The Psychoeducational Assessment of an Individual with Adjustment Difficulties

Guidelines

ORDRE DES
PSYCHOÉDUCATEURS
ET PSYCHOÉDUCATRICES
DU QUÉBEC

Une présence qui fait la différence

This is the third revised edition of the *Guide d'évaluation psychoéducative* [Psychoeducational assessment guide] published in 2008 and 2010.

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Acknowledgments
The Ordre thanks all psychoeducators who at any time reviewed, commented on or added to this document since it was first published in 2008.

Explanatory text providing additional theoretical information

Legal deposit: Bibliothèque et Archives nationales du Québec, 2014
ISBN 978-2-9814596-1-9

This work may be cited as Ordre des psychoéducateurs et psychoéducatrices du Québec. (2014). *The Psychoeducational Assessment of an Individual with Adjustment Difficulties. Guidelines.* Montréal.

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INTRODUCTION

Background to Guidelines

Assessment is the cornerstone of every professional decision. It is a clinical act on which all subsequent treatments regarding the individual in need and his/her environment are based. Assessing an individual demands skill and rigour. For the person assessed, the consequences are important. For that reason, upgrading professional practices in the field of mental health and human relations (Bill 21) requires assessment activities that could create prejudice to the individual's interests to be carried out by professionals[1] who have proper initial and ongoing training and who are responsible for their actions.

Psychoeducators are one of the groups of professionals recognized as being qualified to conduct assessments of certain vulnerable client groups. Among the activities legally limited to psychoeducators and other such professionals are five assessment activities:

- assessing a person suffering from a mental or neuropsychological disorder attested by the diagnosis or evaluation of an authorized professional;
- assessing a person further to a decision of the director of youth protection or of a tribunal made under the *Youth Protection Act*;
- assessing an adolescent further to a decision of a tribunal made under the *Youth Criminal Justice Act*;
- assessing a handicapped student or a student with a social maladjustment with a view to formulating an individualized education plan in accordance with the *Education Act*;
- assessing a child not yet admissible to preschool education who shows signs of developmental delay, in order to determine the adjustment and rehabilitation services required.

These assessments focus on the individual's adjustment difficulties and capacities, the psychoeducator's very area of expertise.

The two other activities reserved for psychoeducators under Bill 21, although not of an assessment-related nature, do not exclude any such operation being carried out in parallel. They are the following:

- determining the treatment plan for a person who suffers from a mental disorder or exhibits suicidal tendencies and who resides in a facility run by an institution operating a rehabilitation centre for young persons with adjustment difficulties;
- making decisions as to the use of restraint or isolation measures in accordance with the *Act respecting health services and social services* and the *Act respecting health services and social services for Cree Native persons*.

1. The professionals in question are psychoeducators, psychologists, social workers, marriage and family therapists, vocational guidance counsellors, sexologists, occupational therapists, nurses and physicians.

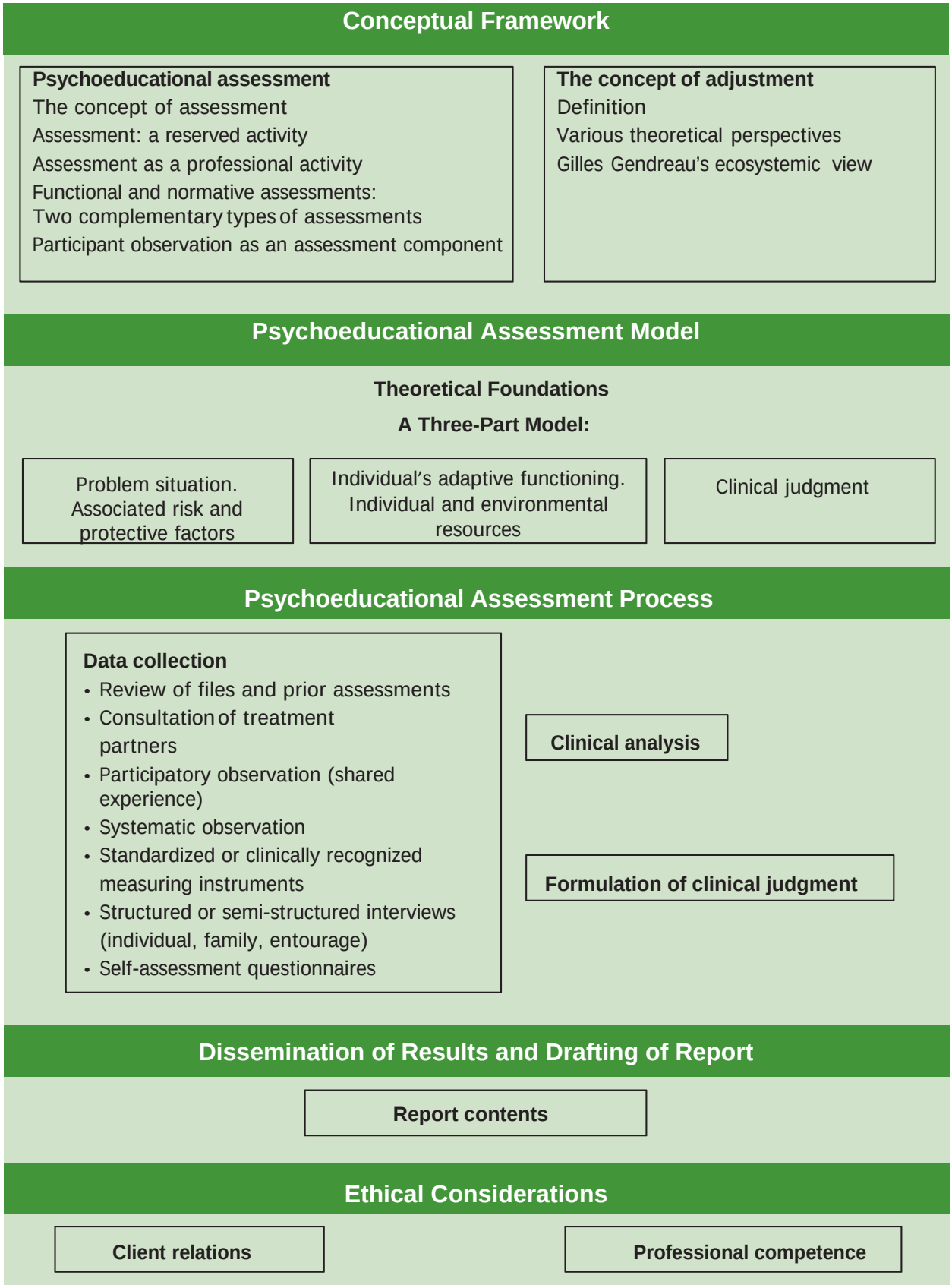
Purpose of Guidelines

The goal of this document is to define a conceptual and applied framework to guide the psychoeducator's assessment process in various contexts, including reserved activities. In keeping with the psychoeducator's field of practice, the guidelines are based on the current understanding of adjustment as well as proven psychoeducation assessment practices. Concretely, this document proposes a model report that psychoeducators can use when assessing an individual with adjustment difficulties.

Although they are not mandatory or required, these guidelines can serve as rules of standard practice to ensure that the assessment practice is conducted with skill and rigour. To that end, psychoeducators are encouraged to apply these guidelines in conjunction with their professional judgment. Given the range of milieus and contexts in which psychoeducators work, the general framework recommended herein must be adapted and fleshed out according to the client groups served—for instance, by specifying significant data to be collected and identifying the assessment tools recommended for that purpose.

Figure 1 shows the structure that underlies the various sections of these guidelines and seeks to guarantee the rigour of the psychoeducational assessment in terms of both its theoretical underpinnings and the process and professional values called into play.

Figure 1 – Structure of Guidelines



1. The Psychoeducational Assessment

As a rule, the assessment process consists of describing, analyzing and interpreting a situation or phenomenon with a view to providing useful decision-making data pertaining to the pursuit of a specific objective. In the psychosocial field, the assessment is considered to have a global, interpretative dimension that goes beyond merely measuring a fact or behaviour. The assessment requires the professional to pose a judgment regarding an individual's situation based on the information at his/her disposal. It involves various phases that focus on collecting the data used to describe and understand the problem at hand, analyzing those data to make a clinical assessment, and disseminating the findings, usually in the form of a written report.

1.1 Assessment: A Reserved Mental Health and Human Relations Activity

The explanatory guide to Bill 21 distinguishes between assessment activities reserved for professionals and other, similar acts. Reserved assessment activities involve making a clinical judgment on the person's situation based on available data and communicating the conclusions of that judgment (section 3.4.1). In keeping with the spirit of Bill 21, the reserved assessment calls on the professional's clinical judgment, similar to a diagnosis established by a physician, and the communication of that judgment (section 3.4.1). The reserved assessment is multi-factorial and differential, meaning that it takes account of a variety of factors that are correlated to identify the individual's problem. It necessitates specific skills and abilities pertaining to each profession's scope of practice. Finally, the assessment and its findings have professional authority status.

Detection, screening, evaluation and contribution to diagnosis are not reserved activities. Although similar to assessment activities, they do not share their full range of characteristics. Among other things, they do not lead to a decision regarding the existence of specific difficulties or the longer-term consequences of such difficulties in the individual's life. The following definitions are provided in section 3.4.3 of the explanatory guide.

- Detection involves identifying indicators of as-yet-unidentified disorders or risk factors as part of interventions that have a variety of objectives.
- Screening aims to distinguish individuals probably suffering from an undiagnosed disorder or a risk factor for a disorder from those who probably have no such disorder.
- Evaluation is the act of considering all indicators (symptoms, clinical manifestations, difficulties or other difficulties) obtained by means of clinical observations, tests or instruments.
- Contribution of the professionnal refers to the assistance provided by various interveners in the execution of the reserved activity.

Section 2.7 of the explanatory guide to Bill 21 provides the following definition of the assessment conducted by a psychoeducator:

> The psychoeducator's assessment seeks to make clinical judgments as part of a process that analyzes the causes and dynamics of disturbances in the individual's relations with his/her environment. It focuses on three areas: the individual, the individual's environment, and the individual's interaction with the network in which he/she operates. The psychoeducator documents and supports his/her analysis using, in particular, participatory observation, conducted through a shared experience with the individual. The psychoeducator establishes a prognosis based on the individual's adjustment capacities in order to determine and implement the resulting treatment plan.

This definition is consistent with the psychoeducator's scope of practice, which involves assessing an individual's adjustment difficulties and capacities, determining a treatment plan and implementing that plan. It also involves restoring and expanding the individual's adjustment capacities and contributing to the development of environmental conditions conducive to the individual's optimal adjustment in interaction with his/her environment.

1.2 Assessment as a Professional Activity

As defined by Gendreau (2001) and later by Renou (2005), assessment is a professional activity that continues throughout the treatment process. The assessment should be present from the start of the process to define the problem, take stock of the difficulties and capacities of the individual and milieu, and plan appropriate treatment. This process is the diagnostic assessment or pre-treatment, and it is precisely to provide support and a framework for this type of assessment that this guide was created.

The psychoeducator's assessment focuses on the individual experiencing difficulties, considered in interaction with his/her entourage. The objective is to put in place and implement a treatment plan or service plan. As a result, the assessment process is indissociable from treatment itself. Both address the individual and milieu at the same time, with "milieu" encompassing both the immediate environment and, more broadly, the individual's social network. This is outlined in Figure 2.

Figure 2 – The Focus and Objective of Psychoeducational Assessment

Focus of the Psychoeducational Assessment	Objective
• Individual experiencing difficulties in his/her living environments • Quality of individual-environment interactions • Resources and deficiencies, in regard to both the individual and his/her environments, that contribute favourably (protective factors) or unfavourably (risk factors) to adjustment **The assessment must be supported by a framework that centres on adjustment**	• Identify the problem faced by the individual and the services he/she requires • Pose a clinical judgment on the adjustment deficiencies and capacities of the individual and his/her milieu • Develop, implement and monitor a psychoeducational treatment plan • Implement effective, rigorous treatment practices **The assessment is indissociable from the treatment**

The assessment focuses on the first of the five fields listed in the *Profil des compétences générales des psychoeducateurs* [Profile of psychoeducators' general competencies] (Ordre des psychoéducateurs et psychoéducatrices du Québec, 2010): "Assessing the situation in a manner that is rigorous and in line with the assigned mandate – [*Translation*]." It is broken down into nine skills, each of which concerns the collection and analysis of this data as well as the production of an interpretative summary.

1.1 Identify focuses and observational contexts relevant to the mandate and situation, while referring to recognized conceptual frameworks.
1.2 Determine valid observation and assessment methods and instruments, whether direct or indirect.
1.3 Define the needs and expectations of the individual and his/her entourage, group, family or organization.
1.4 Draft observation notes in a manner befitting their function and utilization.
1.5 Identify and evaluate the adjustment capacities and difficulties exhibited by the individual, group, family or organization in their interactions with the environment.
1.6 Identify resources and limits of the entourage that may influence the interactions of the individual, group, family or organization with their environment.

1.7 Develop a clinical hypothesis incorporating interaction between individual components and environmental factors, including cultural factors.

1.8 Produce an interpretative summary of the situation that is fact-based and supported by recognized theories.

1.9 Report on the assessment to the appropriate persons or administrative or legal bodies, using written or verbal language suited to the communication context.

During the process, the assessment will focus on treatment follow-up in order to fine-tune planning, facilitating and utilization with a view to achieving the objectives more effectively. At the end of the process, a post-treatment assessment of the results will be conducted to gauge the degree to which the objectives were met and the adequacy of the planning, organization, facilitating and utilization of events arising from the treatment. As Charlebois wrote in 1998, the search for effective treatments requires an evaluation of treatment implementation and results. As a result, it is justified for psychoeducators to focus on improving the quality of their assessments to enhance the effectiveness of their treatments and promote recognition of their profession.

The assessment is a demanding phase in terms of the intellectual rigour, attitudes and relationship skills required. It takes time and does not allow for any shortcuts (Puskas, 2002, p. 167).

1.3 Functional and Normative Assessments: Two Complementary Types

The psychoeducational assessment's data collection and analysis phase calls for two types of information, namely data identifying the adaptive function of the problem behaviours in the individual's interaction with his/her environment, and normative information that describes the individual in terms of his/her achievements and deficiencies in relation to his/her age and culture.

The Functional Assessment

The functional assessment is based on the principle that every behaviour has a function. Breen and Fredler (2003) define the functional assessment of behaviour as a process that identifies contextual (personal, relational or environmental) factors able to trigger and reinforce certain inappropriate behaviours. This type of assessment seeks to highlight problem behaviours and any environmental factors likely to influence the manifestation of such behaviours or maintain them (Willaye and Magerotte, 2003). Rooted in an operational definition of problem behaviours (observable and measurable behaviours defined in behavioural units), the functional assessment aims to identify the ABC sequence (**Antecedents** – **Behaviours** – **Consequences**).

Antecedents are the events or stimuli that precede the behavioural reaction and concern both the individual and the environment (Langevin and Guéladé, 2010). They are the times of the day, places and events in the individual's milieu that occur prior to the behaviours in question. Consequences are those events or stimuli that occur after the behavioural response and influence the probability that it will reoccur.

The functional assessment process generally consists of the following steps:

1. A description of the problem behaviour in question
2. An analysis of the function of the inappropriate behaviour and contributing factors
3. Determination of a more appropriate replacement behaviour
4. Development of strategies to reinforce modified behaviours
5. Development of strategies to reduce the impact of inappropriate behaviours

In addition to achieving an objective understanding of behaviours, the functional assessment serves to determine the moments and situations that trigger or maintain problem behaviours and, at the same time, identify the variables on which treatment should focus in order to improve the situation. The goal of the functional assessment is to grasp the meaning and function of problem behaviours in respect to an individual's adjustment. Behaviours are generally acknowledged to have two main functions: to obtain something that is desired or, inversely, to escape from or avoid something perceived to be unpleasant. In addition to these two main functions, nine secondary functions can be attributed to behaviours that are deemed to be disruptive (Massé, Bégin and Pronovost, 2014, p. 89):

- response to a physical need;
- internal stimulation;
- protection and avoidance;
- power and control;
- social attention and communication;
- acceptance and affiliation;
- self-expression;
- gratification;
- justice and revenge.

Right from psychoeducation's infancy, the assessment of behaviours and situations has always been functional in nature, as shown by Bernard Tessier's work (1968) that marked the development of participatory observation. This point will be discussed further below.

The Normative Assessment

The normative assessment consists of administering standardized tests comparing the individual to a reference group of the same age, sex and cultural community. It serves primarily to identify the nature and degree of the problem situation that the individual is experiencing as well as its chronic or temporary character. It also provides information about the nature and seriousness of the problem. This type of assessment is limited by focusing on one or more specific difficulties and not encompassing the full range of personal and environmental factors that contribute to the problem. However, given the emergence of new scientific knowledge on adjustment and the issues inherent to interdisciplinary and intersectorial collaboration, assessment practices based on observational data alone may not be sufficient for the assessment process (Yergeau and Paquette, 2007). In such circumstances, the use of standardized measuring instruments is indicated, subject to the applicable rules and required skills.

Figure 3 – Two Complementary Types of Assessments

Normative Assessment	Functional Assessment
• Describes the individual in terms of achievements and deficiencies in relation to his/her age (standards) • Uses standardized tests to gauge the nature and severity of difficulties • Refers to recognized classification systems (DSM, ICD) • Provides a statistical snapshot of the problem	• Highlights the functions of problem behaviours and the full range of environmental factors • Focuses on the sequence of events (A-B-C) to grasp the meaning and function of behaviours • Seeks to trace the developmental pathway • Provides a dynamic snapshot of the problem

1.4 Participatory Observation as a Component of Assessment

As shown in Figure 1, several data collection methods can be used in the assessment process. Among these methods, participatory observation is the heart of the practice.

“Observation is the starting point for the entire sequence of operations that can flow from one another over the course of psychoeducational treatment. […] The domain of psychoeducational treatment is the educational experience shared in a given context” [*Translation*] (Gendreau, 2001, pp. 131–132). The act of observing is the starting point for an infinite circular motion that provides input for assessment and treatment. It is an initial study of the facts, an on-the-spot assessment leading to subsequent treatment.

The observer’s attitude may be more or less neutral or engaged, according to his/her degree of engagement. Observing a situation behind the scenes and observing it as a professional with responsibility for the case do not call for the same approach. The purpose of observation is to determine the indicators of an individual’s stage of development, with due regard for his/her age, milieu and culture (developmental achievements, delays and deficiencies). Focus is on an individual’s adjustment difficulties as much as on their adjustment capacities and potential. It also seeks to determine the meanings of behaviours by considering them through the lens of individual-environment adjustment.

It fell to Bernard Tessier (1968) to introduce into the field of psychoeducation the concept of adaptive behaviour as an observable indicator of an individual’s adjustment. Through participatory observation, the psychoeducator seeks to develop an understanding of the situational and historic contexts (“relational field”) surrounding the adopted behaviour, which can be perceived through verbal and non-verbal reactions. The psychoeducator must also try to correctly identify the trigger (“reality-challenge”) that is the source of the imbalance that led to the adaptive behaviour observed (reaction). Next, the observer endeavours to determine and analyze the educational or psychoeducational intervention that was undertaken in response to the reaction (intervention). The final part of the observation process describes the behavioural adjustment that follows treatment and outlines how the situation concluded. Tessier’s work led him to develop a unique observation technique for adaptive behaviours (TOCA). This technique is rooted in a functional view of assessment, the goal of which is to place a behaviour in a spatio-temporal-contextual sequence and to grasp its meaning and function in the individual’s adjustment.

The TOCA technique was reviewed and enhanced by Pronovost, Caouette and Bluteau (2013), who proposed an observation and analysis method for adaptive behaviours (MOACA). This method preserves the six structural elements put forward by Tessier (1968), but adds a clinical analysis framework based on the concepts of interaction and congruence proposed for psychoeducation by Gendreau (2001) and Renou (2005). Pronovost, Caouette and Bluteau also suggested a post-situational analysis process for an observed fact, referring to the components of Gilles Gendreau’s model of the overall structure. That analysis can be used to evaluate the role of the situation components in contributing to the appearance of imbalances or, inversely, in maintaining and restoring balance.

Use of this observation method, whether or not it culminates in a written report of observed facts, can contribute to the validity of data collected and analyzed as part of the psychoeducational assessment process.

2. The Concept of Adjustment

2.1 Definition

A consensus is now emerging that adjustment is the heart of the psychoeducational assessment and treatment process. This concept already underpinned the writings of many psychoeducation pioneers (Guindon, 1970, 2001; Gendreau, 1978, 2001; Tessier, 1968). Other literature reaffirms adjustment's central role in psychoeducation (Bleau, 1997; Caron, 2002; Le Blanc, Dionne, Proulx, Grégoire and Trudeau-Leblanc, 1998; Pronovost, Gagnon and Potvin, 2000; Pronovost, Caouette and Bluteau, 2013; Renou, 2005; Vitaro and Gagnon, 2000). In formulating the psychoeducator's scope of practice as follows, Bill 21 confirmed this view:

> Assess adjustment difficulties and the capacity to adjust, determine an intervention plan and see to its implementation, restore and develop a person's capacity to adjust, and contribute to the development of the conditions in the milieu with a view to fostering the optimal adjustment of the person in interaction with his environment

The concept of adjustment is based on the premise that human beings have a natural propensity to autonomy as well as a regenerative power. Adjustment is the process whereby an individual, subjected to a host of stressors, tries to maintain his/her balance and satisfy his/her needs. The organism seeks to put in place a number of self-regulating processes to preserve, enhance and adjust its level of functioning to maintain its individual integrity while responding to environmental demands (Dubos, 1982). However, not all individuals have the same adjustment capacities. They can vary according to the individual's genetic heritage and personal potential, his/her level of maturity and development, and the resources provided by the individual's physical, family, educational, work, cultural and socio-economic environment. The more an individual's personal repertory of adaptive behaviours is solidly established, the more likely he/she is to react appropriately to imbalances and stressful events that arise during his/her lifetime. Similarly, the more favourable the milieu-related conditions (described as "mesological" by Gendreau) are to an individual's development, the easier his/her adjustment will be. Regardless of the context, the concept of adjustment therefore encompasses two interrelated aspects, the individual and his/her milieu or milieus.

Tremblay (2001) defines psychosocial adjustment as the balance or search for balance between internal well-being and external well-being in certain situations. To understand the adjustment process, several variables must be considered: the individual and his/her level of maturity, emotional balance, degree of autonomy and dynamic and growth potential in terms of his/her physiological, intellectual, emotional and social development. Harking back to St-Arnaud (1983), Tremblay sets out five psychological criteria that can be used to recognize a successful adjustment process in terms of an individual's relationships with his/her social or physical environment:

1) Recognizing needs correctly

2) Correctly perceiving external reality or, at least, correcting erroneous perceptions

3) Acknowledging one's personal limits and those of the environment

4) Demonstrating autonomy and critical thinking in respect to external standards by considering them as a means rather than an end

5) Actively influencing one's environment to address his/her basic needs

While people who demonstrate all these characteristics in every phase and facet of their lives are rare, these criteria can be used as objectives for an ideal adjustment.

2.2 The Concept of Adjustment from Various Theoretical Perspectives

Over the history of psychoeducation, the concept of adjustment has evolved in response to a variety of theoretical perspectives, each of which has contributed to advancing our understanding of human behaviour in different ways. In the profession's infancy, the psychoeducational assessment process was rooted in a unique theoretical model developed by Jeannine Guindon (1970). At that time, "the actualization of the powers of the ego" was applied at boarding schools seeking to rehabilitate delinquent adolescents and emotionally disturbed children. The model was based primarily on a psychodynamic and developmental view of adjustment. Of particular prominence were the psychologists of the "Self."

Over the years, other theoretical currents helped shape the concept of adjustment in psychoeducation, including models rooted in behavioural and cognitive-behavioural theories and, more recently, in developmental psychopathology (Pronovost and Leclerc, 2013). Regardless of the theoretical approach or framework used by a psychoeducator as a foundation for his/her professional assessment, he/she requires a broad understanding of the concept of adaptation[2] to better understand the complexity of human adjustment, especially among individuals experiencing difficulties. The following table outlines the central criteria for optimal adjustment according to the main theoretical perspectives that have marked the emergence of this concept in psychoeducation.

2. Readers who wish to know more about the concept of adjustment may refer to *Psychologie de l'adaptation* by C. Tarquinio and E. Spitz. (2012). De Boeck, publisher.

Table 1 – The Concept of Adjustment from Various Theoretical Perspectives

THEORETICAL PERSPECTIVES (*central factors*)	DEFINITION OF ADJUSTMENT
Psychodynamic perspective *Psychic structures*	Balance between psychic structures (Id, Ego, Superego) Flexible use of defence mechanisms
Psychologists of the Ego *Autonomous Ego*	Personal development and social integration Important role of values, ideology, identity and cognitive structures
Developmental perspective *Stages of development*	Ability to develop physically, cognitively, linguistically, emotionally, socially and morally, and to deal with life's developmental tasks
Behavioural perspective *Behavioural learning process*	Result of learning positive behavioural sequences (antecedents, adopted behaviours, consequences)
Cognitive-behavioural perspective *Cognitive processes*	Rational thoughts consistent with reality, emotional regulation, stress management and effective adaptive strategies Importance of cognitions, emotions and motivations in learning behaviours
Ecosystemic perspective ***Interaction and interinfluence between systems*** ***Appropriateness of interactions***	**State of balance and synergy in the individual's interactions with his/her environment** **High level of congruence between the characteristics of the individual (PAP) and those of the environments and situations to which he/she is exposed (ELP)**
Perspective based on developmental psychopathology ***Developmental pathway*** ***Risk factors and protective factors***	**Optimal development of the individual, depending on life stages** **Individual, family, social and societal characteristics facilitating sound psychosocial adjustment and positive mental health**

2.3 Adjustment according to Gilles Gendreau's Ecosystemic View

Starting with his first works in 1978, psychoeducation co-founder Gilles Gendreau strove to define adjustment from an ecosystemic perspective that saw the individual as a holistic being that developed through interaction between its internal capacities and the opportunities for experimentation provided by its entourage. He described maladjustment as "une perturbation grave dans les relations de l'individu avec son environnement, perturbation susceptible de durer ou de s'aggraver sans intervention appropriée et, à la limite, malgré cette intervention" [a serious disturbance to the individual's relationships with his environment, which is likely to continue or worsen without appropriate intervention, and possibly even despite such intervention – *Translation*] (Gendreau, 2001, p. 68). Through reciprocal interaction, the individual adapts to his/her environment and the environment adapts to the individual. Adjustment is defined as the "progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded" (Bronfenbrenner, 1979, p. 21).

The concept of *interaction* is central to Gendreau's work. He defines "interaction" as a set of relationships between two potentials: the individual's personal adaptive potential (PAP) and the experiential learning potential provided by his/her entourage and environment (ELP). For Gendreau, adjustment is the core of the act that characterizes mental health and human relations professionals who work as educators: education. He describes it as "une contribution à la formation d'un être humain, autonome et capable de devenir pleinement responsable du choix de son échelle de valeurs" [a contribution to the development of an autonomous human being who is able to take full responsibility for the choice of his/her set of values – *Translation*] (Gendreau, 1990, p. 56). This concept is echoed in the concept of "appropriation" that he defines (1993) as the ability to express oneself and make changes to one's life in order to gain greater control over one's experience. This concept is also related to that of empowerment, which has been discussed in literature on support services in a community-based setting (Lavigueur, 1991; Lemay, 2004) as well as self-determination[1] in intellectual impairment treatment services (Lachapelle and Wehmeyer, 2003; Emond Pelletier and Joussemet, 2014).

3. The Psychoeducational Assessment Model

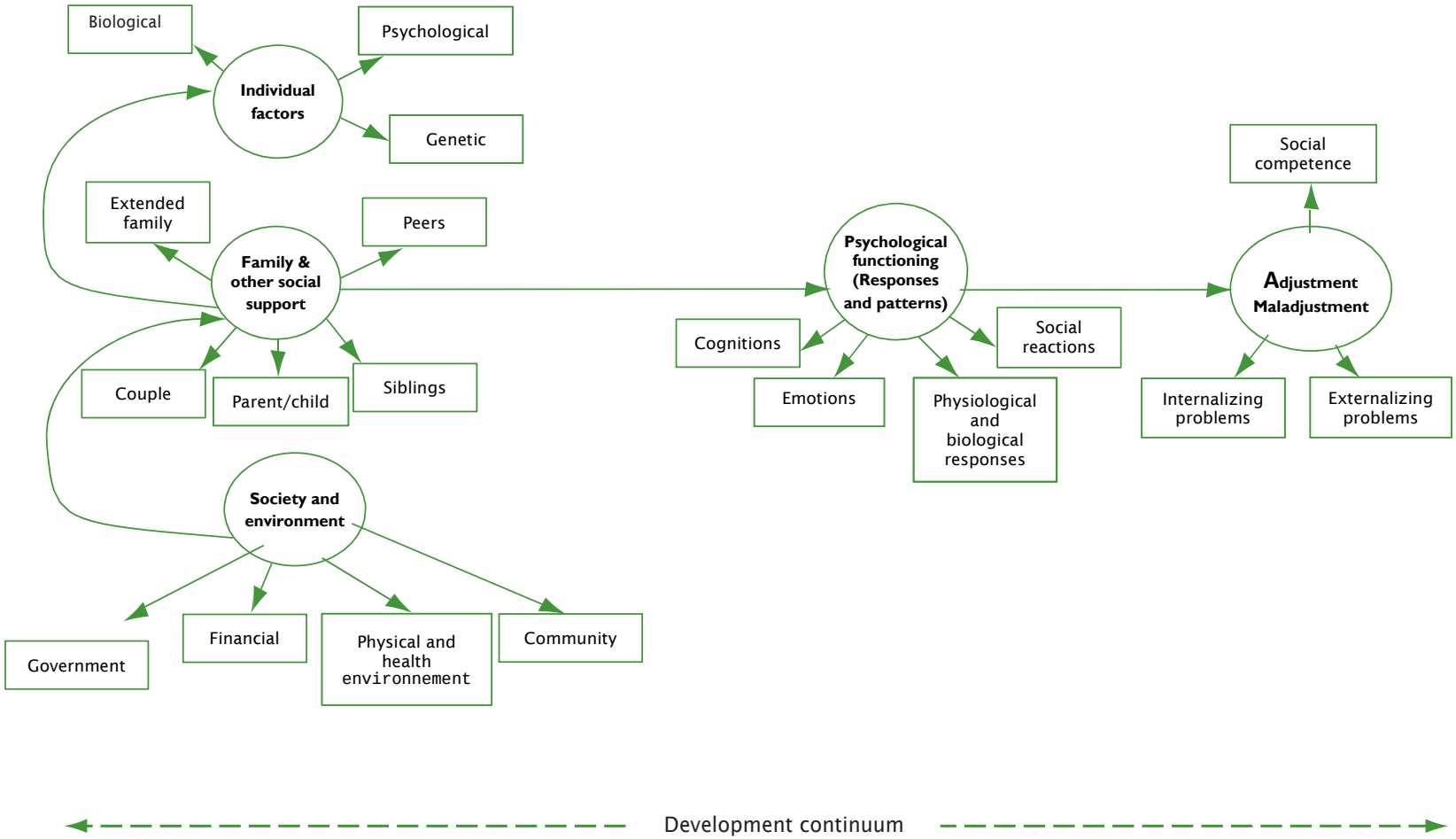
3.1 Theoretical Basis

The psychoeducational assessment model is based on the integrative model developed by Cummings, Davies and Campbell (2000) to explain adjustment. That model was revised and expanded on with the addition of psychoeducational concepts developed by Gendreau (2001). These authors are the two main theoretical sources for the psychoeducational assessment model.

Cummings et al. (2000) consider human development to be a bio-psycho-environmental process rooted in the interaction of individual factors (biological, genetic, psychological), family and social factors (couple, parents, siblings, peers and other members of an individual's entourage), and societal and environmental factors (governance, economic, environmental, community and cultural). These factors play a unique role or have a different impact (risk and protective factors) on an individual's development depending on his/her stage of life. It is clear that processes and events experienced in childhood will have an impact on the outcome of subsequent development. But the quality of an individual's psychosocial adjustment and health, both physical and mental, in his/her developmental pathway is also dependent on individual characteristics like resources for coping with stressors and personal style and temperament, which will all influence the individual's cognitive, emotional, physiological and social responses.

These authors developed an explanatory model of adjustment that conceptualizes the dynamic processes that shape an individual's development and set him/her on a more or less suitable developmental pathway. Normal, at-risk and pathological development is perceived as the gradual formation of an individual's integration, maturation and adjustment capacities in interaction with his/her milieu. The advantage of this model resides in the connections drawn between development, mental health, stress and observable response patterns to explain adjustment. Consequently, it implies a view of treatment that is focused on individual-environment interactions and the development of skills conducive to proper adjustment, which is a hallmark of psychoeducation.

Figure 4 – Psychodevelopmental Analysis Model of Adjustment, by Cummings, Davies and Campbell (2000)



Source: Cummings, E.M., Davies, P.T. and Campbell, S.B. (2000). *Developmental and Family: Process Theory, Research, and Clinical Implications*. New York: Guilford Press, p. 90.

3.2 Description

The psychoeducational assessment model is composed of three parts, whose contents are closely related:

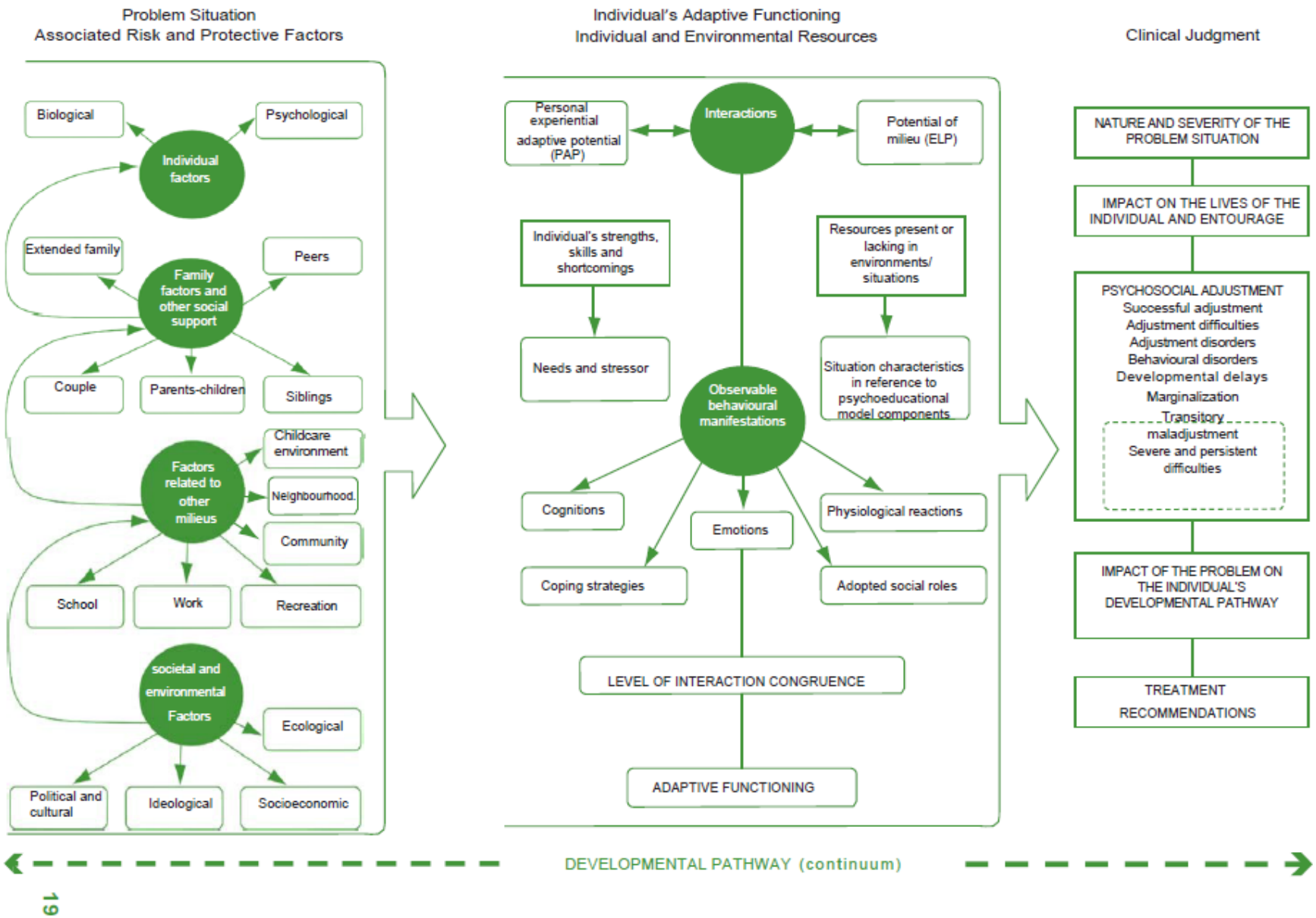
1- Problem situation. Associated risk and protective factors.

This first section of the assessment model, shown on the left side of the figure, refers directly to the model proposed by Cummings, Davies and Campbell (2000).

2- The individual's adaptive functioning. Individual and environmental resources.
The model's central section covers the psychoeducational concepts of PAP, ELP, interaction and congruence. The components of Gendreau's overall structure are also represented.

3- Clinical judgment
The right-hand section of the figure represents the end result of the psychoeducational assessment process, which is the posing of a clinical judgment regarding the individual's adjustment and recommending treatment options.

Figure 5 – Psychoeducational Assessment Model



4. The Psychoeducational Assessment Process

The assessment process is structured around the three sections of the conceptual model. For each section, we will outline the objectives, followed by the theoretical concepts of which the psychoeducator must have a solid grasp, and finally by a summary of the steps involved in this phase of the assessment process.

4.1 PART 1: Problem Situation. Risk and Protective Factors.

Objectives

This first phase of the process is essentially one of collecting data. The goal is to clearly define the problem situation, its history and its manifestations. It seeks to identify all personal, family and environmental factors that contribute to the problem (risk factors) or, on the contrary, that enable the person to adjust successfully to other situations or aspects of his/her life (protective factors). The psychoeducator may have to assess the gravity of the situation in deciding whether to apply measures prescribed by law.

This data-gathering phase cannot be conducted without some analysis. Even at this early stage, the psychoeducator begins to process the collected information, establish causal relationships and formulate hypotheses. This analysis will inform the rest of the data-gathering activities.

A variety of methods can be used at this step: consulting records and past assessments, consulting treatment partners, conducting participant or systematic observation, using standardized or clinically proven measuring instruments, carrying out structured or semi-structured interviews and completing self-assessment questionnaires. Complementary data may be provided by other partners or actors from the individual's milieus.

In selecting the information to be noted, attention must be paid to the assessment's legal framework. In addition, supplementary assessments may be carried out by other professionals in some cases.

Theoretical Concepts to Be Mastered

Since the psychoeducational assessment model is based on a psychodevelopmental perspective of human adjustment, the following concepts must be mastered:

- The developmental pathway (normal, at-risk or pathological). An understanding of various developmental milestones serves as a foundation for analyzing data on an individual's age and spheres of development (physical and motor, cognitive and language, emotional and social, spiritual and moral).
- The risk and protective factors associated with maladjustment pathways. 

The data are analyzed using existing theoretical knowledge of the problem and its manifestations, especially scientific and clinical data that identify specific profiles related to the development of maladjustment pathways.

Steps in the Data-Gathering Phase

Identify the problem situation

- Reason for and source of referral
- Problem behaviours or situations cited; situational contexts
- Level of compromise and gravity of the situation
- Associated legal framework

Describe the problem, its history and its manifestations (anamnesis)

- Problem history: timing of problem's appearance and its evolution; prior assessments and diagnoses, if any; history of treatment and services
- Current manifestations of problem: nature, frequency and intensity; triggers; behavioural sequence (antecedents, reactions and consequences); constancy or variations according to the situation and milieu
- Perceptions and interpretations of the individual and main actors concerned; their awareness of problem and their motivation to change

Determine factors that may be related to the problem

Individual factors

- Biological factors: genetic, neurobiological, physical, temperament
- Developmental achievements, deficiencies and delays; met and unmet needs
- Psychological factors: attachment style and capacity, sense of security; relationships and social skills; self-esteem, self-representation, identity; skills, abilities, productivity; self-control, self-determination; modes of learning, motivational factors and other relevant factors, according to age

Family factors and other social support

- Family factors (relationships and structures): parents, siblings, couple, extended family
- Other social support

Factors related to other milieus

- Childcare
- School
- Work
- Recreational activities
- Peers
- Community
- Neighbourhood
- Other milieus, as applicable

Societal factors

- Political and cultural
- Socioeconomic
- Ideological
- Ecological

4.2 PART 2: Adaptive Functioning of the Individual. Individual and Environmental Resources.

Objectives

This second phase of the process involves analyzing the individual's adaptive functioning. The analysis will focus primarily on the individual's adjustment capacities and difficulties, both internally and in his/her environment. The description of adaptive functioning is based on observations involving the individual and his/her environment as well as individual-milieu interactions.

Gilles Gendreau's model of the overall structure provides a foundation for the analysis of milieu and situation characteristics. This operations aims to assess the congruence of interactions between the PAP and ELP.

For the psychoeducator, this operation involves:

- taking stock of the individual's adjustment difficulties and capacities as well as those present in his/her environment;
- highlighting the meaning and function of adaptive behaviours adopted by the individual and adjustment mechanisms in individual-environment interactions;
- determining the environment's strengths and limits in supporting the individual and his/her development;
- emphasizing the individual's unmet, priority needs;
- identifying stressors affecting the individual's life circumstances and their impact on his/her functioning.

Theoretical Concepts to Be Mastered

The following psychoeducational concepts must be mastered:

- the concepts of PAP (the individual's personal adaptive potential, resources and limits) and ELP (environmental resources and milieu and situational limits);
- the concepts of interaction and congruence;
- the concepts of stress and needs;
- the cognitive-behavioural analysis of observable manifestations (cognitions, emotions, physiological reactions, adjustment strategies, social roles);
- the model of Gendreau's overall structure and its components.

Steps in Analyzing Adaptive Functioning

Describe the individual's adaptive functioning

- Cognitive-behavioural analysis of manifestations associated with the problem situation: cognitions, emotions, physiological reactions; adjustment and problem-solving strategies (coping), adopted social roles
- Characteristics of situations to which the individual is exposed in various environments (level of congruence)
- Stressors: current stress factors, situation-dependent or chronic, affecting the individual
- Met and unmet needs
- Assessment of the capacities and adjustment difficulties of the individual (PAP) and his/her environment (ELP)

4.3 PART 3: Clinical Judgment

Objectives

Based on the data collected and analyzed over the two preceding steps, the psychoeducator must pose a clinical judgment on the nature and severity of the problem situation and describe the psychosocial adjustment of the person experiencing difficulties. The psychoeducator must also assess the problem situation's repercussions on the day-to-day life of the individual and his/her entourage as well as the situation's impact on the individual's future developmental pathway.

That judgment must take interactions between the individual components and environmental factors into account by determining the level of congruence of the current conditions to which the individual is exposed. The psychoeducator must be able to determine the problem's severity in the individual's adjustment process. Is it a crisis situation, a case of temporary maladjustment or a maladjustment that could become long-term if unfavourable conditions persist? Are the adjustment difficulties merely the effects of a temporary difficulty, or are they associated with an adjustment problem or a physical or mental health issue? Whatever the case, the clinical judgment must be based on the data collected and on theories that are recognized by the scientific community.

Since the ultimate purpose of the psychoeducational assessment is to implement a treatment plan, the process must lead to the formulation of recommendations and general objectives for treatment. Ideally, recommendations should be sufficiently specific to set guidelines for indicated and counter-indicated treatments, proposed measures and activities, and implementation conditions. The objectives must be consistent with the mandate received and identify short-, medium- and long-term perspectives. They must be ordered in accordance with the priority needs and expectations of the individual and his/her entourage, while taking available resources into account. The earlier, more intensive and more sustained the treatments are, the greater their chances of having a positive impact on the individual's adjustment.

Theoretical Concepts to Be Mastered

The psychoeducator must have a solid grasp of the following concepts because they are the backdrop against which the clinical judgment is made:

- Psychosocial adjustment and maladjustment (proper adjustment, adjustment difficulties, adjustment disorders, behavioural disorders, developmental delays, marginalization, etc.);
- Mental health (optimal mental health, mental health problems, mental disorders, etc.).

The psychoeducator must be familiar with the descriptive components of recognized diagnoses, particularly those set out in the DSM-5, and take them into consideration in his/her judgment of the individual's adaptive functioning. While the psychoeducator cannot diagnose a mental disorder, he/she can note any indicators influencing the individual's level of adjustment. In such a case, the psychoeducator will have to refer to a qualified professional to continue the diagnostic assessment.

Today, the concept of "positive mental health" is being put forward by public health agencies. This concept distinguishes mental health from mental illness based on a definition of adjustment that is similar to the definition used in psychoeducation.

Steps in Formulating a Clinical Judgment

Pose a clinical judgment regarding the problem situation's nature and severity

Anticipate its impact on the individual's future developmental pathway

Formulate recommendations and general objectives for treatment

Psychoeducators and the Assessment of Mental Disorders

The psychoeducator assesses the individual's adjustment capacities and difficulties. That is his/her field of practice and the purpose of the assessment. During the assessment, the psychoeducator may identify manifestations similar to the symptoms of a mental disorder. In addition to observing such manifestations, the psychoeducator is also able to evaluate them from a more normative perspective by using a standardized measuring instrument (for example, Conners, Achenbach, ADOS, etc.). The use of such instruments is legitimate since they open the doors to a better understanding of the individual's adaptive functioning. This option must be further investigated by a professional qualified to assess mental disorders. In that sense and to that degree, the psychoeducator does assess mental disorders.

The psychoeducational assessment report will indicate that assessment, formulating it in one of the following ways:

The individual assessed presents symptoms associated with mental disorder X. A physician's or psychologist's assessment would be required to positively establish this diagnosis.

At the conclusion of my psychoeducational assessment and based on my observations, my clinical impressions lead me to raise a hypothesis of X (mental disorder), which should be further investigated by a qualified professional.

The psychoeducational assessment of Y has led us to note the presence of manifestations that may be associated with mental disorder X. Consequently, we recommend that Y be examined by a qualified professional in order to establish the presence of such a disorder, if founded, and to adapt the treatment plan accordingly.

The formulation used must not suggest that the psychoeducator is diagnosing a potential mental disorder.

The Route and the Destination

The psychoeducator's assessment has an objective, a destination—namely, to ensure the individual's adaptive functioning. The process, or route taken to get there, must be chosen with that destination in mind. Several steps in the assessment process speak to the importance of matching the route and the destination.

The destination is often announced at the outset in the title of the report: for example, Assessment of adjustment capacities, Psychoeducational assessment, or Assessment of adaptive functioning. It is reiterated in the report's conclusion, where the psychoeducator makes a determination regarding the individual's adaptive functioning in relation to his/her environment. The psychoeducator's conclusions have diagnostic value in regard to this objective, as the designated specialist in the field.

The route taken to arrive at the destination depends on the assessment process and the means by which data are collected: consultations, interviews, observations or measuring instruments. In each case, the psychoeducator must be able to justify his/her choices in keeping with the purpose of the assessment, which is to make a determination regarding the individual's adaptive functioning. If the psychoeducator uses a tool that focuses on specific aspects of the individual's development or functioning, he/she must master the associated concepts sufficiently to include them in his/her clinical analysis.

The assessment is a process whose every step is logically linked with a view to its ultimate objective. The written report attests to that coherence. Similarly, any verbal communication regarding the assessment must also respect this internal logic. As a professional, the psychoeducator is responsible for his/her communications. His/her signature and word are binding upon him/her in respect of the assessed individual and any other stakeholders or professionals that may have access to the assessment. The psychoeducator's responsibilities also include provding a clear description of the assessment's scope and any required follow-up.

5. Dissemination of the Assessment

The final step of the assessment process is the dissemination of its conclusions, which are established through a detailed, meticulous process. Depending on the assessment's context, dissemination can take different forms. In the case of legally reserved assessments, a written report relating the steps followed, the clinical analysis conducted and the psychoeducator's conclusions should be prepared. In other cases, all this content might not be assembled in a single, complete report. However, the psychoeducator must be able to give a full account of the assessment process and the conclusions drawn. The client's file is the ideal place for noting this information. Regardless of the scale of the communication and whether it is verbal or written, the information provided to the client must always adhere to the rules of ethics and professional conduct presented below.

5.1 Written Report

The report is the end product of the assessment process and must demonstrate the professional's skills and rigour. It is also a means by which specific contents can be communicated to targeted recipients, including the client. The report's contents, target audience and end purpose will all have an impact on the manner in which the information is disseminated.

Most psychosocial assessment reports have a similar structure. They include a summary of the observation and assessment data, an interpretation of the findings, the formulation of a clinical judgment and general objectives for treatment[3]. While staying true to these basic principles, the psychoeducational assessment report template proposed here highlights a clinical analysis and judgment that refer to the individual's adaptive functioning in relation to his/her environment and developmental pathway.

5.2 Psychoeducational Assessment Report Template

The report template presented in the following pages covers 10 points.

- Points 1 to 3 cover the contextual data used to trace the individual's developmental history as well as the history of the problem.
- Points 4 to 6 concern the collection of data on the current situation. Point 5 covers direct and indirect observation from a functional assessment perspective. Point 6 covers other, complementary data gathered by the psychoeducator or other stakeholders using validated or clinically recognized measurement instruments (normative assessment).
- Points 7 to 10 describe the findings of the clinical analysis, the clinical judgment and the treatment recommendations.

This template can be modified according to client characteristics, the context and the assessment mandate, as well as the cultures of the various practice settings.

3. This structure was inspired by Goupil and Marchand (2001) and Massé, Bégin and Pronovost (2014).

Psychoeducational Assessment Report

1) Identification

- Date of the report.
- Individual's first and last names, date of birth, sex, age at the time of assessment, civil status and type of work.
- If the individual is a child, the parents' first and last names, the address and telephone number, family structure and rank among siblings.

2) Reasons for the request for an assessment or consultation

- Reason for the referral.
- Summary of specific behaviours or situations that led to the referral, including the adjustment difficulties observed in the individual's various facets of development (physical and sensorial, cognitive and moral, affective and social, functional autonomy).
- Legal context.

3) Anamnesis

- Prenatal, perinatal and postnatal antecedents (if relevant).
- Personal and family history.
- Problem history (timing of problem's appearance and evolution).
- Past assessments and diagnoses (if applicable).
- Treatment and services received.

4) Summary of assessment steps

- Dates of interviews or observations; names of people met; assessment objectives.
- Interview or observation methods and measurement instruments used, if any.

5) Behavioural and situational observations (functional assessment)

- Observations made during meetings or experiences shared with the individual in a variety of situations.
- Problem perception and interpretation by the individual in question and other stakeholders.
- The individual's and other stakeholders' perception and interpretation of the problem.
- Information collected from progress notes and additional information from partner consultations or past files.

6) Results of assessments carried out using validated or clinically recognized measurement instruments (normative assessment)

7) Clinical summary

- Review of adjustment capacities and difficulties, both individual and mesological. Strengths and resources; incapacities and vulnerabilities. Consideration of risk factors and protective factors.
- Identification of stressors.
- Determination of needs.
- Functional analysis of adaptive behaviours observed in individual-milieu interactions.

8) Clinical judgment

- Judgment regarding the status of the situation in terms of the severity of the individual's maladjustment and, if applicable, the risk of compromising his/her development. Impact on the day-to-day life of the individual and his/her entourage.
- Impact of the situation on the individual's future developmental pathway.
- Clinical assumptions and interpretations supported by theoretical underpinnings.
- Clinical impressions of mental disorders, if applicable.

9) Treatment objectives and recommendations

- Indicated and counter-indicated treatments.
- Suggested measures and actions in relation to the individual and the environment, along with implementation conditions.
- Expected impact of treatments.
- Treatments to be prioritized in keeping with the mandate received.
- Complementary assessments, suggested or necessary (if any).

10) Report date, professional's signature and title (Ps.Ed.)

- The licence number may also be indicated.

6. Ethical Considerations

Conducting the assessment and disseminating the results are professional acts that must be carried out in accordance with ethical principles and professional standards. For the client, the assessment's consequences are important; for that reason, it must be carried out with integrity and in full respect of the individual's dignity, values that are the cornerstone of the *Code of Ethics of the Members of the Ordre des psychoéducateurs et psychoéducatrices du Québec* (2013a). Respecting the individual's dignity means respecting his/her basic rights, like privacy, self-determination and fulfillment. Professional integrity is reflected in attitudes and actions that are thorough and meticulous, as well as in maintaining professional skills.

6.1 Client Relations

The professional relationship is essentially defined by the power to do something for someone. That power is based on the professional's expertise, which allows him or her to form a judgment regarding the problem situation. However, professional judgement is not merely a matter of a deductive application of knowledge to practice. Making a diagnosis requires more than just knowledge: it also requires sensitivity to the specifics of each case and a power to distinguish between what is essential and what is accessory (Schön, 1994, mentioned in Legault, 2006, p. 613). Every moment in the assessment process, from the initial referral of the problem to the formulation of a clinical judgment and treatment recommendations, mobilizes relationship skills and attitudes.

Puskas (2002) highlights three such skills that enhance the quality of the assessment:

1) An attitude of openness to others
2) An attitude of openness to the emotional resonance that a meeting with another person may create
3) A sustained attitude of questioning that can steer the assessment process in a new direction in light of new information

For this psychoeducator, the assessment remains a subjective meeting where, through well-intentioned attention free of preconceived notions, the professional allows him- or herself to be surprised by the unexpected and the suffering of another human being (p. 168).

Certain ethical obligations apply in addition to the ethics of client relations. Obtaining free, informed consent, a critical step in respecting the individual's right to decide for him- or herself, is at the top of the list. As specified in sections 15 to 17 of the *Code of Ethics*, the psychoeducator must, before assessing an individual, obtain his/her consent or that of his/her legal representative and explain how the assessment will proceed (observation, interviews, measuring instruments). The assessment process involves other obligations as well, such as the obligation to obtain the client's express authorization whenever a report concerning him/her is sent to a third party (section 23). The client must be informed not only that an assessment process regarding him/her is being carried out, but also that a report of that assessment may be sent, with the client's authorization, to such and such a person. In these situations, the report contents must be made known to the client before being released to anyone else (section 23).

Moreover, if any assessment results obtained using measuring instruments are contained in the report, which is often the case, a release authorization signed by the client is required (section 25).

Finally, section 26 of the *Code of Ethics* restricts the transmission of raw, uninterpreted data to qualified professionals[4]. This measure is first and foremost preventive; its purpose is to avoid any prejudice potentially created when such data reach unqualified persons who could interpret them incorrectly.

6.2 Professional Competence

Acting in a manner consistent with one's skill set is a mark of professional integrity. This is the essence of section 42 of the *Code of Ethics*, which requires psychoeducators to practise their profession in keeping with best practices and general accepted standards.

These guidelines on psychoeducational assessments are part of the psychoeducator's "best practices." Those practices also include recently acquired expertise on personal development and adjustment difficulties, which will inform the professional's observations.

The generally accepted standards referred to above include the rules and obligations set out in the *Code of Ethics* as well as the benchmarks established in accordance with each professional's reserved activities and field of practice. Certain assessment activities cannot be carried out by psychoeducators: namely assessing mental delays, neuropsychological disorders and mental disorders.

Finally, a psychoeducator who uses a measuring instrument must adhere to all established rules and practices. They concern the choice and utilization of the measuring instrument as well as the compilation and interpretation of the results and are indexed in *Normes de pratique du testing en psychologie et en education*, an adaptation of *Standards for Educational and Psychological Testing* (2003). Refer also to the *Lignes directrices sur l'utilisation des instruments* guidelines (Ordre des psychoéducateurs et psychoéducatrices du Québec, 2013b).

In general, it is the professional's responsibility not to undertake an assessment that exceeds his/her skill level, whether in relation to the means used (including the use of testing), clinical interpretations, conclusions or recommendations to be formulated. But it is also the professional's responsibility to maintain and improve his/her assessment skills. These guidelines were created to help enhance the psychoeducator's profession in relation to assessing individuals experiencing adjustment difficulties.

4. Member of a professional corporation.

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ADDITIONAL THEORETICAL INFORMATION

APPENDIX 1

Self-determination[1]

For an individual, self-determination is the act of deciding on his/her own destiny or life free of undue external influence. As a result, self-determination is central to the debate surrounding the relative weight of internal and external factors in determining human behaviour (Lachapelle and Wehmeyer, 2003). Angyal (1941) suggests that living organisms are subject to external determinism, but that they can respond to it with self-determination. In this way, human beings cannot be reduced to mere products of biological, psychological and sociological factors. Their capacity of self-determination allows them to rise above these conditions and improve themselves or change the world in which they live (Frankl, 1988). Self-determination is a faculty that humans never lose and that allows them to shape their relationship with their destiny (May, 1969).

For motivation theoreticians, having self-determination means the ability to engage in an activity out of a desire to do so and by free, personal choice. Self-determined individuals act in tune with themselves (Deci and Ryan, 1985, quoted in Lachapelle and Wehmeyer, 2003, pp. 206–207). One of these authors' major contributions is to see self-determination as a need and natural tendency of the individual, just like adjustment. In keeping with this view, Lachapelle and Wehmeyer (2003) proposed a functional model of self-determination whereby it is viewed as the result of interaction between individual capacities and opportunities stemming from the environment and life experiences. According to this perspective, a self-determined individual acts in an autonomous and self-regulated manner. The individual feels that he/she has control over his/her life and leverages his/her strengths to optimize his/her personal development.

Other studies show the importance of an environment that supports self-determination for individuals with special needs in order to promote internalization and intrinsic motivation. They claim that people with an intellectual impairment, just like non-handicapped individuals, should benefit from an environment that supports their self-determination (Emond Pelletier and Joussemet, 2014).

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1. We wish to thank Martin Caouette, Ph.D., Ps.Ed., Professor in the Psychoeducation Department, Université du Québec à Trois-Rivières, for his collaboration on this document.

APPENDIX 2

Risk Factors and Protective Factors

Risk factors and protective factors are central to developmental psychopathology. Recognized as a distinct discipline since the 1980s, developmental psychopathology arose from the integration of several theories and fields of research, particularly in clinical science, developmental psychology and psychiatry. It is based on the resilience approach and is consistent with the systemic view advanced by Bronfenbrenner. Its main area of interest is normal, at-risk and pathological development processes as a means of understanding the adjustment process, and looks at psychosocial adjustment difficulties by studying developmental pathways and factors that appear to contribute to the adoption of deviant or pathological pathways (Massé, Desbiens and Lanaris, 2014; Vitaro and Gagnon, 2000). This approach holds that a great many factors play a role in determining an individual's developmental pathway. These factors are constantly interacting, and their reciprocal influences may be positive and become protective factors in the face of adversity or, on the contrary, increase the risk of an individual developing a maladjustment or psychopathology.

Protective factors are defined as internal, family, social or environmental resources that reduce the probability that an an individual will experience an adjustment difficulty by limiting the destructive impact of negative stresses on his/her physical and mental health (Dumas, 1999; Plancherel, 1998; Tremblay, 2001; Vitaro and Gagnon, 2000). Protective factors modify reactions to the dangers present in the individual's affective and social environment by attenuating the impact of the risk and negative chain reactions. Protective factors can be said to have a compensatory or risk-reduction role.

Risk factors are biological, family, social or environmental variables that increase the probability that an adjustment problem will arise. The vulnerability risk is acknowledged to rise exponentially with the accumulation of risk factors. Most often, it is a combination of risk factors that makes an individual vulnerable, rather than a single risk acting in isolation. These factors do not all have the same weight, which depends on their nature, the duration of their effect, and the individual's age, sex and specific circumstances. Furthermore, factors may be favourable in one situation and unfavourable in another.

According to Manciaux, Vanistendael, Lecomte and Cyrulnik (2001), the main protective factors generally associated with resilience are the following:

- Internal resources: high intelligence, good problem-solving skills, planning skills, use of adjustment strategies, a feeling of personal efficacy, high self-esteem, an internal locus of control, introspective ability, easy-going temperament, a sense of security through attachment, proper use of defence mechanisms, humour, creativity, etc.

- Family resources: good relationship with at least one parent or a close family member, competent parents, a good upbringing and adequate supervision, and support from a spouse in adulthood.

- Social resources: solid social support outside the family (peers, teachers, neighbours, professionals, etc.), a stimulating, open and supportive school environment, and participation in religious, cultural, associative and humanitarian activities.

Clearly, the individuals in difficulty who are our clients are exposed to an array of risk factors that often covers the range of factors that predispose an individual to psychosocial maladjustment (unfavourable socioeconomic conditions, a disruption to his/her family situation, emotional negligence and abuse, social isolation, chronic physical or mental health problems, etc.). However, psychoeducators would be advised to document the risk and protective factors that characterize the problem situation, or client undergoing assessment, referring to the clinical and scientific literature on the subject.

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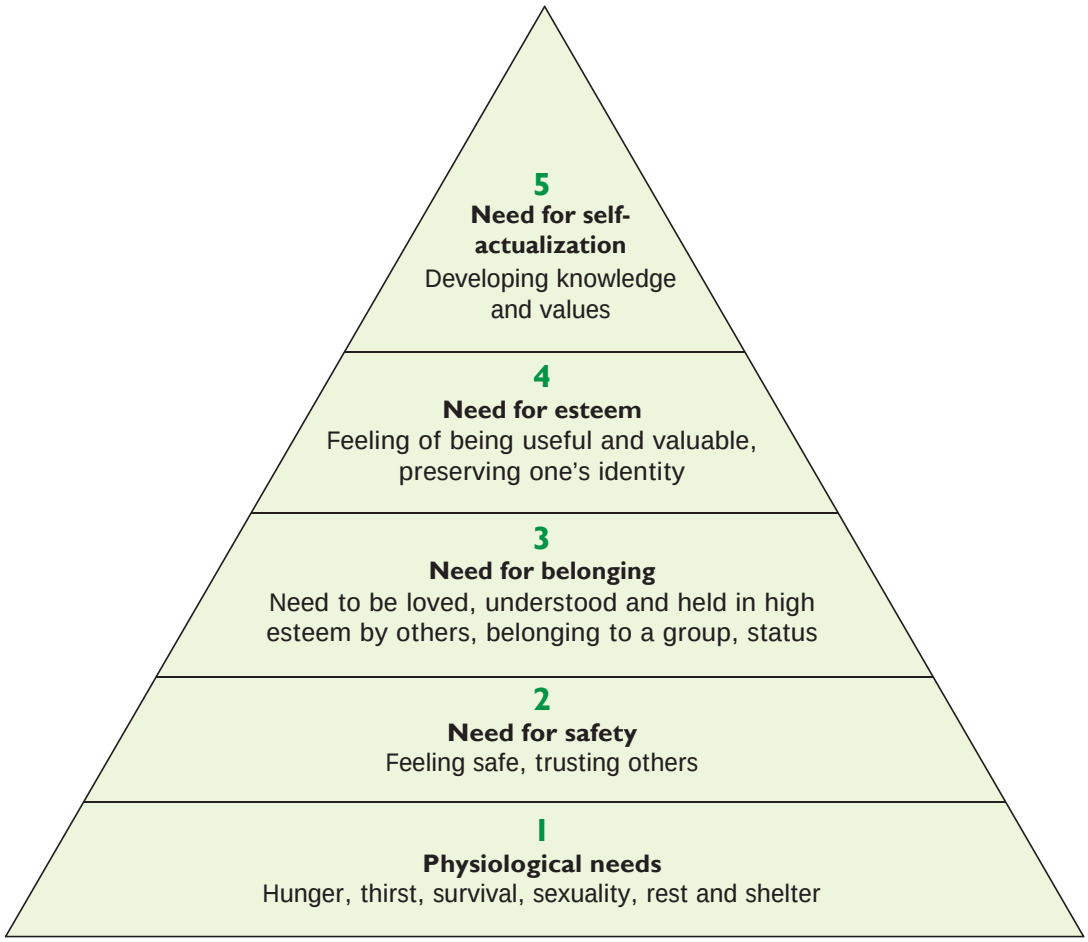
APPENDIX 3

The Concept of Needs

Abraham Maslow, a psychologist who was a leader of the humanistic movement, developed a hierarchy of human needs (1954). According to his theory, humans have basic needs that can be represented as a pyramid. The most fundamental needs must be met before the individual can seek to satisfy needs at successively higher levels.

At the pyramid's base are the individual's physiological needs, those related to survival. Once the person's survival is assured, he/she will be able to satisfy a second level of needs related to safety. The need for safety must be at least partly met in order for the person to address the next level of needs, which are related to love and belonging. When those needs for affection are met, the person can look to the two highest levels, which correspond to esteem and self-actualization (see Figure 1).

Figure 1 – Mazlow's Hierarchy of Needs



According to Maslow (1968), a fully developed adult has the following characteristics:

- an accurate perception of reality;
- acceptance of self, of others and of nature;
- spontaneity;
- problem-solving ability and self-determination;
- detachment and a desire for intimacy;
- freedom of thought and richness of emotional reaction;
- strong, close personal relationships;
- a democratic attitude, creativity and a sense of values.

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APPENDIX 4

The Concepts of Interaction and Congruence

No discussion of the adjustment process is complete without a discussion of congruence. Every adaptive entity, regardless whether it is a member of the plant or mineral kingdom or an animal or human being, lives in a state of congruence between the characteristics specific to the entity and the conditions to which it is exposed.

The Concept of Interaction

In psychoeducation, interaction is a key concept in the work of Gendreau (1978, 2001). As defined by Gendreau, the concept of interaction is rooted in the Piagetian model that, in turn, strongly influence the concept of adjustment in psychoeducation. Piaget (1974) made an important contribution when he proposed broadening the concept of biological adaptation by seeing it as an interaction between two elements: the individual and his/her social environment. Gendreau considers adjustment to be a state of balance resulting from interactions between an individual's characteristics and potentialities, on one hand, and those prevailing in the environments and situations to which he/she is exposed, on the other.

Consequently, interaction can be defined as a set of relationships between two potentials: the individual's personal adaptive potential (PAP) and the experiential potential provided by his/her entourage and environment (ELP). Psychoeducators can facilitate this interaction between the person experiencing difficulties and his/her milieu through planning, organizing, facilitating and using activities or situations with the help of the model of the milieu's overall structure (Gendreau, 1978, 2001; Renou, 2005; Pronovost and Renou, 2013). That model was created precisely to support the implementation of experiential contexts that support the individual experiencing difficulty in his/her development and learning. If the external conditions and means of developing relationships can be considered normal and habitual, the interaction and treatment can be described as educational. If those external conditions and the means used can be considered instead to be specific and specialized, the interaction and treatment can be described as psychoeducational. In psychoeducation, the concept of interaction takes on its full meaning in the experience shared by the professional and the person in difficulty. That shared experience gives the psychoeducator a unique opportunity to collect field data on which to base his/her professional assessment.

Assessing Interactive Congruence

As part of the process, the psychoeducator must first assess the level of congruence, which involves measuring the gulf between the experiential learning potential provided by the milieu and situations (ELP) and the individual's capacities and difficulties, competencies and vulnerabilities (PAP) in taking on the challenges inherent in the situations. A good level of congruence is achieved when the situation presents a *meaningful and appropriate* gulf that takes account of the individual's achievements and potentialities, but also provides a degree of imbalance that prompts him/her to instigate a process of learning and looking for solutions. In other words, this dynamic imbalance allows for the acquisition of

new frames of reference and the development and preservation of interest and motivation. The greater the gaps in the various relationships between the individual's personal adaptive potential and each component of the situation, the more stimulating the situation will be for the individual. If few of the relationships between the individual's personal adaptive potential (PAP) and the various components of the situation (ELP) show a significant gulf, the overall congruence level will be low and the individual runs the risk of remaining passive or continuing to fall back on familiar frames of reference. Inversely, an excessive gulf between the individual's frames of reference and most or all situation components, signals non-congruence, which may lead to failure or demotivation or increase the imbalance between the individual's current potential (PAP) and the situation's current conditions (ELP).

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APPENDIX 5

Cognitive Processes and Coping

The Role of Cognitive Processes

Cognitive processes play an active role in the adjustment process (Beck, 1976). The beliefs, motivations and attitudes that we acquire about ourselves and our world are learned. Some deficiencies (cognitive distortions, irrational beliefs, automatic negative thoughts, etc.) change the way an individual perceives, interprets and reacts to situations and can result in psychopathologies.

The cognitive behavioural approach highlights the importance of cognition and emotions in learning and modifying human behaviour (Le Blanc, Dionne, Proulx, Grégoire and Trudeau-Leblanc, 1998). There appears to be a relationship between cognitions, or the ways an individual evaluates a situation based on his/her expectations and beliefs, and the emotional reactions produced. When confronted with a problem situation, automatic thoughts arise, linked to irrational or erroneous beliefs that produce cognitive distortions which, in turn, lead to negative emotions, which give rise to inadequate behaviours. The emotions are determined by the way in which the situations are interpreted, and not by the situations themselves. Automatic and irrational thoughts (referred to as "cognitive patterns") reflect personal beliefs rooted in childhood and life experiences. They shape the manner in which situations are perceived and information is decoded. A cognitive behavioural treatment therefore aims to modify the individual's affects and behaviours by replacing erroneous thought structures with more rational thoughts that are more consistent with reality. This process allows the individual to better evaluate and deal with problem situations by adopting appropriate behaviours (Massé, Desbiens and Lanaris, 2014).

The Role of Coping

In recent years, the concept of coping has been referred to more and more frequently in discussions of adaptive mechanisms and strategies. Based on theories of stress, Lazarus and Folkman (1984) proposed a model under which adjustment is perceived as a result of the interaction between the individual and the environment, with coping aiming to counter the stressors to which the individual is subjected. The individual reacts to these stressors by using various adaptive strategies that produce psychological well-being in the case of successful adjustment, or, on the contrary, psychological distress in the case of unsuccessful adjustment.

Lazarus and Folkman define "coping" as a series of cognitive and behavioural efforts that generate responses by which an individual deals with a stressful situation. Coping encompasses problem-solving actions like searching for information, considering alternatives and deciding what action to take, as well as such communication behaviours as discussing situations and cooperating with others. It also operates by means of certain cognitive operations—for instance, minimizing distress and focusing on the positive aspects of a situation. Coping involves a cognitive evaluation process that influences the individual's interpretation of reality and determines the nature and degree of the emotion felt in response to the stress. It is generally acknowledged that there is no style of coping that is inherently

positive or negative Instead, the coping strategies used by an individual are described as effective or ineffective, according to whether they advance or hinder adjustment. Sooner or later, an effective strategy succeeds in resolving the problem situation and positively reinforcing the individual's and his/her entourage's perception of his/her ability to deal with the situation (sense of self-efficacy). Inversely, an ineffective strategy results in failure to resolve the problem and leads the individual to adopt a pessimistic attitude and a negative perception of his/her skills. "Proactive coping" is another construct based on the voluntary action process in healthcare. This type of coping is described as the effort to build and accumulate a set of resources that facilitates achievement in respect to various challenges. The individuals see the situations as exciting challenges that motivate them and contribute to their development of a sense of self-efficacy (Schwarzer, 2008).

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APPENDIX 6

The Concept of Positive Mental Health

Positive mental health has recently become a subject of interest. Historically, mental health assessment and treatment have focused on mental illness. This psychiatric conception of mental health implies that individuals are either in good mental health or, if not, suffer from mental illness. In the last decade, the concept of positive mental health has featured more prominently in health promotion research.

From this new perspective, mental health is no longer understood as the absence of mental illness but as a resource that allows the individual to feel good, to be fulfilled and to be satisfied with life, even if he/she is suffering from mental problems (Duhoux, 2009).

This view is particularly interesting for psychoeducational treatment, which aims to support adaptive processes. As a result, the concept of positive mental health is worth describing as a complement to these guidelines.

Definition of Mental Health

According to the Canadian Institute for Health Information (CIHI), mental health is "the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity" (2009, p. 9). This definition is similar to the one provided more recently by the World Health Organization (2013): "Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (p. 38).

In its 2009 report, the CIHI looked at the concept of positive mental health by examining mental health independently from mental illness and viewing mental health as a component of an individual's overall state of health. Referring to Keyes, mental illness and mental health—although interrelated—are in fact two separate things. Mental health is a "complete state" (Keyes, 2007, p. 100). To measure it, we must assess both the individual's mental illness (psychopathology) and mental health. Those with "optimal" mental health have "flourishing" mental health and are free of psychopathology. Nevertheless, an individual with a mental illness can enjoy good mental health in certain limited aspects of his/her functioning. According to study findings (Keyes, 2005 and 2007; Westerhof and Keyes, 2010), only a minority of the population enjoy optimal mental health.

These definitions attest to the fact that mental health is not only distinct from mental illness, but that it is also not limited to the absence of illness. Instead, it is an optimal state of health or one that can be optimized.

In its 2009 report, the CIHI identified five components of mental health (p. 10):

- ability to enjoy life;
- dealing with life's challenges;
- emotional well-being;
- spiritual well-being;
- social connections and respect for culture, equity, social justice and personal dignity.

In the same vein, Westerhof and Keyes (2010) describe mental health as comprising emotional well-being (a combination of being happy, satisfied with life and interested in life), psychological well-being (a combination of self-acceptance, having a purpose in life, autonomy, positive relations with others, and an ability to master one's environment in order to meet one's needs and achieve personal growth), and social well-being (a combination of social coherence, acceptance, actualization, contribution and integration).

These components are valuable indicators to be considered when carrying out psychoeducational assessments.

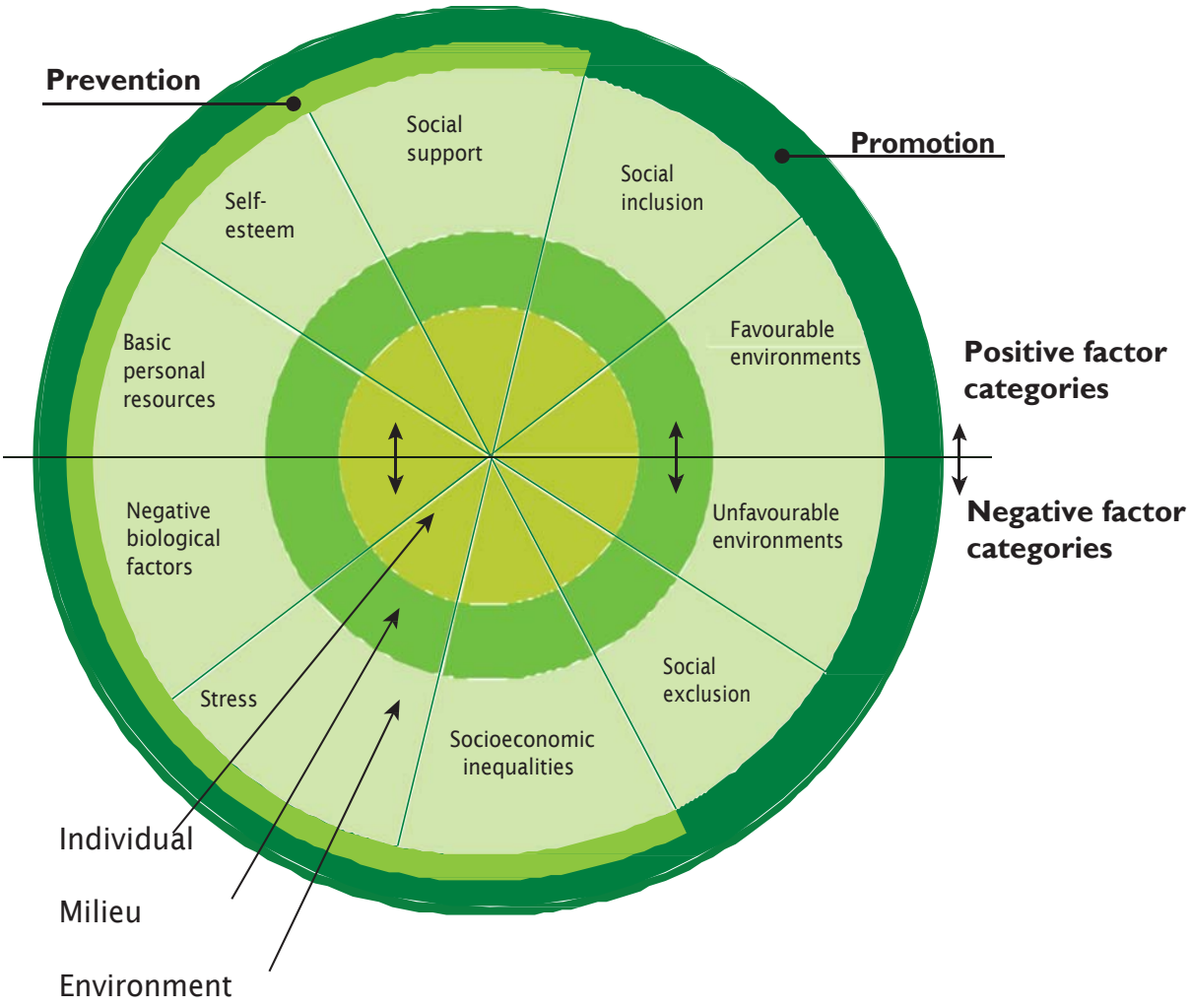
Promoting Mental Health and the Practice of Psychoeducation

Viewing mental health in positive terms is a step towards putting effective programs in place to reduce health inequalities through collaborative and participatory methods that further empower individuals and communities (Jané-Llopis, Barry, Hosman and Patel, 2005). This view concurs with Gendreau's interactionist model, which highlights psychoeducational treatments targeting both individuals and communities.

The Institut national de santé publique du Québec (2008) proposed a conceptual model for mental health promotion and prevention that operates from an ecological and developmental perspective. According to the model, which is shown in Figure 1, promoting mental health seeks to boost personal resources, self-esteem and social support, as well as the positive influence of favourable environments and social inclusion.

To that end, psychoeducational practice must leave room for measures that optimize the individual's personal adaptive potential in interaction with whatever the environment can provide.

Figure 1 – Conceptual Model of Promotion and Prevention in Mental Health



Source: Institut national de santé publique du Québec. (2008), p. 23.

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