand that you are free to withdraw from the study at any time, without having to give a reason, and that doing so will have no negative consequences for you now or in the future with Mental Health and Addictions Service or Eastern Health.
- If you withdraw, you understand that you can contact Jaspen Barker or Dr. Hair and request that data collected from you up to the point of your withdrawal will not be used in the study and your data will be destroyed.
- You understand that your consent form and interview notes will be stored in separate locked cabinets.
- You understand that after the research is completed, non-identifying data will be securely retained for a minimum of five years, as per the Memorial University policy on Integrity in Scholarly Research.
- You understand that you can contact Jaspen Barker or Dr. Hair directly to request a copy of the findings of this study.
- You understand that if you have questions regarding the procedures and goals of the study at any time, you can contact Jaspen Barker by email at g99jjb@mun.ca or Dr. Hair by e-mail at hhair@mun.ca
- You understand this project will be reviewed through the Ethics Committee of Memorial University of Newfoundland.
- You voluntarily agree to participate in this research project.

If you sign this form, you do not give up your legal rights and do not release the researchers from their professional responsibilities.

Your name: _____ Your signature: _____

Date: _____

JB/September 19, 2014

Appendix F

Exploring individuals' experiences of time-sensitive counseling services in rural Newfoundland; A qualitative study.

<u>The Central Question:</u>

What were your experiences with Change Clinic Services?

<u>Possible further questions or probes could be:</u>

(a) What difference has participation in the Change Clinic had in your life?

(b) What is your hope for change following participation in the Change Clinic?

(c) How has Change Clinic sessions impacted your life?

(d) What changes occurred in your life following participation in the Change Clinic sessions?

(e) What were your expectations of Change Clinic sessions and how did they compare to your outcome experiences of this service?

Appendix G

Step 2 of a Phenomenological Analysis
Text Segment Examples of Horizonalization

NOTE: The following text segments are used to demonstrate each of the interpretive steps I used.

P1 26-29

Change Clinic invited the potential or option for change and the support for change. Not so much this is right or wrong, but what you may consider differently. It allowed me to look at options. If something was ambiguous, the questions were asked and the potential outcomes were explored. This showed that things could have been different than what I had thought they could be.

P1 33-35

I would voice circumstances that were unfolding on in my life. Questions were asked to determine if this was based on reality or perception. It allowed me to pursue questions with professionals so that I knew what the reality was versus my own perception.

P1 L38-40

I always felt relieved after finishing the session. I felt listened to and heard. When I returned to my home environment the scenario improved. I felt more open and hopeful. More able to communicate and to see things from a different angle.

P1 L59-62

In a perfect world, you may be able to speak with someone that you do not know. Complete anonymity in rural NL is difficult. In a perfect world, I would have amenity in my personal life so that I never run into the counsellor in a personal setting.

P1 L64-68

The only thing I can think of, if I was new to Change Clinic would be the wait-time. Everyone wants to see shorter wait-times. I know that I can go back if needed. I am grateful that I can go back in and this service is available in a rural area. However, if a loved one wanted to get in, there is such a long period. What if you really needed to speak to someone? The waiting period is such a shame.

Appendix H

Step 3 of a Phenomenological Analysis
Samples of Two Assigned Headings for the Associated Theme Clusters

Outcome of the Change Clinic Sessions

P1 L38-40: *I always felt relieved after finishing the session. I felt listened to and heard. When I returned to my home environment the scenario improved. I felt more open and hopeful. More able to communicate and to see things from a different angle.*

P1 L42-44: *Provided me with the ability to recall different angles of conversations that take place. Provides me with different ways to interpret my own thought patterns. Different ways of viewing the questions.*

P1 L45-46: *I am able to see things in a different light than if I never went to Change Clinic.*

P1 L48-51: *Life has changed. I am guaranteed that change will happen. I will continue to have a forum for different thoughts as stress continues. My hope for change is that things will go my way. I can continue moving forward in a healthy way. I can continue to keep with a healthy perspective if life situations unfold; knowing that I can partake in the program again if needed.*

P1 L53-54: *I found Change Clinic had a positive impact. Forum for me to feel heard and for feedback. At the end I felt confidentiality was maintained in a comfortable and safe setting.*

Different or Missing

P1 L56-57: *I don't know what would be missing. Don't really know. I knew what I was going into. My exceptions were always filled so I don't know what was missing.*

P1 L59-62: *In a perfect world, you may be able to speak with someone that you do not know. Complete anonymity in rural NL is difficult. In a perfect world, I would have amenity in my personal life so that I never run into the counsellor in a personal setting.*

P1 L64-68: *The only thing I can think of, if I was new to Change Clinic would be the wait-time. Everyone wants to see shorter wait-times. I know that I can go back if needed. I am grateful that I can go back in and this service is available in a rural area. However, if a loved one wanted to get in, there is such a long period. What if you really needed to speak to someone? The waiting period is such a shame.*

Appendix I

Step 4 of a Phenomenological Analysis
Sample of a Heading, Descriptive Statement, and Associated Theme Clusters

The heading, statement, and corresponding clustered text segments.

OUTCOME OF THE CHANGE CLINIC SESSIONS

The Change Clinic had a positive impact. I always felt relieved after finishing the session. I felt listened to and heard. It provided me with the ability to recall different angles of conversations that take place and different ways to interpret my own thought patterns. My life has changed. I am guaranteed that change will happen. I will continue to have a forum for different thoughts as stress continues. My hope for change is that things will go my way. I can continue moving forward in a healthy way. I can continue to keep with a healthy perspective if life situations unfold and knowing that I can partake in the program again if needed. I am really thankful for the program. At the end, I felt confidentiality was maintained in a comfortable and safe setting. I am thankful that I life in a rural place where such a program is offered. I has provided me with well-needed support.

P1 L38-40: *I always felt relieved after finishing the session. I felt listened to and heard. When I returned to my home environment the scenario improved. I felt more open and hopeful. More able to communicate and to see things from different angle.*

P1 L42-44: *Provided me with the ability to recall different angles of conversations that take place. Provides me with different ways to interpret my own thought patterns; like different ways of viewing the questions.*

P1 L45-46: *I am able to see things in a different light than if I never went to Change Clinic.*

P1 L48-51: *Life has changed. I am guaranteed that change will happen. I will continue to have a forum for different thoughts as stress continues. My hope for change is that things will go my way. I can continue moving forward in a healthy way. I can continue to keep with a healthy perspective if life situations unfold and knowing that I can partake in the program again if needed.*

P1 L53-54: *I found Change Clinic had a positive impact. Forum for me to feel heard and for feedback. At the end I felt confidentiality was maintained in a comfortable and safe setting.*

P1 L70-71: *I am really thankful for the program. I am thankful that I live in a rural place where such a program is offered. It has provided me with well-needed support.*

Appendix J

Step 5 of a Phenomenological Analysis
The Exhaustive Description

The following are all the theme statements under each heading:

OUTCOMES OF THE CHANGE CLINIC SESSIONS

The Change Clinic had a positive impact on me. I always felt relieved after finishing the sessions. My family and friends also noticed an improvement in me. The social worker providing the sessions made me feel listened to, supported, and heard. I was able to look at situations differently, as well as, interpret my thoughts differently. I recognize that change will continue to happen but I now have a forum for different thoughts as I experience stress. I feel hopeful that things will continue to go my way and I can continue moving forward in a healthy manner. I believe I can continue to keep a healthy perspective as life situations unfold as I know I can access this service again if needed. I am really thankful for this program and thankful it is available in the rural area where I live.

SERVICE IMPROVEMENTS

My expectations were always met from my involvement in this service so I don't know what would be missing. The only thing I can think of is wait-time. Everyone wants to see shorter wait-times, especially if a loved one needed service. I know that I can avail of the service again if needed. However, if someone was newly referred to the Change Clinic, there would be a long wait-time. This is concerning, especially if you really needed to speak to someone. The waiting time is such a shame. In addition to wait-times, I believe having complete anonymity would improve the service. Having amenity in rural NL is difficult. In a perfect world, I would have amenity in my person life so that I would never run into the social worker in a personal setting.

Appendix K

Step 7 of a Phenomenological Analysis
The Composite Description of the Participant's Experience

THE GENERAL QUESTION: What were your experiences with Change Clinic counselling services?

Experiences with Change Clinic Sessions

Change clinic is a counselling service which offers three focused counselling sessions to clients. It was offered as an alternate service to individuals on the waiting list for long-term counselling. It is a helpful experience which positively impacted the lives of the participants. Sessions are focused in order to target the specific issues the participants were facing at that time. The session(s) invited change into the lives of the participants by providing hope that change is possible

The pre- interview questionnaire utilized by the social workers was a helpful aspect of the Change Clinic sessions. The questionnaire assisted participants in identifying their presenting issue and staying focused on addressing that specific issue. The questionnaire helped the participants to prepare for their future sessions by giving them something to think about and work on.

Conversations between the participants and social workers were a collaborative process in which the participants were able to determine the focus of the session. The social workers asked questions that helped the participants to stay focused on their presenting issue(s), as well as, explore their options for change. The social worker's orientation and approach allowed the participants to feel heard, supported, and accepted. The social workers ensured the main issue the participants were facing at that time was identified and addressed.

Expectations of the Change Clinic Sessions

Initially, the participants did not know what to expect as they had no previous knowledge of the Change Clinic service. Due to the lack of information and explanation from the social workers regarding the service, the participants were unaware of what to expect. Initially, the participants were unsure if the three sessions would be sufficient. After the first session, they gained a better understanding of the Change Clinic process and procedures. Emphasis was placed on the importance of going into the sessions with an open-mind and a willingness to try new things. After becoming familiar with the service, the participants' individual expectations were met.

Outcome of the Change Clinic Sessions

Participants were relieved after completing the Change Clinic sessions. Outcomes were described as achieving a better understanding of themselves and their presenting issues. Participants experienced less stress, increased socialization, less mental health issues,

increased confidence, and less reliance on medication. Participants obtained a better understanding of themselves and gained tools which assisted them in dealing with their presenting issues. The sessions encouraged the participants to step outside their comfort zone and try new things. The participants are now better equipped to deal with issues. They were proud of their achievements; noting how family and friends recognized their improvements. The participants were thankful for the program and thankful that it is available in the rural area in which they reside.

Service Improvements

There is a lack of information regarding the Change Clinic service available to the public. In order for the public to be more aware of this service, there needs to be increased publicity. The social workers providing the service must provide better explanations of the service, including its policies and procedures, to clients.

The wait-time for service is a major concern for participants. Given this concern, increased accessibility and availability of the service is needed. It is recommended that the Change Clinic service be available more than one day per week, with increased staff and extended hours of operation. This would help to ensure that individuals could assess the service when needed.