REFLECTIONS ON A PRACTICUM IN CLINICAL SOCIAL WORK
ADULT COMMUNITY SERVICES FOR THE PRAIRIE NORTH HEALTH REGION
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Abstract

Battlefords Mental Health Centre, North Battleford, Saskatchewan was the site of my practicum experience from January to April, 2009. The opportunity to practice social work and counseling theories in North Battleford was significant, given the history intertwined within the local area. Saskatchewan Hospital was the first institution specifically designed to provide mental health care and rehabilitation for individuals diagnosed with mental illnesses. With the introduction of psychotrophic medication in the 1970’s, individuals were treated instead of controlled, and institutions were replaced by mental hospitals in local communities. The Saskatchewan Plan changed mental health policies from an institutional approach to small mental hospitals (Dickinson, 1984), followed by a community based system.

Today, federal and provincial governments are endeavoring to change the face of mental illness. As the highest indicator of disease that results in unemployment, disability or death (Conway, 2003), the alleviation of mental illness has grown significantly in public importance. The National Mental Health Commission, launched in 2007, was created in response to recommendations of the Standing Senate Committee on Social Affairs, Science and Technology (2006) report “Out of the Shadows at Last”. Governments now recognize that without intervention, individuals with mental illnesses are at risk of further marginalization in our globalized economy.
Mental health centers play a major preventative role for governments in ensuring individuals with mental illnesses have access to support as requested. Social workers implement brief therapies to empower clients in articulating their chosen goals and assisting them in lifestyle changes. Examples of cognitive behavioral and solution focused therapies demonstrate that social workers can implement therapies to assist individuals in creating positive life changes.
Acknowledgement

It is with sincere gratitude that I acknowledge Leora Harlingten, MSW, Dr. Wai Yuen, PhD, Program Manager, and all the staff at Adult Community and Addictions Services for their vital input during my practicum. All of their unique and personal contributions to my clinical training were invaluable and insightful toward future counseling experiences.

Dr. Judy White has been instrumental in offering her encouragement and mentorship as my practicum supervisor and I am thankful for her time and perseverance. When Dr. Robert Twigg’s retirement from the University of Regina precluded his involvement as my second reader early in my practicum, Dr. Ailsa Watkinson graciously accepted the challenge.

I further wish to acknowledge the memory of my daughter, Kathleen, and my brother, Jim, who have inspired me to continue learning. The courage of my stepfather in battling vascular dementia demonstrated a tenacious spirit and inspired family to remember that which is most important in life. I would be remiss not be mention my mother, Agnes, who always sees the best in me.

I dedicate my paper to all those who journey through the sea of stigmatization, self blame, and ill health in order to reclaim some sense of normalcy in their lives. I commend all those who work in the mental health field and strive for the betterment of mental health services, increased public awareness and more understanding of the multiple challenges facing those with mental illness.
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Introduction

The completion of a Masters in Social Work has been a source of inspiration, requiring dedicated resolve and determination to overcome the hurdles and obstacles while working full time. The decision to pursue further studies as a mature student reflects the values I learned through my family of origin, early immigrants to Canada who worked hard all their lives to ensure the wellbeing and survival of their families.

After obtaining my Bachelor of Social Work, I moved to the Battlefords, choosing to work with mentally challenged individuals for the past thirteen years. It has given me insight into dual diagnosis of individuals who are cognitively challenged and possess mental health issues. As a result, I have developed a deep respect for the struggle in obtaining mental health support for those not considered to be part of the dominant group.

The impetus that has kept me focused toward completion of a Master’s degree is a fervent desire to learn more about the counseling field and to keep learning about the multiplicity of human needs. More than reaching a goal, it is a desire to serve a specific population and obtain the skills that will create a pathway for possible solutions for potential clients. It was a positive experience that confirmed the role of social workers in mental health and the ongoing need for people to be heard in a supportive environment.

When I applied to the University of Regina, I outlined several objectives that I sought to accomplish prior to and during my practicum:
• To read extensively and review theories, psychiatric disorders and cognitive challenges to mental health clients, in preparation for a clinical experience.

• To deepen knowledge of clinical theories in order to assist adults toward a healthier perspective.

• To expand knowledge base of adult programming available in the Battlefords Mental Health Centre.

• To accept referrals through the intake process, screening for alcohol and drug use and assessing individual risk to suicide and abuse.

• To promote a therapeutic relationship with adults who may or may not have a mental health diagnosis and/or intellectual or cognitive challenges.

• To develop counseling skills that will enable individuals to empower themselves in identifying what they need and the changes they wish to make.

• To counsel adults with mental health issues or diagnoses toward a healthier lifestyle.

• To assist adults through assessment and counseling strategies to a better understanding of their individualized situations and promote self growth.
Brief History of Mental Health in Saskatchewan

With the passing of the Insanity Act in 1906, Saskatchewan acquired responsibility from the federal government to care for the “insane”, prior to the term mentally ill (Dickinson, 1984). People that were considered “insane” had minimal rights in society compared to others and suffered oppression of various forms.

Saskatchewan is well known for its history of mental health institutions. Saskatchewan Hospital, a landmark in the Battlefords, was built in 1914, followed by Weyburn’s Mental Hospital in 1921 to address the needs of those requiring extensive mental health care and rehabilitation. The establishment of hospitals for mentally ill started an evolution of care, relieving many families of their former responsibility and shifting emphasis to a government institution.

The Canadian Mental Health Association, Saskatchewan Division, recounted the local history of mental health, reflecting the struggle for normalcy within the lives of mentally ill on their website. Early advocates envisioned governmental support to replace the familial system. More awareness of the realities of mental illness and increased societal support of people with mental illnesses was pivotal to reversing the prevalence of stigmatization.

In 1922, the Mental Diseases Act recognized that mental illness was linked to disease, not a criminal matter, requiring a court order prior to imprisonment of anyone deemed mentally ill (Dickinson, 1984). By the 1920’s, both Saskatchewan hospitals were overcrowded and patients were experiencing
isolation and stigmatization from their families and from the general public (Dickinson, 1984).

Early advocates of mental health policy crusaded about the potential health risks to patients living in mental institutions. A change of policy occurred with recognition by the provincial government that the living conditions in mental institutions had deteriorated significantly and appointed a committee to study the delivery of psychiatric services.

Through the recommendations of the study, mental health clinics and psychiatric facilities in hospitals were developed. Training schools were created in 1930, emphasizing the areas of psychology, psychiatry, and mental hygiene as well as medicine in preparation for psychiatric nursing. Psychiatric nurses’ training was formalized in 1947 and the following year, the Saskatchewan Psychiatric Nurses Association was formed. The Mental Hygiene Act of 1950 granted people the right to be voluntarily admitted to an institution (Dickinson, 1984).

The Canadian Mental Health Association, created in 1950, was given responsibility to advocate for those with mental illness and to change public perception. With the arrival of psychotropic drugs, opportunities arose for many of those afflicted by mental illnesses to try the new medications. With psychological theories providing increased understanding to mental illness, change was imminent to the mental health system. The deinstitutionalization of patients from psychiatric hospitals in the 1960’s heralded revolutionary reform.
that ended patients working at the hospital, political patronage, and prefaced a
new approach to supporting mental illness (Dickinson, 1984). In order for
community psychiatry to develop, the concept of patients being controlled was
replaced by a policy of treatment (Dickinson, 1984).

The Saskatchewan Plan was devised to transition from the large
institutions to small mental hospitals or clinics in communities (Dickinson, 1984).
As part of this plan, rehabilitations centers served as local community supports
to former patients. A public welfare system, designed to support patients in
short term rehabilitation, provided financial support in their local communities.
The Mental Health Association continued their role of providing day support as
required. Primarily patients were released into the community with the onus on
the patient to continue taking their medications and seek assistance as needed.

In 1972, intellectually disabled individuals were separated from the
mentally ill into two different departments, decreasing the actual numbers of
mentally ill and resulting in budget cuts to mental health that year. A task force
in 1980 studied the delivery of mental health services in Saskatchewan and
devised the present community-based system. Dickinson (1984) reports that
psychotropic drugs were crucial to mental illness being medically recognized as
treatable. With patients in the communities, the large institutions were
considered unnecessary and financially unviable with smaller mental hospitals
holding the future for treating mental illness (Dickinson, 1984).
The Battlefords Mental Health Centre Team

The Mental Health Centre is located in Battlefords Union Hospital, accessible to anyone with a Saskatchewan Health card and is a free service to all residents of Saskatchewan. The hospital is part of the Prairie North Health Region, including Meadow Lake, Lloydminster, Maidstone and adjacent areas. The vision of Battlefords Union Hospital is to create healthy people in healthy communities by ensuring appropriate access to quality health services for all people within the region. A mission statement encourages people to work together, showing respect, compassion and dignity to all, regardless of cultural, social and economic factors. Creativity and innovation are valued in the journey toward learning, maintaining partnerships, in an ongoing commitment toward a safe and supportive environment for all. In keeping with the integrity stated in their mission statement, there is no direct fee for mental health services.

Adult Community Services is funded by Prairie North Health Region, Ministry of Health, to serve the Northwest Region of the province, providing mental health assessments and treatment services for anyone eighteen years and older, throughout the life span. Many individuals arrive at the Mental Health Centre, hopeful that whatever illness or temporary disorder that has availed them will be controllable. For others, a local doctor or psychiatrist has referred the individual for counseling to support them in learning to manage their symptoms. Those in crisis require immediate
support from a counselor or psychiatrist, often followed by an assessment by a psychologist or psychometrician.

**Inclusion of Substance Abuse Services**

A provincial initiative in June, 2008 combined Adult Community Services with Addiction Services, providing a wide range of mental health services and substance abuse programming to individuals and families within the Prairie North Health Region. Adult Community Services offers mental health assessment and treatment services centrally at Battlefords Union Hospital, North Battleford. Meadow Lake and Lloydminster have mental health clinics where assessments and counseling services are offered. A rural social worker travels out from North Battleford to the surrounding area four days a week to provide counseling to individuals unable to access service in North Battleford.

Adult Community Services in North Battleford has a substance abuse program with a residential component for a longer rehabilitation and an outpatient access at the hospital. Meadow Lake has its own treatment centre where anyone with substance abuse can be served as an outpatient or as a resident. Telehealth is a service that links health professionals on a secure site, facilitating a safe exchange of health information. Through this approach, Northern communities can access psychiatric services without traveling great distances.
**The Mental Health Team**

Battlefords Mental Health is comprised of a wide range of psychiatric rehabilitation components including inpatient services, psychiatry services and therapies. Professionals include community psychiatric nurses, adult community service workers, addiction workers including psychometricians, and child and youth workers. Four psychiatrists diagnose and recommend treatment, referring clients to all disciplines within the team. Another psychiatrist from Saskatchewan Hospital offers part time services at the hospital in order to connect directly with his patients in the community. Four psychologists provide psychological assessment, counseling and group work.

Dr. Wai Yuen, a registered psychologist, is the program manager for Adult Community Services, overseeing all aspects of the team. Therapies, part of the inpatient clinic, has an educational component to teach individuals coping skills, awareness of mental illness, tolerance for others and themselves, and self esteem building through crafts and learning life skills.

Adult Community and Addictions Services has four social workers, including one Master’s in Social Work, two therapists, five addiction counselors and two psychometricians. The addiction counselors and psychometricians require specific university degrees other than social work. A therapist can be a social worker or a professional with credentials in the counseling field. In contrast to major centers, there has not been a commitment to hiring counselors with a Master’s Degree in Social Work in North Battleford.
Intake

The first point of contact is through the intake worker where individuals may self refer to Adult Community Services when mental health issues are beyond what they can cope with. A family doctor, recognizing that certain aspects of a person’s life require change, makes referrals on their behalf. Individuals with or without a diagnosis or any previous involvement may self refer, request more intensive therapy or reconnection with a former counselor. Most requests from Adult Community and Addiction Services are short term, often comprised of up to several sessions with a counselor.

An intake process facilitates all referrals to Adult Community Services. Each new intake is assigned to a specific worker and matched according to need. Each worker designates a set number of new spaces for referrals, to be available each month, in addition to their current caseload. Referrals from physicians, schools, court, or other professionals are assigned to workers at the same time as direct requests from individuals. Psychiatrists also make internal referrals for programming through intake, on behalf of clients who may or may not have a mental illness.

As part of their workload, designated staff within the team alternate providing intake services Monday to Friday. The intake process is the catalyst to facilitate direction to any area of mental health. Staff facilitates multiple roles of assessment, group work and counseling. The client base is generally composed of individuals eighteen years of age or older and reflects ages
throughout the life cycle. A small percentage are sixteen to seventeen year old youth, who may be living independently in the community, yet represent risks to themselves or others.

Monthly intake meetings review any changes to the intake process, the length of time that elapsed before any new referrals, and any new ideas or recommendations to improve services on intake. The information recorded during each intake generates into monthly statistics, gathered by the intake coordinator.

Counselors collect statistics for Adult Community Services by diarizing all persons seen, the length of time service was provided, the area the individual resides, and the waiting time prior to initiating service. Counselors note the specific areas they were consulted on during each visit. Statistical recording generates part of the feedback on the number of hours per month contributed by each counselor. Totals are combined with provincial statistics giving the Ministry of Health a breakdown of services and the numbers of professionals required to support the ongoing demand. The importance of reporting outcomes is paramount to ensuring sufficient programming dollars for the coming year.

To address inequalities within the mental health population, advocates at both federal and provincial government levels have worked many years to address the unmet needs of those with mental illness by generating awareness and lobbying for increased mental health services. A final report on
Saskatchewan mental health by John Conway (2003) connects the shortage of psychologists, psychiatrists, and nurses in Saskatchewan to the quality of services currently being provided. In addition, waiting lists in the public system result in services being more difficult to access across Saskatchewan. Depending on where an individual resides in Saskatchewan and the length of the waiting list in that particular area, those who require mental health services may be waiting up to several months. Mental health services are most often utilized either through public mental health or private services, paid through individuals’ insurance programs. Those with minimal income are forced to use the public system, waiting for a service desperately required and having no other choices to implement.

Confidentiality

Confidentiality is a major concern and all new workers receive confidentiality training organized by Battlefords Union Hospital at the onset of duties within the hospital. Confidential files are created to protect individuals known to personnel and are only handled by the intake coordinator and the potential assigned worker. In these situations, the intake coordinator refers the confidential intake directly to the appropriate counselor who processes the confidential file in its entirety.

Groups Facilitated

Several programs are facilitated by Adult Community Services. A safe driving program enables drivers that have lost their license to regain it, once
they have completed the training and met all the requirements. Addiction groups offer individuals opportunities to build awareness about themselves through Recovery Education Group, Hopeview Centre, Domestic Violence Treatment Group and Program Gambling. Other groups currently being offered are the Anxiety Group, Lawson Coping and Support Group, Alternatives to Violence and a Women’s Wellness Group for adult victims of domestic violence. An Alzheimer’s Support Group meets weekly with a team member providing leadership. Anger Management will be restarted if there is sufficient interest. All the groups play an integral part in the lives of the participants, enabling them to change perceptions, alleviate stressors and return to their normal lives sooner.

Adult Community Services and Addictions Services meet weekly as a group to discuss specific cases and make recommendations about policy and procedures within the scope of the unit. The group session provides opportunities to share information and to obtain feedback about difficult cases.

**A Clinical Experience at Battlefords Mental Health Centre**

The initial step of making the call to intake or accepting a referral to counseling through a psychiatrist or another doctor is a huge step in our society. The fear of stigmatization that accompanies a mental health diagnosis causes hesitation to seek help. Wang et al.(2000) and Csiernik, Forchuk, Speechley and Ward-Griffin (2007) identified that many people with a mental disorder delay obtaining help as long as they can. Oppression as a result of being labeled
mentally ill occurs in the workplace, in communities, from professionals and by those who feel superior (Csiernik et al., 2007). Another layer of oppression is endured by people of color who are unfairly judged by their skin tone as well as a disability of illness.

The ones that follow through to counseling demonstrate great courage and resilience in exposing their vulnerability, especially when there is recognition by themselves or others that the process has to be regenerated. With increased understanding of the broader context of mental illnesses, Chen and Mak (2008) suggest that cultural bias may be lessened through the promotion of cross cultural awareness and proactive education of professionals.

In my work, it was not uncommon to encounter individuals who benefitted from psychiatric drugs without having a mental health diagnosis. Their journey to mental wellness often meant a return to a psychiatrist or a referral to a counselor to assist in identifying emotions that have triggered uncharacteristic behavior. Since embarking on a practicum in clinical social work with Adult Community and Addictions Services, I sought to learn the dynamics of counseling through a clinical experience in mental health, practicing theories, creating changes in collaboration with clients and assisting them in reaching their potential through goal setting and proactive strategies.

**In-service Training**

I was fortunate to be part of an orientation presented by Dr. Wai Yuen which included an overview of the therapeutic approach, the main counseling theories, and the language that could create a personal, meaningful dialogue with clients. Dr. Yuen’s
reviews summarized points from social work communication class and reminded me that counseling is a partnership between your client and yourself. A crucial part of that process conveyed a message of hope for the future while creating empowerment for clients to make their own choices.

Through aboriginal awareness training offered through the local health district, I had an opportunity to review how aboriginal people were treated unjustly as a result of the Canadian treaties of 1871 to 1877, the pain caused to First Nations people by the residential school system, and the lingering racist views that still resonate within our society. Anyone that is hired by the health district is required to attend this training in an effort to educate staff and dispel racism.

**Definition of Mental Illness**

“A collection of disorders characterized by symptoms such as extreme mood swings, disturbances in thought or perception, overwhelming obsessions or fears, or high levels of debilitating anxiety,” mental illness reflects behavioral and physical changes that impacts lives irrevocably. Mental illness is not short term or a temporary emotional reaction to circumstances. Impairments in functioning affect multiple aspects of a person’s life, compromise relationships and change the interconnectedness to the family unit. Individuals may begin to gain insight that their ability to function is compromised on their own, or their family members as well as friends describe their distinct alterations in behavior, temperament and overall judgment.

Individuals may be affected by a physical as well as a mental illness,
impacting on their ability to perceive rationally what they are experiencing (Frank, 1973). These distortions are such that it is difficult for a person encountering mental illness for the first time to be able to distinguish that losses have occurred. Psychoanalyst Norman Doige (2007) suggests that as the brain generates inaccurate and exaggerated thoughts, the impairments in functioning result in cognitive distortions about themselves, others and their connection to the systems at large. It is not uncommon that even as a person begins to unravel the threads of illness, unwillingness to accept a possible mental illness causes individuals to conceal that their lifestyle has changed beyond measure. Circumstances that delay seeking professional help include a lack of belief by the person themselves, their family and friends. Confronting a possible illness creates negative emotions of personal vulnerability weighed against what they perceive as societal expectations of perfection, creating further delays toward wellness.

Mental illness is “diagnosable, sufficiently severe to impede functional abilities, and considered to require, and could likely benefit from, mental health treatment.” With a psychological assessment through a psychiatrist or a psychologist, a diagnosis can be confirmed whether or not there is an ongoing need for psychological assistance.

**Counseling Experience with Adults**

I researched the theories until I felt confident that the ones I had chosen would serve the broadest spectrum of the population being served. In the process, cognitive
behavioral and solution focused theories were deemed the most suitable and versatile as they are both brief psychotherapies that would fit many of the issues that clients were presenting with. During the intake process, potential clients were selected for me by my supervisor. As clients were referred to me from intake, it became clear that for some individuals, the process of asking for help was such a huge step that the assistance they received from the intake worker was all they could process for the present. Over half of my clients did not show up for their first appointment. For others, the courage to continue after one or two visits waned and they too did not continue. A follow-up call ended the involvement unless clients returned. A few clients attended sessions each week since the beginning of my practicum and I am grateful for the dialogue and the relationships that developed as a result of our shared experiences. The lessons in counseling that I was able to impart to clients as part of my practice enriched the entire experience, ratifying the role of social workers in mental health.

Attending to the diverse and multiple needs of the presenting clients, first at intake, then at counseling takes intense concentration and inclination to research for the right approach, creating an initial atmosphere of trust that could lead to engagement in the counseling process. It is important to convey reassurance that symptoms could alleviate over time, with the client’s willingness to create change and following a psychiatrist or psychologist’s orders for medication support. I was amazed at the resilience of those that phoned, came in to the Centre, or reached out in any way. Some individuals lose their courage and conviction, deciding not to keep their first appointment, exercising their choice.
The population served by Adult Community and Addiction Services are facing significant life changes, stressors, transitions, marriage and/or family breakdown, multiple losses and life stressors. Their coping mechanisms have been inadequate or short lived, necessitating intervention that will turn their lives in a positive direction. For many individuals, short term counseling empowered them to build on their strengths, increase coping skills and set obtainable goals for the future. Others benefit from more intense counseling over several appointments and possibly a referral to another aspect of mental health, such as addictions or marital counseling.

Couples seeking counseling may specifically request marital assistance at the time of the initial intake process or clinicians can refer them later, as individuals indicate their readiness. Both parties of a partnership are required to apply separately for couples counseling to ensure their commitment to the relationship and to the counseling process.

There were common threads that wound throughout individuals’ experiences at the onset of therapy -- resilience, vulnerability, poverty, losses experienced within the family of origin, unemployment, low self esteem, and self blame. Clients came in for support during multiple changes in circumstances that were beyond their current level of coping. For most people, there was recognition that they needed assistance in order to reach their determined goals. Many displayed strength and determination that enabled them to make contact with mental health, if only on a sporadic basis. In their daily fight with fears, they struggled to make good choices and to follow through with their plans for success.
Interactions with Youth

Occasionally, counseling services for youth of sixteen to seventeen may be requested of adult community services when youth are living as adults in the community or they present as a potential risk to themselves or others. The following examples during the intake process are a testament of the extreme pressures that youth encounter through peers, their home environment, or family structure. A female teenager with muscular dystrophy had contemplated suicide a number of times and recognized that she was depressed and vulnerable. She spoke with an intake worker, who reflected back to her an acknowledgement of the pain she was feeling, including a fear of a disease that she shared with her two young brothers. Between distance to the hospital and her multiple losses, she never showed up for her first counseling session.

A sixteen year old girl was presented to intake through a referral from a local high school teacher. She admitted that she had tried to slash her own wrists and that she had been sexually abused at six years of age. Although there had been a diagnosis of oppositional defiant disorder a few years ago, she talked about being depressed. During intake, she grew restless and did not maintain eye contact. Her appointment for counseling was scheduled to occur in a couple of weeks. Being dependent on others for a ride from her reserve, she either chose not to come or was physically unable to keep her appointment to see me. Attempts to reconnect were fruitless and I was unable to speak with her again. There were times that I felt powerless to assist teens in changing their way of viewing themselves in the world. Yet these teens had recognized that one hope for the future was in counseling and they had made the initial call for help. The
policy of the health district is to offer counseling services, reiterating to clients that it is their choice to commit themselves to treatment.

A sixteen year old female arrives at intake with a known diagnosis of bipolar disorder. She cried as she told me how much she missed her family of origin and that she lived with her aunt and uncle in the city in order to attend high school. She had a history of multiple suicide attempts, including more than one attempt of tying a rope around her neck. A picture she had drawn at school of herself hanging from a rope alerted her teacher and she was brought to the mental health centre immediately. Her low self esteem projected from her as she described her feelings of despair. With a direct referral to a psychiatrist, she was immediately interviewed and a counseling referral followed. On the recommendation of the psychiatrist, she was returned to her extended family immediately instead of being admitted to the ward for observation.

A teenage boy expelled from a Northern school had been idolizing the participants of school shootings, drawing his fancied involvement with such an event and requesting a copy of the CD from the school library. A psychiatrist from the local health region requested that intake refer him to another psychiatrist, asking for a second opinion about the young man’s potential mental state.

An Essential Service

Statistics recorded by the intake coordinator over the past year identify that the number of people asking for counseling services is growing considerably. For example, in March, 2009, there was an increase of more than one hundred requests from the previous year, for that month only. Depending on circumstances and timing, other
months could reflect a much higher increase in demand. Battlefords Mental Health Centre promises the community at large that services will occur within the shortest time possible. It is an essential service that is expected by the extended community and a vital aspiration of the local health district’s vision. Counselors are required to record information to attribute how well the public is being served. With monthly reports from records meticulously maintained, it is clear that the existence of trained counselors serve a major role in offsetting the effects of mental illness.

Heppner, Cooper, Mulholland and Wei (2001) verify there is a link between solving a problem, the ability to adjust to various pressures that impact on a person’s wellbeing, and reflecting outcome measurements as part of psychotherapy. Being able to access a counselor in a timely manner and speaking freely about issues that create undue worrying about problems or negative thinking encourages those with mental issues to continue seeking help from a counselor. Doige (2007) suggests that many people with anxiety related to views about their own self image or self esteem and coping with substance abuse can be assisted to replace cognitive distortions through mental health counseling. Gaining access to a counselor as quickly as possible is critical for anyone in crisis. Those that live on reserve must rely on others for transportation to a mental health centre and another element of anxiety is created when potential clients know that they are unable to help themselves and are waiting for the availability of a ride to a nearby mental health centre. At times, there are a limited number of counselors and a short term waiting list is maintained for those in crisis waiting for their first appointment.
Later on in my practicum, as my potential client load lessened to a faithful few, I was given a few additional clients that required immediate support. Through sharing their respective journeys, I began to understand that the theories I had been researching could make an integral and intimate difference in people’s everyday lives. As their diverse needs stretched my practical knowledge, I constantly researched for additional information in psychotherapy books, journal articles, the Saskatchewan health internet, and consulted with my supervisor. I looked forward to the weekly interaction with all my clients, anticipating how I could adapt aspects from the theories. It was not known until the latter part of my practicum whether the opportunity would be available to complete the entire time at Battlefords Mental Health Centre. Once that was determined, I was relieved that I could continue developing a rapport with my clients, listening to their stories, asking the pertinent questions that could lead them to critiquing their coping methods and encouraging them to create healthy goals.

As my practicum neared completion, the last step was transferring clients, with their permission, and arranging for their ongoing contact with another counselor. Each transfer meant exploring in depth the client’s needs and matching them to an appropriate counselor, keeping in mind that counselor’s availability. Paramount in the continuing care for each person was ensuring they would receive the best support possible and continue their journey to wellness.

Working within the mental health field is challenging yet many counselors and professionals continue in this field in their commitment to improve the lives of others. Engaging individuals in making better choices and assisting them to create new
directions in their lives is critical to the lives of many who arrive at the mental health centre. With sensitivity, a sense of humor, ability to project feelings of caring and commitment to clients, and skills learned from brief therapies, counselors assist clients toward solutions and goals for the future.

Factors to Consider About Mental Illness

The shame and the stigma encountered by many of those affected by mental illness can result in concealment of symptoms until their situation is at risk or uncontrollable and requiring significant intervention. Fear of the unknown and the myths associated with mental illness may jeopardize an individuals’ responsibility to themselves, thereby increasing their symptoms rather than confronting the illness. Wang, Gilman, Guardino, Christiana, Morselli, Mickelson et al (2000) summarize that the patient’s lack of knowledge of their mental health, an unwillingness to accept a mental illness, and the risk of side effects from treatment choices, contributes to a decreased ability to cope with the onset of mental illness.\textsuperscript{vi}

One in five people will be diagnosed with some form of mental disorder sometime in their lives.\textsuperscript{vi} An opportunity arises to treat mental illness more positively at that critical point before the illness progresses with persistent and dramatic changes to lifestyle (Holt & Treloar, 2008). Early intervention with medication and psychosocial support can offset the potential harm, alleviate symptoms and assist individuals to rehabilitation.\textsuperscript{viii}
Mental illnesses can be disabling and costly to the individual as well as to society when left undiagnosed. On the other hand, medication and support can enable many to cope reasonably well. In other cases, severe mental illness may arise as a result of genetic predisposition, triggered by events or body chemistry, and will require long term intervention, psychosocial support and counseling. When mental illnesses are “severe disturbances of thinking, feeling and behavior”, they are more difficult to treat and may or may not react positively to medication, resulting in losses of income, relationship breakdown and disconnection to community.

Whether the illness is a long term disability or the effects from the illness have exacerbated into a disconnection from the family and friends, losses to the person’s self esteem can be enormous. Recent studies acknowledge that family may choose to deny their relationship to a family member with a mental illness rather than endure the shame of connection to a perceived illness. In the family subsystem, Kawanishi (2006) suggests that when someone in the family is affected by mental illness, the entire social system begins to function differently, creating increased stress, conflict and blame.

There are healthy choices that can be introduced to support treatment plans as an individual begins to experience the physical and mental changes that could accompany unstable mental health (Horowitz, 2008). Self care in the form of physical exercise, relaxation therapy, calming activities or talking to friends are strategies that can assist in regaining health (Holt & Treloar, 2007).
Psychotherapy or weekly visits to a mental health counselor can assist those who are seeking to regain their health. The most important tool is self awareness as monitoring when symptoms start reoccurring can offset negative implications to long term mental health.

**Resilience and Mental Health**

Resilience is characterized as “a successful adaptation – more than survival” to significant life stressors in the face of adversity, reducing risk and increasing the value of protective inner and environmental factors. In the midst of turmoil as mental challenges arise, an inner resilience can create hope and optimism for individuals. The capacity to overcome such odds has been described by Fraser, Richman and Galinsky (1999) as a buffer as well as a suppressant against genetic and environmental risks.

Resilient individuals possess the ability within themselves to moderate a disorder and lessen the long term effects on themselves by being aware and watchful when symptoms reappear (Fraser et al., 1999; Jenson, 2007). Graziano (2008), a clinical therapist, writes that he initiates a client’s resilience by assisting them in the process of finding their own solutions and strengthening their competencies so that change can occur. Being resilient and aware of mental health issues creates a cognizance of the risks to self and a responsibility to proactively use the coping methods that maintain inner health.
Mental Health Today

Geoffrey Nelson (2006) reported that government reform has been incomplete in planning for those with moderate mental health who live in their own communities, often without consistent follow up or formal support. As long as complications are minor and symptoms can be managed within the health system and their local doctor, individuals with moderate mental health can ignore threatening symptoms and disregard the need for treatment. With the onset of recurring mental health, a safety plan may not be in place and individuals at risk to obtaining any formal supports.

Various forms of dementia fall under the parameters of mental health and can result in individuals arriving in the mental health centre who functioned previously as members of society. With age, the risk of dementia increases with five percent having a severe form and ten percent a milder version (Andreasen, 2001). Nelson (2006) identifies that transitions between systems is not easily addressed between mental health and community causing a breakdown in service delivery at the community level. Social workers network with care providers within the communities to transition those with dementia into care.

Increasingly, it has become more apparent to government as studies in different provinces report a breakdown in mental health support that the present system is failing many of those with mental illnesses. In his executive summary on mental health in Saskatchewan, John Conway (2003) reports that
mental illness is the second highest indicator of disease that results in unemployment, disability or death.

In 2007, the federal government created a Mental Health Commission to develop a national mental health strategy, initially exploring ways of eradicating stigmatization and discrimination that create barriers for those with mental illnesses. It has instilled hope that the proposed changes by the joint cooperation between provincial and federal governments will create opportunities to dispel public misconceptions, biases and identify those supports that belittle and label individuals as malfunctioning members of society (The Standing Committee on Social Affairs, Science and Technology, 2006).

For many individuals encountering an ongoing mental illness, there is a subtle yet alarming disconnection from society (Csiernik et al., 2007). The face of poverty permeates many walks of life when serious or recurring mental illness affects a person’s ability to earn a living. In reviewing current social policy, Nelson (2006) summarized that poverty, a lack of affordable housing and discrimination are all factors which further alienate those with poor mental health and may contribute to long standing illnesses that preclude them from employment and their rightful place in society.

In their research, Lauber, Nordt, Falcato and Rossler (2004) identified that the stigma experienced by those with a mental illness permeates life domains, cloaking a sense of wellbeing and ability to be independent with a decreased sense of self. The final report from the Standing Senate Committee
on Social Affairs, Science and Technology, Out of the Shadows at Last, posed the question whether stigmatization has become a polite way of justifying discrimination.

In some families, (Kawanishi, 2006) internalization of feelings about having a mentally ill family member transforms the family subsystem, requiring the unit to make adjustments that may be detrimental to the member with an illness. Those with mental illnesses have reported that the social distance between themselves and others is deliberate to intentionally ignore anyone not considered the norm, causing a breakdown in peer and family groups (Lauber et al., 2004).

The frustration about being misunderstood excluded and isolated from family and peers has adversely affected some individuals to commit acts that are uncharacteristic of them, with incarceration and a possible mental health diagnosis the unexpected result. In Lang’s (2005) study of 395 patients in primary care clinics with 199 men and 196 women, patients preferred to receive counseling for mental illness where they would receive any other type of health care, thereby avoiding any possible stigma connected to a mental illness.

Counseling Theories

A description of cognitive behavioral and solution-focused theories will include examples of each theory and the role of the counselor in assisting clients to reach their goals. As I reviewed the various theories, it became apparent that certain ones were more suited to the clients that came to the local mental health
centre. Using theories that engaged the client through feedback and a focus on positive change held promise and hope for the future. In the process of determining which theory to implement, I researched the common factors approach and found that Hubble, Duncan and Miller (1999) shared similar expectations with myself on what dynamics were important to potential clients.

**The Common Factors Approach**

The common factors approach details building a therapeutic alliance of trust, hope and mutual respect with clients that is based on Carl Rogers’ (1961) insightful approach of generating respect and acceptance to all clients (Hubble et al., 1999). Rogers (1961) identifies the need for the therapist to understand and accept how the client feels in relationship to self and the world. One of the most powerful strengths of Rogers’ theory is the assurance of hope to each client that their journey is part of the process of becoming their own person. Hubble et al. (1999) have expanded on Rogers’ (1961) early work with the development of weekly progress reports with client’s direct input, reassuring the importance of goal setting and providing feedback on personal growth.

Many therapies have been identified as successful in the mental health field, yet research has not proven the validity of any one therapy over another (Hubble et al., 1999). Frank and Frank (1991) analyzed different types of therapies and concluded that the therapeutic value of all therapies has a similar effect. Hubble et al. (1999) and Frank et al. (1991) collaborate that empathy contributes to bridging the gap between counselor and client. However, the use
of empathy by counselors may create an imbalance of power when the client’s lived experience has not been negotiated collaboratively with the counselor (Clark, 2003). Part of the social worker’s role as a counselor is to ensure that the client has been respectively heard from their own perspective. A broader concept of empathy needs to be “reconceptualized as a process of caring inquiry into the lived experience of the other, and a process of dialogically created shared understanding of the cultural and contextual meanings that shape that experience.”

In the mental health field, there is often limited time to offer assistance to individuals, sometimes only one or two sessions before contact is dissolved. During that short span, the client and counselor together will determine goals, identify what will reinforce them, and create independence for the client (Hubble et al., 1997). Cognitive behavioral and solution focused therapies were chosen as they were both brief therapies yet could be expanded to address any other identified needs. A self-monitoring tool that has been integral in teaching clients how to critique themselves as part of cognitive behavioral and solution-focused theories of development was implemented whenever clients showed a readiness for self observation.

**Cognitive behavioral Therapy**

An approach that combines philosophical, psychological, behavioral, and technological aspects of human behavior, cognitive behavioral therapy identifies thoughts, feelings and behaviors that have interfered with personal goal setting
In his study of the science of neuroplasticity, Doige (2007) reflects that cognitive therapy is based on the premise that problematic mood and anxiety states are caused by cognitive distortions that create inaccurate and exaggerated thoughts. Through clarification of thinking processes, cognitive behavioral therapy assists clients in taking positive steps to mental wellness and making lifestyle changes over time.

Learning how to cope with change is one of the most difficult goals to achieve, and for some individuals, a lifelong process. One of the two men I supported during my practicum had an unspecified personality disorder and was detached from his culture and birth family. He identified that his desire for a partner years previously had resulted in a court action followed by living in fear and shame of what he had done.

In order to avoid temptation, he lived almost reclusively, socially withdrawn from his peers and community. He wanted to make friends and find a job but his inner fears thwarted him from realizing his dreams. O’Donohue, Fisher and Hayes (2003) use shaping as a behavioral intervention to work toward a solution, incorporating other techniques to reach client goals. Through writing a letter, stating his feelings about the incident and offering apologizes, he made the first step toward believing in himself. With reassurance that he could manage his emotions successfully, he began the process of replacing negative thoughts for positive whenever he felt unsure of himself, a form of cognitive restructuring and a continuance to behavioral shaping. Practicing at home, he
utilized self talk to replace any negative thoughts, taking deep breaths as he reiterated the positive statements about himself. His ongoing goal was to decrease his anxiety and fears.

With his low self esteem, he struggled to follow through, sometimes missing his appointments and requiring reminders to return to counseling. In our last session together, he set long term goals of obtaining a job and generating friendships, visualizing how his goals could change his life. We practiced positive thinking and visualization. He agreed on homework of using deep breaths while continuing to declare positive statements about himself whenever he felt fearful or anxious. Over time, reframing of his negative thinking assisted him to look upon himself in a more realistic manner.

In an initial meeting with a retired woman, she identified that her life history included depression, an adjustment disorder, and emotional abuse that had scarred her relationship with her husband. She portrayed a deep strength of conviction yet was unable to be positive about herself. A diagnosis of bipolar disorder of her adult son created fear that her mental stability could be compromised by the stress of her son's diagnosis. As I gained her confidence, she was willing to enter into a problem-solving relationship. During the weekly sessions, she continued to demonstrate a tenacious determination, a resilience to survive, and to overcome obstacles in her thinking.

O'Donohue et al (2003) summarize the problem-solving process as steps in determining each client’s ability to process their own thoughts from a positive or
negative perspective and implement coping mechanisms to address situations that cause stress. Through goal setting of eliminating negative thoughts and creating positives in her life that would decrease her stressors, she became less critical of her husband, identifying that he had been supportive to her in creating boundaries with their son. She displayed increased confidence about decisions she was making, balancing her life with daily yoga, her love of pottery and learning to build her life based on what she felt was important to her.

She has been successful in replacing negative thoughts by using mind visualization. She told her own story of overcoming depression to her son and empowered him to connect with someone who could assist him. In order to gain a further understanding of herself and her son’s illness, she attended a mental health conference.

In reference to narrative therapy and its strength of reframing the stories of womens’ lives, Brown and Augusta-Scott (2007) portray the concept of women being intuitively guided by inner feminine goals of satisfying their family needs first and denying their own expectations. As in the example above, some of the women I served were ultimately driven by the needs of their family first, to the detriment of their own mental health. Most of the clients I have seen were women with a commonality of being in transition due to losses in relationships, changes in family dynamics, victims of abuse and a diagnosis of a mental illness. Brown and Augusta-Scott (2007) contend that as women feel unable to meet the demands of their own or societal expectations, they are likely to blame
themselves. During my practicum, women presented themselves to mental health services more often than men. In the community of the Battlefords, an increase in immigrant workers to the area has brought more women into the mental health centre.

A grieving widow with diabetes and high blood pressure had lost her husband two years ago. She was conflicted about having a new relationship, someone with heart disease. Initially she was experiencing rapid breathing, palpitations and recurring thoughts that kept her from sleeping, creating a risk to her physical health. Former coping mechanisms were not effective and she experienced panic attacks and anxiety several hours per day, resulting in anxiety, sleeplessness and depression. As she identified her feelings of anxiety, she realized she was troubled about being pressured to change her living arrangements. She felt a deep responsibility toward an adult daughter with diabetes who lived with her.

As we practiced relaxation through mind visualization, a calming exercise encouraged her to replace negative thoughts for positive. She was able to picture a favorite landscape in her mind. A month later, she was using calming activities to relax and mind visualization whenever needed. She could picture a lake in her mind with the water rolling onto the shore, the sound of the waves on the beach, and the quiet solitude. Her mind visualization of replacing negative thoughts for positive was an exercise she used just before bed to quiet her mind. A homework assignment was implemented of asking herself to
acknowledge if her negative thoughts were real or not. She has stopped worrying about her daughter through the exercise of connecting to her real thoughts and realizing that her daughter is capable of making her own decisions.

By the following week she was sleeping peacefully through the night. During our second last appointment, her story unfolded from beginning to end of how her husband became sick with cancer, shortening his life span that ended a few months later. Through the process of cognitive behavioral therapy, she was beginning to understand her feelings of guilt over her husband’s death and how these feelings had impacted on her. She recognized that her current partner’s heart problems created anxiety in her mind when she connected the parallels between her husband and her new partner. By using cognitive behavioral therapy and disputing irrational thoughts, replacing them with positive, she was able to implement a favorite positive thought of the beach and the waves tumbling in to relax herself. She continued practicing relaxation to create serenity within herself, using mind visualization at night when she had difficulty falling back to sleep. As a result, she was able to control her anxiety better, identifying for herself when something she was thinking about was not real and irrational. Throughout the process we worked on unconditional self acceptance.

Replacement of irrational beliefs proved to be very effective and eliminated the use of mind visualization. With feeling relaxed and prepared for
any changes ahead, her newest goal was to empower her daughter in checking on her own insulin levels and encourage her to see a diabetic counselor. She acknowledged that our time together had made a big difference to her in being able to talk to someone every week and cooperatively work together.

In another example of cognitive behavioral therapy, a middle aged, mentally challenged woman revealed at intake that she had been experiencing flashbacks about assaults received from her brothers during childhood. She reacted to her neighbors in a senior complex by expressing her agitation with a raised voice and telling them to leave her alone. She described the lack of support from her family, her depression, and identified that she wanted to change the way her family interacted with her. With her husband in long term care and unable to move closer to him, she was feeling isolated.

William Howatt (2000) reports that sexual abuse violates the victim by betraying boundaries with deliberate and volatile means, producing long term effects and susceptibility to other forms of abuse. My client felt emotional abuse from her family all her life as members continued to treat her with indifference and disrespect. She demonstrated resilience in coping with her mental challenges through volunteerism, listening to music and a willingness to try different things to improve her wellbeing.

As her identified goal was to connect more positively with family, the first step was writing a letter to her sisters to relate how she felt. The next step was visualizing positive thoughts about her family and replacing any negative thoughts, especially when night sweats occurred. A second goal was planning how she could change her life and bring herself closer to her husband in long term care. During feedback, she prioritized
how changes could be made and realized a plan that could bring about the desired changes. By learning to advocate for herself through identifying her inner desires, she gained increased confidence, receiving praise for whatever she accomplished. Another reinforcement of cognitive behavioral therapy was being able to talk to her doctor about a referral to a diabetic counselor.

In reviewing her goal setting and coping strategies, her letters to family had produced action for herself and she had learned to self advocate. She acknowledged that it felt good to have written the letters and to know that she had progressed to being her own advocate. She expressed feelings of relief, like a wave had passed over her, when she realized what she had accomplished for herself.

**Solution-Focused Brief Therapy**

A brief therapy that does not require extended preparation, solution-focused brief therapy focuses on goals chosen by the client. With a basic tenet of immediacy, the therapist assists the client to discuss issues or problems and examine ways that leads to solutions. A major difference between solution-focused and cognitive behavioral therapies is the duration of solution-focused sessions, usually two or three visits. The therapist is the catalyst that assists clients to articulate goals for themselves, gently leading the client to describe what is most important. Together, the therapist and client plan a strategy that will move the client toward the identified goals.

Solution-focused therapy is a positive experience for clients, with principles that build on elements that have worked before, positive exceptions, building on client strengths and the miracle question that creates a direct pathway to finding solutions.
(de Shazer, Dolar, Korman, Trepper, McCullum & Berg, 2007). With the miracle question, pointing out varying degrees of prior success reaffirms the client’s ability to overcome the obstacle.

A young woman with a history of dysthymia had been traumatized by groups of girls during her school years and had recurring dreams of trauma, of seeing the girls’ faces just prior to being physically hurt. She had tried replacing her tormentor’s faces with someone close to her but the dreams continued to haunt her. Whether she had awakened with a bad dream or being unable to relax, thoughts started racing and her dysthymia condition flared up. In solution focused therapy, the client identifies a connection to strengths and times when the person felt they were managing well (de Shazer et al., 2007). Through her rituals of exercise and expressing her spirituality, she had created a positive direction that helped her to overcome personal hurdles before. With the validation that she had the ability to connect to her strengths, she shared her previous coping strategies of playing music, talking things over with girlfriends, her mother and boyfriend. She demonstrated resilience in her determination to overcome her issues and was motivated in goal setting.

Through building a trusting relationship and providing feedback about the pain she was experiencing, my client disclosed about a rape that occurred when she was a teen and had been kept secret. Marijuana served as a means of calming and coping in the short term, masking her low self esteem and disconnection from parental and in-law relationships. When asked the miracle question, she wanted to be drug free in order to obtain a job and to have better
relationships with her in-laws and family. She was very aware that marijuana use had affected her memory and way of living. She remembered times before using drugs when she felt more enthusiastic about life and her relationships were more satisfying.

With goals of cutting back on marijuana and creating boundaries with her in-laws and family, her long term plan was to stop drugs altogether and maintain a job. The immediacy she felt about her marijuana habit and her resolution to obtain a job resulted in decreased use within a short time and success in starting a part time job. She acknowledged that it was hard to quit on her own and was willing to see an addictions counselor.

Her success in generating better relationships and respect between herself, her partner, in-laws and family, magnified her desire to continue growing as her own person. She felt that she had learned a great deal about herself and was coping better. With a transfer to an addictions counselor and her ongoing commitment, she has the opportunity to receive intervention and support integral to her continuing journey.

A middle aged First Nations female presented with depressed feelings about multiple deaths, including many suicides, in her family of origin. Recent suicides had reminded her of losses in her own family, generating negative thoughts about herself. Her marriage to a survivor of sexual abuse had ended suddenly and she became a single parent. For her, one of the strengths in the past had been her marriage. It was difficult for her to accept that he was not
coming back. In making small steps that could assist her in overcoming negative feelings, she stated a determination to keep healthy, to create art, writings, and painting as a way of expressing her losses. Her deep connection to her culture and ability to reach others through her art were identified as her strengths and resilience. With reassurance that her ongoing focus on art is a healthy outlet, her long term goal was to reinvent herself as an artist.

With acceptance that her husband was gone, she focused on the present and stated she wanted to continue being a good mother. For her children, she planned to paint a family tree with all the family names on her wall, writing a note about each member and giving paper copies to her son and daughter. In doing all these positive steps, she decided what her role would be and what she planned for the future. As our time together was very limited, she agreed to be referred to another counselor.

A twenty-two year old woman was in the mental health centre briefly. She had a history of instability in her family of origin and had been living with a boyfriend that had introduced her to the drug trade, alcohol, and the benefits of being a drug dealer. As a result of a physical disorder combined with medication and sleeplessness, she was deemed unfit to leave the centre. Asked what it would look like if a miracle happened, she expressed wanting to reauthor her own life, to make a choice to stop the drug scene, the alcohol pattern and return to schooling. The realities keeping her from her goal were issues of needing a place to live, a job, and to reconnect with mother. As she was facing issues of
loss, guilt and remorse, she was assured that her relationships could be rebuilt and we focused on the immediacy of rebuilding relationships and survival.

It was not long before she was feeling much more positive and restated her plan of stopping involvement with drugs and alcohol. She had analyzed that what she was doing in her life was not working (de Shazer et al., 2007) and had initiated one of her goals of rebuilding relationships with her mother and best friend. Resilient in her determination to succeed on her own, to find a job, her long term goal is to turn her life around through completing her education. As issues with her former boyfriend were unresolved at the time therapy ended, a referral was made to another counselor. Resolution to complete outcomes as identified may weaken and clients can choose to discontinue therapy until such time as their symptoms reappear.

Opportunities arise to assist clients that have been certified to stay on the ward for a short period of time. A woman was admitted with bruising and poor memory about an incident that had brought her to the centre. None of her three sons were close to her and her fifteen year old was verbally abusive. She had more of a relationship with her daughter and grandchild but all were distant. A relationship with her partner ended some time ago.

When asked what was important to her in the future, she wanted peace, quiet, friendship, and a sense of accomplishment as well as challenges from work. As we discussed the present and the future, she shared her love of poetry that included
posting poems on the computer. Earlier strengths and regular patterns of exercising with yoga and self relaxation had stopped since choosing alcohol.

With solution-focused therapy, it is important to concentrate on what is happening at present, linking to the future, and avoid analysis of any past dysfunctions. As a way of creating a sense of hope with someone who had been struggling to cope with the realities of her life, we talked about her goal of abstinence, keeping healthy and rebuilding a relationship with her youngest son. She rekindled former strengths of doing activities that kept her busy such as walking, accessing books from library, reading, and handiwork. She wanted to control her time on the computer and to avoid friends that drink alcohol.

It was important for her to keep working on partnerships. She imagined that her life could be richer and less stressful if her relationships were fulfilling. She was determined to stay healthy and avoid triggers that could tempt her and to recognize when she needed help. Our last visit, she stated clearly that she was determined to keep trying. With her permission, she was transferred to another therapist.

Management of mental illness

An ongoing theme that resonates within the parameters of mental health is the resilience of those who choose to self monitor, track their symptoms and change their lifestyle accordingly in order to live more positively with a mental illness or disorder. Through following a disciplined lifestyle, earlier symptoms could gradually fade over time or with monitoring, changes in wellness could be readily addressed. The empowerment of making the choice to seek professional help strengthens those who
struggle with a recurring illness to be more confident in their abilities. One of the most difficult aspects for many people is the acceptance that mental illness is a reality and that medication or time will not totally eradicate it. For those whose mental illness is debilitating, creating hope for the future is pertinent to survival. 

Through counseling and the intervention of brief therapy, many individuals have an opportunity to gain a fresh start. With a deepened understanding of themselves and increased awareness of pitfalls that have interfered with healthy living in the past, clients can rejuvenate their capacity for healthy living. With a positive view of their future through goal centered outcomes and the support of the mental health team, both new and former clients can reap long term benefits.

**Anti-oppressive Social Work Perspective**

With its emphasis on social justice, anti-oppressive social work strives to intercede with systems and governments to protect the rights of those who have little or no voice and who have been considered inferior to the status quo of the dominant society. Brown and Strega (2005) suggest that in order to deconstruct oppression of those who are labeled mentally ill, society as a whole has to be more aware that there are inequalities between those without any illness or disorder and those who are deemed mentally fit. At a time when government policy is being restricted by fiscal restraint and increased accountability, the lure of the global marketplace pushes the priorities of anyone with mental health problems to the back seat of the political agenda. Anyone with moderate mental health who experiences renewed difficulties may have lost therapeutic
relationships that have assisted them in the past. With the current system of waitlists and staffing shortfalls within mental health, moderately ill are unwilling to risk being viewed as mentally ill. Societal myths about psychiatric patients separate them philosophically from society and create fear of being discovered (Csiernik et al., 2007).

As the threat of globalization creates a smaller world, increased poverty and further marginalization of those with limited ability to earn a living will continue to rise (Dominelli, 2002). With economics and accountability being paramount to governments, services will be closely scrutinized for value to the public. In Paulo Freire’s theory of the internalization of oppression, those in power are unwilling to relinquish their status as there has to be an oppressed group in order to ensure a position of power (Mullaly, 2002). People with a mental disorder are continually shaped by the dominant group, limiting their inclusion in mainstream society, and legitimizing the status quo.

Social workers are in a position of supporting and negotiating for clients’ rights. In a quest to seek justice, we as social workers can inadvertently place ourselves in a dominant role that compromises the social work code of ethics. Both Dominelli (2002) and Mullaly (2002) caution those working with people who are viewed as oppressed to ensure priorities are clearly those of the clients and that they are empowered to make choices and trusted to carry out their own goals.
Proactive Mental Health Support

With a person centered model for wellness, prevention and access to reduce harm are cornerstones of quality care (Daniels, Carroll and Beinecke, 2009). There are similarities between the person centered and the strengths model as defined by Chopra, Hamilton, Castle, Smith, Mileshkin, Deans et al. (2009). Recovery is seen as the opportunity to build self esteem, create hope, and rebuild relationships while addressing oppression in the community and workplace. There is a connection to brief therapies such as solution-focused, building on client strengths, and cognitive behavioral approaches that are directed toward client goals.

People with anxiety and depression have learned to cope better through understanding themselves, replacing cognitive distortions over time, and living in harmony with their environment. Using brief therapy, counselors can assist clients in realizing their intuitive strengths and build on coping mechanisms that will offset the ongoing risks and challenges of life.

Conclusion

New technologies today can identify possible causes of mental illnesses, providing insight through genetics and the science of neuroimagery (Andreasen, 2001). Possibly it is a concept that fits within our society to fix those with mental illnesses and radically change them. Scientists have already started to understand how changing one area of the mind can impact significantly on another part of the brain (Andreasen,
They have also discovered that many of the diseases that result in mental illnesses have been caused by factors other than genetics (Andreasen, 2001).

When Stephen Harper, Prime Minister of Canada, addressed the nation in 2007 about the government’s plan to address stigmatization of the mentally ill through the formation of the National Mental Health Commission, he stressed that a million Canadians are fighting mental illness of some form. Are both provincial and federal governments doing enough to positively alter the lives of those affected? With the emphasis on economics and the impact of our global society, more often governments are asking that people look after themselves. If an action plan with both governments is to become a reality, reports such as “Out of the Shadows at Last” (The Standing Committee on Social Affairs, Science and Technology, 2006) must become a reality and social workers hired to reduce wait lists.

The media could be utilized to educate the public and gradually decrease the negativity that many movies and sitcoms portray about those with a mental illness. The Ministry of Health could offer advertisements on radio or television that educate about the role of counselors.

Social workers can reject the current social order and follow an anti-oppressive approach to ensure their clients are being heard and always respected for their views and goals. Individual self evaluation will determine that social work methods are open and without prejudice or bias. With advocacy, agencies and governments may respond to requests for services relevant to those who have been multiply oppressed to be served in a collaborative and meaningful manner. Social workers have been integral as
voices for those who have been oppressed, transforming issues through networking in social justice. The role of social workers in the mental health field is increasingly important yet positions are at risk of being left empty. If the impetus could be changed to an increased focus on mental wellness instead of illness, the significant steps taken to health and wellbeing in communities could become a reality.
Reference List


References


