Profiles in Social Work

Episode 46 – Stephanie Francois

Intro - Hi, I'm Charmaine Williams, Associate Professor and Associate Dean, Academic, for the University of Toronto, Factor-Inwentash Faculty of Social Work. Welcome to Profiles in Social Work. This podcast series is produced by our Faculty and Alumni Association. In 2014 the Factor-Inwentash Faculty of Social Work is celebrating 100 years of contributing to Social Work Practice and Education. You can find out more about us by visiting us online at www.socialwork.utoronto.ca We're glad you could join us today. The series Profiles in Social Work highlights how social workers are making a positive difference in our communities by presenting stories of how social work graduates are using their degrees. We hope you will enjoy this series. Especially if you are thinking about a career in social work or interested in hearing about what social workers do.

Profile – Stephanie Francois

My name is Stephanie Francois and I graduated from the University of Toronto Factor-Inwentash Faculty of Social Work in 1999.

I actually started my undergrad doing environmental science and I didn't even know what a social worker was. I took psychology as an elective course and some sociology courses and I also took some anthropology courses and I really liked it. And I had never been exposed to anything like that in high school. Later on when I finished my undergrad I was looking into possible things I could do and I ended up putting in my application for a Masters in Social Work. To be honest I still didn't quite know what a social worker did or what it was. I had an idea and I think really I learned what it meant to be a social worker as I studied here, as I took courses, as I did my placements, the more I worked in the field, the more I became connected to what social work really meant.

My son was three months old when I started at the Faculty and I was exhausted. I remember the school being very supportive. It was a bit hard balancing having a newborn and being up all night and coming in and juggling placements and things so I think for me that's one thing that really stands out; being able to be in an environment

where they are supportive and that they can be accommodating to a variety of different populations. That was a taste of social work.

One thing that I remember, probably learning more about the different models that were used in social work when we were doing clinical practice, how to apply these models when we were working with people; Integrating the theory with the practice. I really found that quite fascinating. I learned a lot about mental health. I remember taking quite a few mental health courses here. The main thing was that connection of learning about the models in social work and applying that to clinical practice. That's something that has stayed with me.

I work in an outpatient area at the hospital. My second placement was at this hospital and then I got hired. When I started working there I started off in a rehab area doing medical social work and then I moved to adult mental health, children's mental health, and within children's mental health I've worked on the inpatient unit, day program outpatient area where I was dealing with individuals who were experiencing symptoms of depression or anxiety, trauma, ADHD, anger stuff, family stuff, pretty much anything and everything was sort of in that section of the counselling area. But now I'm in a sub-specialized area within that program where we work with individuals who've experienced a first episode of psychosis. They're still dealing with a lot of other things but the funding was given to specifically work with this population in a more intense way. There are seven people on my team. It's a multi-disciplinary team: social workers, a child and youth counsellor, occupational therapist, psychiatrist, nursing. A team is very important in the hospital, the communication is very important. How we coordinate case management and treatment is very important. Underneath all of that there is a counselling piece that happens too with the individuals and with the family members on an individual level and we also do groups. It touches anything and everything.

When someone experiences a first episode of psychosis they lose touch with reality and this happens for many reasons; it could be for medical reasons, it could be for emotional types of reasons, maybe trauma, depression, anxiety, it could be genetic. People could have schizophrenia, or bi-polar disorder, maybe in their families. It could be drug induced. Maybe they've experimented with marijuana or E. You don't always know what you're taking, mixed with different things, it's not always pure. A lot of youth, when they come in they might be like "but I only used it once". But once can be all that it needs to be for someone to have an episode of psychosis. Sometimes people think you have to be some hardcore drug user but that's not the case. It's kind of like an allergy. Some people can eat peanuts and they're totally fine, some people not so much. So it's the same with drugs. Some people it just doesn't agree with them and then they have the

break where they experience psychosis, then they recover, but the thing is from then on in they need to stay away from the drugs or they're going to have another episode. And that's where we run into a lot of challenges.

Some of the individuals that I work with, they range between the middle to late teens to mid-twenties. We go up to thirty-five technically but I tend to work with teenagers. When I used to work on the inpatient unit I would see people when they were in crisis. They would come in to the hospital and some of them wouldn't speak at all. I've had it where people maybe speak really fast and they have lots of energy and they almost feel like they have superpowers or that they can do anything. Some people might describe where they see things or hear things that aren't really there, any of their senses can be affected. When I am talking with them they may be looking at other things or responding to other things that aren't in the room. It's more acute and maybe they're at risk to themselves or somebody else. That's why they've been admitted to hospital. Then once they're feeling a little bit better and then they go home, then they move to our outpatient program and that's where I am now. So that's more where I see people when they're back to how they were feeling before. They still have some symptoms but they're able to live at home and maybe go back to school or go back to work.

There's a myth about psychosis that people are dangerous if they have schizophrenia or that people can be aggressive and that's not the case. That's not what I see. Usually people are just like anybody else we would meet. You're just meeting the person, they're just going through something that's challenging. We help them with a variety of different methods. Some people do need medicine. Some people like to try without medication and we do some counselling and support and sometimes that helps. Sometimes making shifts in what's happening around them really helps. Maybe they have too much stress in their life and they need to make some changes in their life. It varies depending on where they're at with their recovery.

Now that I'm in the outpatient program I would get a referral and that person could still be in the hospital. I would meet with the team, meet with the person, find out what's happening, explain what we do, answer any of their questions. Over the course of a number of different sessions gather information: Does this person need help with managing their symptoms? Do they need help with treatment? Do they need help connecting with other people or other resources? Maybe it's work or school, or anything, financial, housing, whatever it is. So we gather all of that information, set up a treatment plan. And the treatment plan could be that I am meeting with them individually doing some of that work with them or their family or other support members in their lives or, some of them would rather participate in our group program and they like to be

connected with the other youth and then I meet with them informally. The groups we run, the drop-in group where we do fitness and then another group we have is an art group. One of them is a cooking group. We have dinner together and then we all hang out and play games or cards or chat. Whatever comes up. We also have a metabolic program because the medications cause a lot of weight gain. Fitness is a big piece and nutrition. So I do a lot of the fitness at our program. I run some yoga for the youth, we get to do a lot of different activities outside, walking, soccer, football, and it's just nice to be able to incorporate nature into a lot of what I do, to be able to incorporate fitness. It makes it less medical I guess. I really enjoy being a part of that and doing it through means like art or fitness, other modalities; having that leverage to be creative within my job.

The biggest challenges are probably challenges caused from the system. It's the pressure of seeing people, getting so much work done with them in a certain period of time. I have a bit less of that pressure because we have up to three years working with someone, but when I'm trying to get people connected to other services they have a lot of those barriers in place and they have so many criteria that maybe this person can't qualify for their program; they can't access different resources. Maybe that environment can't support them at that time. Running up against some of these restrictions in trying to set people up so that they can manage out in the community, I think those are some of the limitations. And then as a social worker we have to navigate some of that and be able to get the resources that people need and advocating for people is a huge piece that comes up within the hospital system and within the community. Then it's trying to get all those things in line to essentially give the person coming in whatever they need so that they get the best care.

Some of the rewards in doing this work: I meet people when they're in crisis and it's just really nice to see people have hope and believe that they can get better because there is so much stigma around mental health. To allow them to see that they can pretty much achieve anything that they want to achieve and we'll build supports around them to allow them to do that. And it's so nice when they get to that place and then they don't need us anymore. That's actually the best thing. That's what I like to see.

Being a social worker, to me, means being authentic. A lot of the youth that I work with they know if we're not authentic. They've said this to my face. So I value that. They've taught me that it's about being with them, with what they're going through, and giving them the environment to allow them to grow and for them to find what they need to recover. I sort of see myself walking with people, not doing things to people.

When you're working in a place where there's a lot of suffering people need to be able to sit with their own suffering and to be comfortable with that. We can only take people as far as we've gone ourselves. When they are thinking of becoming a social worker people really need to think about self-care.

It's a great field to be in. I really enjoyed being in this field. There are so many avenues for social workers.

Outro - This is Charmaine Williams from the University of Toronto Factor-Inwentash Faculty of Social Work. Thank you for listening to our podcast. In 2014 our school is celebrating 100 years of social work research, teaching and community service. For more information about the faculty and our programs we invite you to visit our website at www.socialwork.utoronto.ca