

**Integrating Theory and Practice:
Clinical Counselling Experience at
The South East Integrated Care Center**

Development of a Practicum Report

South East Integrated Care Center

Moosomin, Saskatchewan

January 6, 2010 to April 1, 2010

A Practicum Report

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ABSTRACT

This Master of Social Work practicum report is a culmination of my clinical experiences at the South East Integrated Care Center in Moosomin, Saskatchewan from January 6, 2010 to April 1, 2010. This practicum experience is in portion of the requirements to obtain my Masters of Social Work degree from the University of Regina. During this practicum, I was able to meet my goals which included: exploring counselling theory and its application to individuals with palliative health issues; gaining an understanding of issues related to resources available to rural palliative care individuals; gaining knowledge and skills to work with a multidisciplinary team and gaining experience in group work.

The report is divided into nine sections which include ideology, values, theory, strategies, ethics, skills, relationships, practicum findings and visions. Within the practicum findings the writer will provide case examples to demonstrate knowledge and practice. The writer will also include compiled statistical information obtained through the practicum and provide overall themes of evaluation. This paper will conclude with a summarization of the benefits and learned experience gained through this practicum.

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INTRODUCTION

LIFE IS A JOURNEY

Birth is a beginning
And death is a destination
And life is a journey
From childhood to maturity
And youth to age
From innocence to awareness
And then perhaps to wisdom
From weakness to strength or
From strength to weakness
And often back again
From health to sickness
And we pray for health again
From offense to forgiveness
From loneliness to love
From joy to gratitude
From pain to compassion
From grief to understanding
From fear to faith
From defeat to defeat to defeat
Until looking backwards or ahead
We see that victory lies not
At some high point along the way
But in having made the journey
Step by step
A sacred pilgrimage
Birth is a beginning
And death a destination
And life is a journey

Author Unknown (BellaOnline, 2010).

This Master of Social Work report is a culmination of my clinical experiences within the South East Integrated Care Center (SEICC) in Moosomin, Saskatchewan from January 6, 2010 to April 1, 2010. This practicum experience is in portion of my requirements to obtain my Masters of Social Work degree from the University of Regina. Throughout this paper I will propose that although the original focus of the practicum was altered I was able to meet my goals

which included: exploring counselling theory and its application to individual's with palliative health issues; gaining an understanding of issues related to resources available to rural palliative care individuals; gaining knowledge and skills to work with a multidisciplinary team and gaining experience in group work.

The report is divided into nine sections which include ideology, values, theory, strategies, ethics, skills, relationships, practicum findings and visions. Within the practicum findings case examples will be provided to demonstrate knowledge and practice competencies. In addition, this report will also include compiled statistical information obtained through the practicum and will provide overall themes of evaluation. This paper will conclude with a summarization of the benefits and experience learned through this practicum placement.

Personal Reflection

Throughout my educational process I had been unable to identify an area of practice that encompassed my values, goals, used my abilities and strengths, and provided me with a sense of personal and professional satisfaction.

Although practicing social work within a medical social work environment was not in the realm of my educational vision, I believe that my life and the experiences I have encountered have directed me towards this area of practice. It is only in reflection of this journey that I feel I have identified an area of practice that embraces and enhances my values and abilities as a person and as a social worker.

Location

My family and I have had the opportunity to access palliative care resources within a rural setting several times during my life. My first experience with palliative care was as a seven year old. My paternal grandmother was diagnosed with terminal liver cancer and was admitted

to the hospital into palliative care. Due to my parents' decision to protect my siblings and I from my grandmother's pain and suffering, I was unable to visit her. Our only contact with my grandmother was one visual wave from a hospital window to us children waiting in the car below. In reflection, I understand my parents' decision to shield us from the effects of cancer on my grandmother but I question if this decision was made in the best interest of us as children, or in the best interest of my grandmother.

During my teenage years I volunteered as a candy striper within the hospital and experienced many similar situations to what I experienced as a child. Death and dying was a secret which should be hidden from the view of children and others. I don't recall ever seeing any children within the care ward. In later discussions with friends who had relatives pass away; few were permitted to have contact with them or even attend their funerals.

In my 30's my father became terminally ill with stomach cancer and refused to have his children with him during treatments or hospital stays. The situation only changed after my siblings and I explained to our mother that we felt isolated from him, excluded from participating in his care, and emotionally unsettled. It was only then that we were allowed to spend time and speak to our father about his illness and death. I spent two days with my father in the palliative unit and, during this time, I was allowed to process my feelings, have questions answered, and begin to understand and prepare myself for his death. In reflection, this time allowed me the opportunity to acknowledge, accept and incorporate this impending loss into my life which I was unable to do previously with my grandmother's illness and death.

I was unable to make the connection between my desire to practice social work and my personal experiences until May 2008 when my husband was diagnosed with terminal lymphoma. From the beginning I involved myself completely in all areas of his treatment. This involvement

allowed me the time and opportunity to address my concerns, process my feelings, and comprehend, not only the disease and its physical effects on my husband, but also the psychological and psychosocial affects the disease had upon our lives and the lives of our families. It became apparent to me that the area of palliative care was where I wished to make both a professional and personal contribution.

Through this experience, and in reflection of past experiences, the picture became clearer to me. I understood that the feelings I experienced, and the actions and directions that I have taken in my life, are derived from unresolved grief related to my grandmother's death; and part of the grief process related to the illnesses of my father and husband. William Worden (1991) states that, "unresolved grief can affect our whole lives, psychologically, physically and socially" (p. 18).

I believe that these personal experiences, taken together with a theoretical approach to social work, may assist others who are experiencing and making palliative decisions. My hope is that the combination of experience and knowledge that I hold may assist others in making palliative decisions that are the best for the individual but also encompass the values and beliefs they have as a family. It is only with understanding, empathy, knowledge, and discussion of death and dying that we can provide the best service to the individual and family.

Ideology

Defining "Rural"

To comprehend the scope of this clinical practicum experience at the South East Integrated Care Center it is necessary to define the term "rural".

Geographers define rural as a socially and culturally constructed phenomenon one which is often applied with reference to communities in areas that are agriculture

or resource dependent, where people identify themselves as being rural residents and where people display a lifestyle that is born from their rural identity (Castleden, Crooks, Schuurman, & Hanlon, 2010, p. 284).

In contrast, the Canadian Journal of Medicine states that “in Canada communities of up to 10,000 people are often classified as rural” (Rourke, 1997, p. 113). This writer has chosen to use the geographer’s definition of “rural” as it provides a more holistic understanding and reflects the lifestyle of the rural populace.

Importance of Palliative Care

Palliative care is increasing in importance within North America, Europe, and Canada. Since 1978, Europe’s aged population has accounted for 10% of the total population (Husebo & Dahl, 1998). It is stated that, within North America, the largest single segment of the population is aged 85 and older (Kortes-Miller, Habjan, Kelley, & Fortier, 2007). Within Canada statistical surveys have seen a tremendous growth in the aged population from 10% in 1980 to a predicted estimated rate of 130% in 2031 (Husebo & Dahl, 1998).

Within Canada, 200,000 deaths are reported annually with 75 percent attributed to individuals aged 65 and older (Kelley, 2007). It is reported that 70 percent of these deaths take place within a hospital environment or away from home, and 39% take place within long-term care facilities (Kortes-Miller et al., 2007).

The advancement of life sustaining technology has increased the life span of individuals and has contributed to a strain on palliative care services (Kelley, 2007). The strain has been experienced due to a lack of available resources, professionals and capable caregivers (Aoun, Kristjanson, Oldham, & Currow, 2008).

Rural Palliative Challenges

This practicum was performed within a rural setting and therefore the specificity of rural palliative issues needs to be addressed. Rural palliative care addresses the same concerns as found elsewhere within North America, Europe, and Canada but, primarily due to location, experiences additional challenges. The following information provides us with a basic understanding of these additional challenges:

1. Government of Canada statistics suggest that 32% of the Canadian population lives in rural areas and this segment of rural population increased to 50% within Saskatchewan. (Government of Canada, 1992).
2. A Canadian study performed by Dolan and Thien (2008) reported that the greater the distance from an urban center, the greater the increase in poorer health.
3. There is little research into the lack of resources available to rural or remote areas, or how to organize and fund the services that are available (McGrath, Holewa, & McGrath, 2007).
4. Palliative care tends to be focused in urban areas where rural participants have to travel great distances to access services. If participants are unable to travel they can't access the resources (Passik et al., 2002).
5. Psychological and psychiatric services and access to mental health are limited. These limitations are due to an insufficient number of providers who are mainly based within urban areas (Passik et al., 2002).
6. Challenges in rural health care delivery include: fewer service delivery providers, geographic isolation, transportation problems, limited funding, lack of service availability, and cultural diversity (Kelley, Sellick, & Linewich, 2003).

This writer proposes that, although a large segment of the population resides in rural areas, the issues and concerns of this population are not being researched or addressed. Available resources continue to be implemented primarily in urban areas. This lack of recognition of the concerns and issues of the rural population, along with the continued lack of available resources, have brought rural palliative care to a critical point within Canada, and especially within Saskatchewan.

Rural Definition of a Good Death

It must be recognized that rural individuals may have a different perception than urban individuals in what is seen to be a *good death*. In a recent study conducted in rural Alberta, participants identified four areas that influenced a *good death* (Wilson, 2009). This study reported that participants wished to remain in their communities to receive service, they had a strong desire to remain among their support systems of friends and community, they identified the need for more formal and informal resources, and they talked about a need for consistent and reliable services (Wilson, 2009). This writer believes that the rural identified influences of a *good death* are comparable to those wished for by all of the population despite rural or urban residency. The basis for a rural population identifying these four areas as influences of a *good death* is that, due to lack of resources, services and trained professionals, rural individuals are usually relocated to larger urban centers to receive treatment. This relocation of rural residents disconnects the client from family, friends and supports and is viewed as a negative process to death.

Practicum Description

The South East Integrated Care Center Location

The South East Integrated Care Center is located in Moosomin, Saskatchewan, on the

Trans Canada highway 8 kilometres from the Manitoba border and two hundred and seventeen kilometres from Regina. The population of this community is approximately twenty-eight hundred individuals (Government of Saskatchewan, 2005). The economic base of this area is primarily derived from farming, ranching, and potash mining. It is the experience of this practitioner that the ethnic background of the community is primarily British, Irish, Scottish, and Ukrainian descent with families having longstanding three to four generations of roots in the area.

Development of the Integrated Care Center

The South East Integrated Care Center is part of the Regina Qu'Appelle Health Region (Government of Saskatchewan, 2005). The Center was completed and opened in 2008 and has integrated and replaced the Moosomin Union Hospital, the Eastern Pioneer Lodge, and the Eastern Saskatchewan Pioneer Home. The Center also includes the Community Services Department which was originally located in a separate location (Government of Saskatchewan, 2005).

The development of this Care Center occurred through years of fundraising by the community and through provincial contributions. The Provincial Government contributed 65% of the 21 million dollars with the community raising 6.7 million dollars towards the construction of the project. The community was able to raise the funds through two local hockey games which challenged the World Guinness Book of Records for longest games played; and through raffles, memorials, and bequests (Government of Saskatchewan, 2005).

The South East Integrated Care Center has twenty-seven acute beds, fifty-eight long term beds, outpatient services, emergency care, a diagnostics laboratory, community and mental health services, physiotherapy, home care, and public health. The goals of the Care Center Board

were to have all services accessible to the public within one structure, thereby simplifying and coordinating services (Regina Qu'Appelle Health Region, 2010a).

Service Area

The South East Integrated Care Center employs seven physicians who work several days a week from satellite offices to provide service within their own community and to reduce the flow of individuals to the Center itself. The physicians cover a designated service area from Broadview (west), to the Manitoba border (east), to Tantallon (north), and to Fairlight (south) with a service population of approximately twenty-seven thousand. The current service area is a source of conflict, as individuals from outside of the service area are accessing services due to their own doctor shortages and health care facility closures. If these outside accesses are taken into consideration, the service area population then rises and is estimated at forty thousand individuals (Bearing Point Management & Technology Consultants, 2009).

Palliative Care

In designing this new facility, the community recognized a need and a desire to have palliative care designation within the Center. During the construction, contributions could be made specifically to the palliative unit to assist in purchasing special equipment such as recliners and fridges. These items were identified as features that could provide the individual, the family, and the caregiver more comfort while accessing palliative care services.

The South East Integrated Care Center has two designated palliative beds. The importance of the palliative function within the Center was also addressed by a core group of professionals who established a committee called *Hope* in order to address concerns and evaluate services provided. This Committee is not active at this point due to time limitations of the professional committee members.

Practicum Placement

Within this practicum placement, my original goals were to work specifically with rural individuals and families with palliative issues (see Appendix A). The intent was to focus on gaining clinical experience and identify the availability of resources to assist rural palliative clients and families.

It is important to note that the South East Integrated Care Center does not have a designated position for a Social Worker within any part of the Care Center. The undertaking of this practicum was not only to provide counselling and support for rural individuals and families with palliative concerns, but also to develop a process to identify a need for a designated Social Work position within the facility itself.

Practicum Development Process

Within the practicum developmental process it was identified that the course of action taken must be consistent and reflective of Social Work standards and practices. In proceeding with the officially accepted Social Work Standards of Practice (Saskatchewan Association of Social Workers, 2001) as a foundation, the development process proceeded as follows.

The initial development for this practicum began with a letter of introduction to inform all departments that a social work practitioner would be participating in a Master of Social Work practicum placement within the Facility (see Appendix B). The letter provided several points of information; it established the practitioner practicum goals, it provided available service dates, it included a referral process, and it provided a list of known available support services. This introduction provided general education and awareness to the staff as required by Social Work Standard VII to “ensure that managers and senior staff of the organization understand, support, and implement the values of the social work profession” (Saskatchewan Association of Social

Workers, 2001, p. 8).

The second stage of development was to devise a referral document that would identify the individual requesting service and provide a summarization of the concerns of the client (see Appendix C). This practitioner felt that adding the areas of required consent and goals for service were imperative to the success of the social work intervention.

The intent of this practitioner in including a consent form on the referral was that, once the referral was received, it would be immediately clear to the Social Worker if the client was in fact an active participant. As stated in the Standards of Practice document: “social workers believe the client has the ability and the right to make decisions in all areas of his/her life with the potential for positive or negative impact on their sense of physical, spiritual, and mental well-being (Saskatchewan Association of Social Workers, 2001, p. 2).

In requesting that the referral agent identify the goals of service, this practitioner proposed that, for Social Work intervention to be successful, it is important to clarify the expectations of both the staff and the client. This referral form also provided a basis for communication between Facility staff and the Social Worker (Jeffrey, 2008).

A key aspect of the practicum was to compile written resources that could be provided for palliative clients, families, and caregivers. This segment of the process was viewed as important by the practitioner and professional associate, and was also requested by the Regina Qu’Appelle Health Region in response to initiating a service that would not be sustainable upon completion of the practicum. It was believed by all professional participants that, in providing resources developed through the practicum, those clients, families, and caregivers would have general information available to them if requested (see Appendix D).

The intent of the resource development document was to provide a quick reference

guide for professionals to access for general information. The practitioner also developed resources and information that is available to address more specific needs and provide more thorough information (see Appendix E). This process is consistent with Social Work Standard 3.3.6, which states that the practitioner should provide knowledge which includes “range of services offered by different departments of government, non profit agencies, and community programs that could be accessed by families” (Saskatchewan Association of Social Workers, 2001, p. 5).

During the first month of the practicum placement referrals were slow in coming. It was identified that the physicians and nursing staff were unaware of the skills and benefits that a Social Worker could provide and therefore were unsure of what services could be offered. As a result, they did not make consistent referrals.

Alteration and Adaptation

To address the lack of referrals, a meeting was held between the Patient Care Coordinator and the Social Work student. Through discussion, it was proposed that the student change her hours of availability in order to encompass the morning debriefing of acute nursing staff. It was felt that, by adapting these hours, the practitioner would have more direct access to client status and to physicians for discussion and consultation. Therefore a request was made to broaden the spectrum of the practicum to include referrals for all clients with psychosocial issues, as well as those with palliative care needs.

It was also identified during the consultation meeting that the original referral process as proposed was too time consuming. Staff indicated that having to file a referral and forward it on to the practitioner was not time effective or efficient. Clients in the Acute Care Center may only be admitted for a short time, and in order to address the psychosocial concerns of the individual,

actions need to be taken quickly. Withdrawing from the designated referral process and adaptation to morning debriefings was in the interest of clients and provided a more efficient and effective process for identifying and addressing client needs. This change in process is in compliance with Social Work Standard VI as “social workers in health care settings will treat clients with respect and ensure the barriers to communication within and between services are minimized” (Saskatchewan Association of Social Workers, 2001, p. 7).

The impact of the practicum adaptation to incorporate attendance at the morning rounds and debriefings was immediate. During the first debriefing it was identified that a client had been admitted and was displaying signs of depression and anxiety. This practitioner had a discussion with the staff about what information and intervention could be provided, and immediately made contact with the individual. This practicum adaptation provided an environment for social work services to be delivered in a timely and efficient manner and created a more functioning interdisciplinary work environment.

This practitioner also proposes that, in altering the original practicum, the practitioner was able to increase competence through a wider range of gained experience and knowledge. As a result this practitioner addressed issues of depression, anxiety, suicidal ideation, and family conflict. These opportunities for increased knowledge were provided due to the adaptation and the slight change in practicum focus.

Social Work Competencies

As a follow up, this practitioner initiated consultations with both the Patient Care Coordinator and the Chief of Staff of the Care Center six weeks into the practicum. These discussions focused upon services noted by the practitioner that could be addressed through a social work perspective. These services included: performing mini-mental assessments,

completing depression assessments, participation within family consultations and planning processes, client discharge planning, and the provision of resource information. These consultations also met with Social Work Competency Standards which included “working with professional interdisciplinary teams within the health system and in promoting professional social work knowledge and skills” (Saskatchewan Association of Social Workers, 2001, p. 6).

It is the belief of this practitioner that, in altering the original focus of the practicum, a larger population of clients was accessed, and their needs were more adequately met. In addition, the practitioner gained a larger and more encompassing practicum experience. This alteration also assisted the Care Center in recognizing the benefits of a Social Worker on staff and demonstrated the types of services that Social Workers can provide.

Values

Personal Values of Palliative Care

This practitioner believes that death is a natural process of life; and that everything has a beginning and an end. I believe that, in treating the client, you must treat them in a holistic manner which includes physical and psychological aspects as well as spiritual and social aspects. This practitioner believes that it is imperative to the quality and success of treatment that family be involved and active within care. It is only through this co-ordination of individuals and supports that a complete plan of care can be initiated. I believe it is not only important to treat individuals as a whole, but to inform them of their options and therefore support them in the self determination of their treatment or care. It is these initiations that separate a palliative care team from a treatment team (Canadian Association of Social Workers, 2005).

I feel that I was able to offer clients an understanding of the pain and grief which they were experiencing. I acknowledged and openly shared experiences when it was appropriate and

when it was requested. A case in point was in introduction of this writer to a daughter whose father was receiving palliative care. On initial introduction the daughter displayed signs of anger and dismissed the writer stating “you don’t know what it’s like to lose a father.” This writer was empathetic to the woman and stated “I don’t know all the feelings you are experiencing but I also lost my father”. This sharing of information is consistent with a person centered approach to practice described by theorist Carl Rogers who believed that communicating the understanding of the issue to the client promotes an atmosphere of trust and allows for the client to foster change (Sharf, 1996).

Understanding Successful Interventions

It is difficult to evaluate the success of palliative interventions (Worden, 1991). Palliative care is provided through a client centered approach with an inevitable outcome. In accordance with the requirements of both the World Health Organization and Regina Qu’Appelle Health Region, therapy should be provided with a focus on quality of care while reducing stress to ensure that the transition from life to death is made easier for all (World Health Organization, 2004; Regina Health District, 2002). If success is defined within palliative care, it would be to provide the individual and family with a meaningful and quality end of life experience (Irwin, 2009).

Comparison of Palliative Care Values

The World Health Organization provides a clear outline of what palliative care is and what the expectations of such care should be. The focus of palliative care is not on a cure for the diagnosis, but on quality of life for the diagnosed individual as well as the caregiver and family (World Health Organization, 2010). Palliative care moves from a treatment approach to the provision of comfort and addresses death as a natural process in life. Palliative care seeks to

address all aspects of care as equal (Irwin, 2009).

There are a number of definitions of the term palliative care available in the literature. For the sake of this discussion, I will be utilizing the definitions used by the World Health Organization, Canadian Hospice and Regina Qu'Appelle Health Region.

World Health Organization

The term palliative care refers to the active total care of patients whose disease is not responsive to curative treatment. Control of pain and symptoms of psychological, social, and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families (World Health Organization, 2004). Palliative Care:

1. Affirms life and regards death as a normal process.
2. Neither hastens or postpones death.
3. Provides relief from pain and other symptoms.
4. Integrates the psychological and spiritual aspects of patient care.
5. Offers a support system to help patients live as actively as possible until death.
6. Offers a support system to help the family cope during the patient's illness and in their own environment (Jeffrey, 2008, p. 2).

Canadian Hospice Palliative Care Association Definition

Hospice palliative care strives to help patients and families address physical, psychological, social, spiritual, and practical issues, as well as their associated expectations, needs, hopes, and fears. Palliative care assists individuals in preparing for and managing self-determined life closure and the dying process. Palliative care also assists the individual and family in coping with loss and grief during the illness and throughout the bereavement process (Regina Health District, 2002).

Regina Qu'Appelle Health Region Philosophy of Palliative Care

The Regina Qu'Appelle Health Region's philosophy of palliative care is consistent with those visions of the World Health Organization, Canadian Hospice Palliative Care, and those of this writer. The following definitions clearly identify the expectations of the palliative team, and the Regina Qu'Appelle Health District in order to provide the best quality of life for the palliative client:

Regina Health Care Services believes that every individual has the right to participate in informed discussion about the health care resource options that may help to optimize the quality of his/her life during the course of living with a life-threatening illness, especially when dying, and to choose the best possible options based upon that information (Regina Health District, 2002, p. 1).

Palliative care strives to meet the physical, psychological, social, and spiritual needs of clients and families, with sensitivity to their personal, cultural and religious values, beliefs and practices, through client-directed supportive interventions, whether or not the client is receiving anti-disease therapy (Regina Health District, 2002, p. 1).

Regina Qu'Appelle Care Services also believes that care should be delivered in a client focused, family centered environment (Regina Health District, 2002). "It is the client's right to access information and services from an interdisciplinary team of appropriately trained professionals and volunteers, who receive continuing palliative-care education and evaluation" (Regina Health District, 2002, p. 1).

All of these definitions together have assisted me in forming my understanding of palliative care within this practicum and within this final report.

Medical Model versus Palliative Approach

There is a definite shifting of philosophical focus within palliative care from the medical model to a palliative approach. The medical model is designed as an overall approach to treat individuals who are ill with the goal of restoring clients to their original level of health (Chinook Health, 2004). The medical model treats the individual in isolation of their psychosocial and environmental factors. The focus of the medical model is on the disease and in the treatment of it. Within this approach professionals are viewed as the experts of treatment and in control of decisions in regards to treatment. This model does not meet the needs or address the issues experienced by palliative individuals and therefore a new approach was developed in order to better meet these needs (Chan, 2002; Chinook Health, 2004).

The palliative approach is a multidisciplinary team approach that establishes a working collaboration between all medical professionals and the individual. The social work practitioner's participation within the palliative team is necessary in order to provide assessment, planning, problem solving, and the provision of psychological care through relationship building, education and evaluation (Thompson, Rose, Wainwright, Matter, & Scanlan, 2001).

The palliative approach views all aspects of the individual and attempts to identify strengths within the individual and family that will assist in the treatment and comfort of the client. The palliative approach recognizes the client as the expert of their lives and encourages the individual to use that expertise to provide input and direction in all aspects and decisions of their individualized treatment (Chan, 2002; Chinook Health, 2004).

The palliative approach includes several main core components:

- Recognition of the progression of a terminal illness.
- Medical professionals need to be open and honest in a palliative diagnosis and

prognosis.

- The provision of open and forthcoming education to clients, families and caregivers.
- Recognition and incorporation of client goals, clients can bring a unique set of skills, knowledge and attitude to the situation.
- Recognition of physician's role in treatment.
- De-medicalization of end of life care.
- Recognition that the death is not a medical event but a relational and spiritual event. (Froelich, O'Connors-Rogers, & Decker, 2009, p. 5).

Importance of Psychosocial Care

The National Council for Hospice and Specialist Palliative Care Services has defined psychosocial care as care that is “concerned with the psychological and emotional wellbeing of the patient and their family and caregivers; including self esteem, insight into an adaptation to the illness and its consequences, communication, social functioning and relationships” (Jeffrey, 2008, p. 3).

Addressing psychosocial care is important to successful intervention within palliative care. Individuals experiencing a terminal illness may feel a sense of loss of control or anger towards the situation and face multiple complex medical and psychosocial issues (Jeffrey, 2008). This sense of loss of control and anger may have an effect on physical health, quality of life, and contribute to, or initiate, poor choices and decision making in regards to treatment and care (Irwin, 2009).

This writer addressed psychosocial care during the practicum by applying social work

approaches that provided support and assisted in bridging the communication between the individual, the family, and the caregivers. This writer focused on communication to identify and address concerns, feelings and provide resource support. The purpose of these initiations was to involve, inform, and improve the emotional and psychological well being of the individual, family, and caregivers to reduce fear, anxiety, and personal concerns. The goal of addressing psychosocial care issues is to reduce distress and provide the best quality of life and therefore a meaningful death (Jeffery, 2008).

Tools of Palliative Care

This writer recognizes that medical social work is based upon the theories and practices of social work. Although theory and practices provide the foundation, the practitioner should be aware of, and apply, accepted tools to assist in providing the best quality of life and care for those within palliative care (Sheafor, & Horjesi, 2003; Howatt, 2000).

Loss Lines

Griefworks is an organization founded in 1995 by Celia Ryan LISW-CP, CT. The organization provides an educational and information based web source site which specializes in grief counselling and loss. The offered education and counselling is provided through Ryan and her Master Level Health Counsellors (Griefworks, 2010).

Loss lines are based upon the premise that we all uniquely experience loss within our lives. In applying a loss line to identify the time frame and loss for the individual, the theory is that the practitioner can identify coping skills the individual used to adapt to the loss. Loss lines also assist the practitioner in identifying secondary losses that may have resulted from the initial loss (Griefworks, 2010).

Music

Another tool used within palliative care is the inclusion of music. Music has been used throughout our lives to connect us with our feelings, special events, and shared ideas. So many of our important life events are accompanied by music; nursery songs, graduations, weddings, birthdays, and funerals (Foster, 2006).

Songs are our connections to life. They connect us to our inner world; they bring us closer to others; they keep us company when we are alone. They articulate our beliefs and reaffirm our values. They arouse, they accompany and they release. And as the years pass, our songs bear witness to our lives and give voice to our experiences. They rekindle the past, reflect the present and project the future. Songs weave tales of our joys and sorrow; they express our dreams and disappointment, our fears and triumphs. They are our musical diaries, our life stories. They are sounds of our development (Bruscia, 1998; as cited in Foster, 2006, p. 2).

In 2009, a qualitative research study was performed by Lucianne MaGill through the University of Windsor, Ontario. The basis of the research was to identify the overall effects of music therapy on caregivers of advanced cancer patients (MaGill, 2009). It was found that music provided the patients and caregivers with joy, comfort, relief from distress, meaning, aesthetic beauty, and peace which improved their sense of empowerment (MaGill, 2009).

Music has also been found to have holistic therapeutic abilities as follows:

1. Physically: Induce body motions, assist with pain control.
2. Emotionally: Connection to feelings.
3. Cognitively: Increase awareness, remembrance and understanding.

4. Spiritually: May provide meaning to life (Foster, 2006, p. 3)

This writer proposes that the use of music in palliative care is a simple treatment that provides numerous benefits with no known negative effects. This writer found that the majority of families within palliative care supplied music before suggested by medical staff or this writer.

Guided Imagery

Guided imagery is a directive approach used within acute and palliative care to assist the client with relaxation, lowering of anxiety, increasing body awareness and alternative thinking. Within guided imagery the client is asked to create a positive image within their minds. This image could be a real or imagined place or person where the client finds comfort and solace. Once the client has identified a place or person the practitioner will work to maintain and increase the image through questions of, “what do you see?”, “what do you smell?”, and “what’s happening?” The purpose of guided imagery within palliative care is to provide the client with positive thoughts and provide distraction from pain and the present situation (Howatt, 2000).

Guided imagery enables the client to create a place of sanctuary that can be obtained in times when discomfort and hope may be at its lowest. Guided imagery creates discussion based on real life experience or those of imagination. Either way the image the client creates provides comfort for them and assists the practitioner in gaining a further understanding of who the client is beyond the symptoms of the illness which often define clients within a palliative setting.

Memory Journals

William Worden (1991) believes that one of the techniques of grief counselling is promoting the use of writing or drawing to assist the individual, family, or caregiver in memorializing the palliative client in booklet form. Worden (1991) explains that this creative

expression should be individualistic and should contain information of the client's birth place, childhood memories, expressed feelings, and advice. The direction and contents of the memory journal is created by the individual or family in what information and memories they wish to include. The practitioner may offer suggestions on items to include such as pictures and audio or video tapes but the choice to incorporate these items is that of the individual (Worden, 1991).

Memory journals assist the individual with leaving a legacy of their life and provide the caregiver or family with a continued connection to the individual after their death.

Relationships

Respecting Client Goals

Within the visions of both the World Health Organization and the Regina Qu'Appelle Health Region, client participation is seen as a fundamental aspect of care (Regina Health District, 2002; WHO, 2010). It is only through establishing a positive and open relationship with the client that the practitioner can achieve the social work practices of autonomy and self-determination.

The practitioner can build client relationships through recognizing that the client is the expert of their own lives and therefore is the best person to determine their lives. Although the goals of the client may differ from those of the practitioner it is paramount in client relationship building that their goals be respected and promoted.

De-medicalizing Palliative Client Care

The World Health Organization states that palliative care is a movement away from treatment of the disease to comfort and quality of life for the individual (WHO, 2004). This practitioner believes that attempts should be made to include and maintain personal aspects of the client's life, therefore reducing the medical aspect of care and be more consistent with a

palliative approach to care. These attempts build and promote trust between the client and practitioner.

Relationships with Co-workers

As discussed earlier it was evident within the first meeting that the SEICC palliative team was unaware of social work practices and what potential benefits social work could provide to clients. Through adaption and co-operation from all team members an approach was developed that provided the best environment for this writer and nurses to consult on all clients and increase their knowledge of the benefits of social work practice. This adaptation of practicum created an environment to increase the knowledge of other team members in the practices of social work but also increased the knowledge of the approaches used with other team members. In working from a collaborative approach the team members increased their knowledge and awareness of other team member's approaches and personalities.

Theory

To adequately strive to understand palliative care, we need to understand how grief plays an intricate role in the palliative experience. It is important to understand grief and to provide appropriate and effective treatment for individuals, family and caregivers. Grief is usually categorized into three areas; anticipatory grief, grief, and bereavement (National Cancer Institute, 2009).

Defining Grief

Charmaz and Milligan's (2006) definition of grief is stated as "the emotion elicited by involuntary loss ... loss gives rise to grief and the varied emotions included in grief" (p. 516).

Although Charmaz and Milligan's definition provides a basic understanding of the emotion of grief, they do not address the physical, cognitive, behavioural, social, or spiritual aspects of the

individual experiencing grief (Servaty-Seib, 2004). Due to the lack of incorporating all psychosocial aspects of the individual, theorists are unable to agree upon a unified definition (Servaty-Seib, 2004). However, theorists widely accept that grief is an individualized experience and focuses on the loss of an attachment or relationship (Charmaz, & Milligan, 2006).

Due to this inconsistency of definition, theories applied to address grief are general outlines and do not adjust for personality traits, cultural background, developmental level, nature of the relationship, mode of death, availability of support, or preceding or ongoing stressors (Servaty-Seib, 2004).

Charmaz and Milligan (2006) take the position that an understanding of grief includes the following components: (1) grief is an emotion; (2) grief consists of varied feelings, both transitory and relative enduring; (3) grief is socially shaped and controlled but individuals interpret and enact it; (4) current cultural and professional practices reduce grief to an individualized problem; and (5) contemporary definitions and debates about grief are social constructions meriting sociological scrutiny in their own right (p. 517)

Grief and Culture

Grief is similarly experienced throughout various races and cultures. The variation of grief occurs primarily due to influences of religion, socialization, rituals, manner of death, and family beliefs that accompany grief (Lobar, Youngblut, & Brooten, 2006).

Within Western culture, medical technological advancements and distancing of children has redefined the meaning of quality of life and institutionalized care. These advancements have reduced our contact with death and isolated the death event to institutional care. Western culture has allowed the care of the dying to be removed from vision, and has ensured that control be given to professional care givers (Lobar et al., 2006).

Contrary to the beliefs of Western cultures are those of Caribbean and Mexican cultures. These cultures appear to be more accepting of death due to the lack of medical technologies, frail economics, high young death rates, and strong religious foundations. Death has been accepted and incorporated into the culture of these people through art, literature, rituals, and celebrations such as Dias De Los Muentos, or Day of the Dead. It is through these cultural inclusions that these countries have socialized death (Bowman, 2000; Lobar et al., 2006).

Hispanics also have a variation of their own experience of grief. Hispanics believe it is their obligation to limit the knowledge of the seriousness of the disease to the person who is dying. Hispanic culture believes caring for the dying is their obligation and they take control of all aspects of the death (Lobar et al., 2006).

Asian culture again varies in the grieving process. Within Asian culture, grief is shared with family, friends, and people of religion. The grief is visually displayed through wearing white uniforms and wailing. Asian culture approaches death with a positive attitude and death is seen as a rebirth to a better life and is therefore celebrated (Lobar et al., 2006).

Although this is not an inclusive list of the grief processes related to all cultures it does provide examples of how culture influences the grieving process.

Grief and Psychosocial Typology of Disease

Grief may also be experienced individually depending upon the psychosocial typology of the disease. According to Davey and Ellis (2000), individual grief may be experienced depending on several factors linked to the diagnosis including:

- (1) Shame: Is the disease a socially acceptable disease such as heart disease or does it carry social stigma such as AIDS.
- (2) Lifestyle choice: Is the disease contributing to negative lifestyle choices such

- as; smoking or excessive alcohol consumption.
- (3) Communication or cognitive skills: Does the disease affect the individual's ability to communicate and actively participate in cognitive social skills.
 - (4) Information: Is there information and knowledge in regards to the disease or is it unknown, rare or contagious.
 - (5) Visual deformities: Is the disease causing visible deformities that can be viewed by others.
 - (6) Prior experience: Have the family and caregivers had prior experience with disease and treatment.
 - (7) Is the disease consistent and ongoing or intermittent in its development (p. 71).

Grief and Secondary Losses

There is some agreement that grief is associated with loss of an attachment or relationship (Charmaz & Milligan, 2006). With a primary loss it is clear why we react and feel grief; when our parent, brother, or husband is dying or has died we feel the loss of the attachment and the relationship. A secondary loss is seen as resulting from the consequences of the primary loss. Secondary losses may be individualized and create both physical and psychological concerns (Davey & Ellis, 2000).

Secondary losses are a normal part of the grieving process as family and caregivers understand the consequences and adaptations that have resulted from the primary loss. For example if a husband dies, the primary loss is the death of the attachment or relationship with the husband. The secondary losses could include the resulting changes in financial status, suddenly living alone, and changes in friendships and changes in relationships. A child of that marriage

may also experience secondary losses but differently than those of the spouse. Secondary losses for a child may include developing an awareness that the father will not be there for the birth of a grandchild, for a graduation, or to walk a daughter down the aisle on her wedding day (Davey & Ellis, 2000).

Secondary losses are not as visible and recognizable as primary losses, but can develop into complicated grief if not recognized and addressed in a timely manner (Davey & Ellis, 2000). To address secondary losses the family and caregiver have to draw upon personal, social, and cultural resources to give meaning to the loss and use these resources to incorporate the losses into their lives (Neimeyer, 1993).

Defining Anticipatory Grief

Anticipatory grief is defined as “grief experienced when a death is expected” (Alberta Health Services, 2009, p. 1). Anticipatory grief varies based on the individual characteristics, experiences, age, gender, experience of loss, meaning of relationships, and availability of resources (Charmaz & Milligan, 2006).

Anticipatory grief can include all of the physical, psychological, social, and spiritual aspects of grief and bereavement. The uniqueness of anticipatory grief is that these aspects are experienced while the individual is still living. The responses to anticipatory grief are individualistic and based upon unpredictable occurrences (National Cancer Institute, 2009; Waldrop, Milch, & Skretny, 2005). Anticipatory grief is an individualistic struggle for the client, family, and caregiver between letting go of and holding on to life (Black, 1994).

Phases of Anticipatory Grief

Anticipatory grief is a feeling of mourning that occurs for family members with the anticipated loss of a loved one or an attachment (Charmaz & Milligan, 2006). Anticipatory grief

is unique and is experienced differently within each individual at different times and at different levels of intensity. Although anticipatory grief is uniquely experienced there are some common stages that individual`s may share (Children`s Medical Center, 2010).

Commonly shared phases:

- Phase 1 (Realization) - in this initial phase the individual has come to the realization that treatment options to cure are no longer viable. The individual may experience feelings of sadness and depression at this realization (Children`s Medical Center, 2010).
- Phase 2 (Concern) - within this phase family and the palliative individual may feel there are regrets and past experiences that need to be resolved. During this stage there is an increase in anxiety and fear due to the increased attention and focus towards the palliative individual (Children`s Medical Center, 2010).
- Phase 3 (Rehearsal) - palliative individuals may start to rehearse their death and ponder what the lives of their families will be like without them. The individual may begin to plan for his/her death by making funeral arrangements or implement a Health Care Directive. During this phase individuals may start to focus more on life after death and spiritual aspects of death. The individual may also experience loss of faith as well as loss of meaning of the world and of their lives (Children`s Medical Center, 2010; Davey & Ellis, 2000).
- Phase 4 (Imagining) – this phase mostly involves family and caregivers. Discussion and thoughts will focus on what will life be like without the palliative individual (Children`s Medical Center, 2010).

Grief and Bereavement

The grief process is usually categorized into three separate areas; anticipatory grief, grief and bereavement (National Cancer Institute, 2009). This writer agrees with the view of Elizabeth Kubler-Ross who felt grief had an ebb and flow and therefore found it difficult to define into specific categories (Kubler-Ross, 1997). Therefore, this writer has chosen to categorize grief as “before death” (anticipatory grief) and “after death” (grief and bereavement). Leming and Dickinson (1997) describe “after death” grief as “emotions and behaviours to cope with the loss of companionship and the feeling that the death has initiated” (p. 206).

Grieving assists the family and caregivers in adapting to the death and assigning a new relationship to the deceased which in return will provide them with the ability to refocus on the future (Canadian Mental Health Association, 2010). It is important to note that grief is as unique as the individual’s experience and therefore the process can’t be defined as occurring in a certain amount of time (Canadian Mental Health Association, 2010). The individual may progress through the stages but they may revisit or reassess stages several times before acceptance and having the ability to move forward (Canadian Mental Health Association, 2010).

Stages of Grief and Bereavement

The initial stage of grief and bereavement occurs immediately after the death. Individuals may experience feelings of numbness or shock even if the death was anticipated. Individuals describe this stage as “sleepwalking” or “going through the motions” with an unrealistic view of what is occurring. This initial stage is varied in time frames and may last from a few weeks to several months (Canadian Mental Health Association, 2010, p. 2).

The second stage of grief and bereavement begins when the initial shock and disorientation of the death has tapered off for the individual. It is during this second stage that

physical symptoms of grief may begin to appear. Many individuals express symptoms of shortness of breath, fatigue, or stomach upset (Canadian Mental Health Association, 2010).

This second stage also enacts a period of emotional turmoil for the individual. Family and caregivers may struggle between feeling angry with the individual for dying and affecting their lives in such a significant manner, to feelings of guilt for having thought negatively towards the individual (Canadian Mental Health Association, 2010). This second stage of grief can be described as an emotional rollercoaster where emotions and attitudes towards the death of an individual vary greatly from moment to moment (Canadian Mental Health Association, 2010).

The final stage of grief and bereavement is the process of incorporating life and death. The family and caregivers have processed their feelings and have come to accept the death of the individual. Within this stage the family and caregivers have found individualistic meaning for the death. In finding meaning of death, the family and caregivers can begin the process of incorporating the death of the individual into their lives. This stage of the process is seen as one of reflection and examination. Individuals are able and willing to discuss the death and reflect upon memories and stories of the deceased. The individuals may also begin a personal process of examining their own lives and priorities (Canadian Mental Health Association, 2010).

Grief Theory and Family Responses

Grief creates an emotionally charged environment for the individual, family, and caregivers (Bowman, 2000). In practicing grief theory within palliative care it is imperative that a practitioner be aware and knowledgeable of family responses (Worden, 1991). Family and caregivers have difficulty in processing and retaining information and therefore may respond with various behavioural and emotional reactions (Waldop et al., 2005).

Six (6) Family Modes

1. Reactive: illness generates distress
2. Advocacy: vulnerability ignites assertive reaction
3. Fused: illness and decline are shared
4. Dissonant: diametrically opposed viewpoints cause struggle
5. Resignation: decline and death are anticipated
6. Closed: outward responses are impassive (Waldop et al., 2005, p. 91).

The family or caregiver may experience one or more of the emotional and behavioural responses listed above. The reactions are unique to the individual but usually are directly connected to the client's illness progression and any other unforeseen events involved with their palliative care (Waldop et al., 2005).

Positive Factors of Grief

This writer agrees with the thoughts of Frantz, Trolley and Farrell (1998) that suggest that death is an imminent and necessary part of life. Although death is a naturally ending process to life, few individuals are prepared for the death of a loved one or are willing to process the affects of grief. Grief and its individualized process is associated with change and adaptation that involve negative aspects such as; emotional and physical distress, changing social networks and economic considerations (Franz et al., 1998).

Although death is typically viewed as a negative event there are noted positive factors that arise from the ending of life (Franz et al., 1998). As stated within the grief process, the final stage of grief is that of reflection and examination (Canadian Mental Health Association, 2010). It is noted that families and caregivers use this time of grieving to support and provide compassion not only for the dying individual but for those around them (Franz et al., 1998).

Grieving families begin to establish a mutual bond with a concentration on re-establishing and solidifying family and relationships (Franz et al., 1998). The grieving family and caregivers may begin to reflect upon their own mortality and query their spirituality and take steps to improve their personal health and their spiritual connection (Franz et al., 1998).

Grief Theorists

This writer proposes that, to understand grief, we must examine some of the noted grief theorists; John Bowlby, Eric Lindmann, Elizabeth Kubler-Ross, John Schneider and William Worden. Although this is not a comprehensive examination of all grief theorists this sampling does provide an overview of the theories and beliefs of grief.

John Bowlby (1969)

The first and most well known theorist of attachment theory is British psychiatrist John Bowlby who, in 1969, developed the secure attachment theory (Howatt, 2000). Bowlby's theory suggests that all individuals have an innate need to be connected with others (Howat, 2000). Bowlby theorizes that all relationships and connections are based upon the child-parent relationship. If a child was provided with a safe and secure base, he/she will have established the foundation to develop positive and effective relationships, in the future. In developing positive and effective relationships, the individual will increase their self-confidence and autonomy (Howatt, 2000). In examining attachment theory in relation to palliative care, Bowlby suggests that the greater the perceived loss of attachment the more intense the reaction that will be displayed (Howatt, 2000).

Eric Lindmann (1942)

Grief counselling owes much of its history and development to psychiatrist and researcher Eric Lindman (Howatt, 2000). Eric Lindman's theory of grief developed from a

devastating 1942 nightclub fire which took the lives of 493 individuals. Lindman studied the reactions of survivors and family members of those who had died and concluded that death and other inevitable events cause grief which creates emotional upheaval for the individual. Through this emotional upheaval an individual learns through four stages to either master the situation or maintain the emotional upheaval creating further emotional impairment (Howatt, 2000).

Lindmann's clinical reports became the cornerstone for further grief research (Howatt, 2000).

Lindmann's Four (4) Stages of Grief include:

1. Disturbed equilibrium: stage of emotional upheaval and distress.
2. Grief work: preoccupation with the deceased.
3. Working through the grief: emotional reactions, guilt and anger.
4. Restoration of equilibrium: reducing further difficulties resulting from grief.

Elizabeth Kubler-Ross (1969)

Probably the most well-known theorist of grief is Elizabeth Kubler-Ross. Kubler-Ross was a pioneer of support and personal trauma and dedicated her life to the study of life and the transition to death. Kubler-Ross opened the doors through her research to discuss the taboo subject of death and paved the way for other theorists of grief. In 1969, Kubler-Ross created the five stages of grief which include: denial, anger, bargaining, depression, and acceptance. The five stages of grief are described through surfacing emotions of the grieving process that can occur at any time for any amount of time. These stages were instrumental in increasing awareness, understanding, and creating practices with death and dying (Kubler-Ross, 1997).

Kubler-Ross's model of grief is simple in form and the progression through the stages is seen as an individual journey with ebb and flow (1997). Kubler-Ross (1997) believed that progressing through these emotions will provide the individual with acceptance of the death

which in turn allows the individuals to heal and finally move forward in their life.

John Schneider (1984)

John Schneider's eight stages of grief also known as "the process of grieving" focuses on the transformational stages of grief and proposes that personal growth can result from the loss of an attachment (Schneider, 1984). The Schneider model is a holistic approach as it incorporates physical, cognitive, behavioural, and spiritual aspects of the individual. The Schneider Model is divided into eight stages (Schneider, 1984).

The Schneider Model of grief is as follows:

Stage 1: The initial awareness of loss: A significant change has caused a threat to the body's homeostasis. Within this stage the individual may experience numbness, shock and disorientation.

Stage 2: Attempts at limiting awareness by holding on: The individual concentrates on using energy, past coping skills and resources to limit hopelessness and despair.

Stage 3: Attempts to limiting awareness by letting go: The person recognizes the limitations to one's loss, this allows for separation from the deceased to begin.

Stage 4: Awareness of the extent of the loss: This stage is most readily known as mourning which recognizes loneliness, pain and exhaustion.

Stage 5: Gaining a perspective on the loss: This stage involves the acceptance of the loss and feelings of patience, forgiveness and peace.

Stage 6: Resolving the loss: This stage is one of goodbye and resolving unfinished business with the deceased. The individual will begin to pursue new interests and commitments.

Stage 7: Reformulating loss in the context of growth. This is the connection between identifying personal strengths and limitations and recognition of their own mortality.

Stage 8: Transforming loss into new levels of attachment: Reintegration of physical, emotional, cognitive, behavioural and spiritual aspects of the person. The individual may develop a new approach to life with a new attitude and a higher understanding of acceptance and loss (Schneider, 1984).

William Worden (1991)

William Worden's four stages of mourning has become the new generation of grief therapy (Howatt, 2000). Worden's theory recognizes the interplay of grief affecting both our psychological and physical health. These stages of mourning are based upon recognizing that the death has occurred and working through and accepting the pain and feelings involved. Worden believed that only by working through the pain can an individual progress and adjust to life without the deceased and have the ability to move forward (Worden, 1991). Worden's mourning stages include: accepting the reality of the loss, working through the pain of grief, adjusting to the environment in which the deceased is missing, and emotionally relocating the deceased and moving on with life (Worden, 1991).

Worden believed that there is no time limit for the completion of mourning and that grief may reappear within any and all aspects of the mourner's life. Completion of mourning is measured in the decrease of emotional and physical pain negatively experienced by the mourner (Worden, 1991).

Psychosocial Assessment

Although psychosocial care is widely accepted within a medical environment as important, the definition and provision of care is vague and under researched (Thompson et al., 2001). Within a palliative approach, assessments are performed to identify and then provide the best quality of care and support. The initial assessment will be medically based to address

aspects of choice in treatment, opportunity, dignity, and to identify psychological, social, and spiritual support (Jeffrey, 2008). Once the initial assessment is performed and identified, the social work practitioner will assess several aspects of the individual, family, and caregiver (Jeffrey, 2008).

Assessment Aspects

1. Meaning of the illness to the client.
2. Review client's hopes and fears.
3. Identify family issues: roles, conflicts, and family dynamics. A genogram will be beneficial.
4. Practical issues: finances, health care directives.
5. Social issues: Culture and ethnicity.
6. Strengths.
7. Coping style.
8. Other stressors.
9. Previous losses (Jeffrey, 2008, p. 7).

Assessment Scales

To assist in providing the best quality of care, this writer worked in co-operation with the client to assess the individual. This writer used measurements that were consistent with and available through the Agency (Jeffrey, 2008). The assessment scales used within this practicum were; Becks Depression Scale (see Appendix F) and Beck's Anxiety Scale (see Appendix G). This writer attempted to identify a quality of life scale used within the Regina Qu'Appelle Health Region but responses received were varied and adapted from other areas of practice or agencies.

This writer chose not to apply a measure scale that was improvised and not consistent throughout social work practice or the Regina Qu'Appelle Health Region.

Psychosocial Intervention

Psychosocial interventions are performed through applying social work approaches to provide the best quality of care to enhance the well-being, confidence, and social functioning of the client and family while reducing anxiety, depression, and stress. The goal of psychosocial interventions is to assist the individual and family with developing coping skills and provide a sense of control (Jeffrey, 2008).

This writer provided an environment that encouraged the individual or family to express their feelings and concerns. Psychosocial interventions included providing information, locating resources, and assisting in arranging practical support for legal, personal, or financial concerns. This writer also provided social intervention through liaison with Mental Health Services and other agencies to assist with appropriate support (Jeffrey, 2008).

It was essential to understand that support holds multiple meanings that require individualized attention for clients. However, in order to provide direction, it is essential to have a strategy or foundation of thought that will continue to formulate a path that remains supportive and adaptive to the needs of each client.

Strategies

Generalist Perspective

Generalist perspective as described through Sheafor and Horjesi (2003) is defined as “approaching every client and situation in a manner that is open to the use of various models, theories and techniques and will consider several levels of intervention from micro to macro” (p. 86).

This writer discovered that it is a necessity within a rural medical center to practice from a generalist perspective. It was this practitioner's experience that every individual encounter presented their own unique psychosocial concerns and issues. Therefore, this writer found that to provide the best quality of palliative care a variety of approaches, perspectives and theories were needed and applied. This writer was required to work within various client systems around the individual or family and assume various roles including advocate, mediator, and counsellor.

Assumptions and Criticisms of Generalist Perspective

Within the generalist perspective it is assumed that the practitioner will not predetermine the approach or perspective used prior to a complete assessment. In so doing this allows the practitioner to meet the individualistic requirements of the individual and not pigeonhole the client to a specific approach. This requires that the practitioner be knowledgeable and open to applying various approaches (Sheafor & Horjesi, 2003). The generalist approach also requires that the practitioner be able to adapt to the unique situations of the clients and be able to work in co-operation with various client systems, community sectors, and agencies that affect the client (Sheafor & Horjesi, 2003).

Social work theorists are divided on the effectiveness of the generalist perspective. The most important factor of the generalist perspective is that it allows the practitioner the opportunity to develop and apply approaches that are specific to the individual. However, this is also the criticism of the perspective, in that there is no specialized approach within the generalist approach and practitioners may become overwhelmed with the various systems, concerns, and agencies (Sheafor & Horjesi, 2003).

Solution Focused Brief Therapy

The concept of solution focused brief therapy is based upon the works and practices of Bateson, Jackson, and Erickson which has evolved from problem focused therapy (Sharf, 1996). Erickson believed that what maintains a problem is more important than what has caused it (Basile, 1996).

Solution based therapy is a talking therapy which has a focus on achievement of a solution and not on the problem. The practitioner will assist the individual in identifying successes and how success can be accomplished and repeated in the future (McConkey, 2002). Through co-operation, the client and practitioner will examine the strengths and resources available to the individual. Through these resources the client is asked to identify a preferred future. Solution therapy is based upon the idea that the client is in control and determines the success of the situation (McConkey, 2002).

Assumptions of Solution Focused Brief Therapy

It is assumed through solution focused therapy that the individual is the expert of their lives and therefore has the ability to identify and resolve their own concerns through their individual strength and resources. The practitioner working within solution focused therapy provides assistance with support, alternative solutions, new insight into the problem, and mobilization of the client (Collins, Jordan, & Coleman, 1999; Sheafor & Horjesi, 2003).

Key Concepts of Solution Focused Brief Therapy

There are three major concepts involved with solution focused therapy. In first addressing a situation a practitioner will ask the individual to scale their problem. This scaling assists both the individual and the practitioner in identifying the intensity or difficulty and provides a baseline of where the client is at. Solution focused therapy works to identify periods where the problem is less intense and attempts to replicate those times (Berg, 2007).

A second concept within solution focused therapy is the miracle question. The miracle question is a short direct statement asking the individual to envision their preferred future and goals (Berg, 2007). There are many versions of the miracle question but the basis is “Suppose something happened tonight while you were asleep and the problem you are having disappeared. When you awoke what would be the first thing you would notice that would begin to tell you a miracle happened?” (DeShazer, 1985).

The third concept is the coping question; questions are asked in reference to identify resources and strengths that the individual possesses to assist in developing a plan for future success and repeated success (Berg, 2007).

Ecosystem Perspective

The ecosystem perspective is a combination of Ecological theory and General Systems theory (Sheafor & Horjesi, 2003). The ecosystem perspective is the result of the work of Carol H. Meyer who believed focus of treatment should return from a person-centered to a person-environment approach (Mattaini & Meyer, 1998). Meyer believed that individuals were being treated in isolation of their environment and recognition was needed to account for the play and interrelation of the client’s environmental aspects (Kemp, Whittaker, & Tracy, 1997).

The ecosystem perspective proposes that individuals interact with their environment within specific boundaries or systems. These interactions are constantly affecting and being affected by other systems to achieve balance. The ecosystem perspective believes, due to the various interactions and systems, that there are multiple possibilities of intervention and practice models that can be applied (Sheafor & Horjesi, 2003).

The ecosystem perspective believes these interactions are constantly being affected and affecting other systems in order to achieve balance. This perspective believes there are multiple

avenues and possibilities of interventions as well as various practice models to be applied (Sheafor & Horjesi, 2003).

An ecomap is created through the co-operation of client and practitioner to identify the systems and the environmental factors. The ecomap is a visual road map that provides a holistic view of the individual's life (Mattaini & Meyers, 1998).

Crisis Intervention

Crisis intervention is to be applied to meet acute and psychological crisis (Sheafor & Horjesi, 2003). Crisis intervention is applied when the individual or family is in a time limited period of highly stressful or tragic events (Sheafor & Horjesi, 2003).

During these critical times the individual or family is unable to function and their adaptive coping skills are ineffective. The goal of crisis intervention is to cushion the impact of these events and provide support to mobilize strengths, coping skills, and resources to reduce long-term dysfunction (Sheafor & Horjesi, 2003).

The practitioner will address a crisis intervention through quick and direct response. The practitioner will be aware of limited time and focus on predisposing events and the meaning of these events to the individual or family. Once the crisis is identified the practitioner will assist in decision making with the individual or family and take appropriate action (Sheafor & Horjesi, 2003).

In 1996, Gilliard and James created a Six Step Crisis Intervention Strategy that assists the practitioner in addressing a crisis situation (Howatt, 2000).

Six (6) Step Crisis Intervention Strategy

1. Define the problem.
2. Ensure client safety.

3. Provide support.
4. Examine alternatives.
5. Make plans.
6. Obtain a commitment (Howatt, 2000, p. 187).

Although the steps remain straightforward in identifying a crisis situation, it is necessary to remember that each situation will differ. It is individual experiences that have led to a point of crisis and it is individualistic in how clients will react and what they are willing to change. It is important to note that the practitioner should review these steps with the client in order to create a sense of control and confidence in the client to effectively handle any future crisis.

Ethical Considerations

During my practicum placement I was presented with the opportunity to address several ethical issues that challenged my ethical decision making skills. In reflection of these ethical decisions, several of the ethical challenges were derived from practicing within a rural community where individuals interact on both social and professional levels. In addressing these ethical decisions I referred to the Canadian Association of Social Workers (2005) Code of Ethics for direction. There were a number of specific areas that were most relevant.

Value 5: Confidentiality in Professional Practice

“Social workers respect the importance of the trust and confidence placed in the professional relationship by the clients and members of the public” (CASW, 2005)

In providing support to those with palliative concerns this practitioner developed both professional and personal relationships with the individual and family. This practitioner proposes that within a palliative care environment, where individuals are within a vulnerable stage, it is important to develop relationships beyond a professional basis.

Through the development of these relationships information was released to this writer which included personal affairs, fears and concerns. This writer recognized that relaying this information would provide the staff and physicians with a clearer understanding of the individual but could also be determined as breaching client confidentiality. In reflecting upon the Code, this practitioner believes that relaying information received from the client to the other care team members is a breach of confidentiality unless it directly affected their care.

Care has multiple meanings depending on the position within the care team. As a social worker, there is the potential to use client information in a powerful way to affect the responses provided by others such as nurses or doctors. However, the information that clients provide to social workers should be used in a manner that enables the practitioner to provide individualized support that builds stronger trusting relationships. During times of crisis or a required period of support, it must be remembered that everyone has life events, experiences or thoughts they wish to remain private. To breach this information creates a power differential in the client practitioner relationship and further dehumanizes those who may seek support.

Value 1: Respect for the Inherent Dignity and Worth of Persons

“Social workers uphold each person’s right to self determination, consistent with that person’s capacity and the rights of others” (CASW, 2005).

This writer believes that self-determination of care and treatment is an issue within rural medical care. It was this practitioner’s experience that individuals still refer to themselves as patients and permit treatment without complete information about available options.

During this writer’s practicum experience individuals appeared to want to remain as spectators of their care and allow physicians and staff to take control and make the decisions of their treatment. This practitioner heard comments from individuals to physicians such as; “You

don't tell you how to run my business so won't tell you how to run yours" or "You're the one that understands this stuff, do what needs to be done." This writer is aware that communicating in this manner is not consistent with the palliative approach or with those of social work self-determination.

This writer encouraged all individuals to question and take an active role in receiving treatment and to initiate consultations with other physicians if necessary to understand and gain information and clarity. The responses from individuals in regards to taking an active role were; "I don't want to cause trouble" or "They know what they are doing".

Value 1: Respect for the Inherent Dignity and Worth of Persons

"Social workers respect the client's right to make choices based on voluntary, informed consent."(CASW, 2005).

This writer also struggled with issues related to client self-determination. Situations arose where this writer wanted to take control and address concerns in an immediate manner. This writer was aware of the consequences of not addressing issues in a timely and efficient manner and wanted to protect individuals and families from those situations.

This writer experienced a family in complete conflict over their father's care and treatment due to the lack of a Health Care Directive. This writer, in living within a small town, is aware of the financial hardships and family conflict that arises when a Last Will and Testament is not in place.

Value 2: Pursuit of Social Justice

"Social workers advocate for fair and equitable access to public services and benefits"(CASW, 2005).

This writer has established within this paper that both the WHO and the Regina Qu'Appelle Health Region view addressing all psychosocial issues as a major focus of palliative care. This writer, through discussions with the Chief of Staff of the SEICC, discovered that the psychosocial issues of the clients seeking service within this area were not being addressed. The reasons for this lack of service are; no designated social work position; lack of expertise; time constrictions; overloading of clients; and staff shortages. This practitioner consulted with Adult Mental Health Services and found that clients can anticipate a three month waiting list for service. In consultation with Addiction Services it was learned that a one month waiting list is required for consultation and 6-8 weeks for addiction treatment.

This practitioner views this lack of available service to address psychosocial issues as in direct conflict with the visions of palliative care stated within WHO and the Regina Qu'Appelle Health Region. Therefore, this writer initiated steps through compiling statistical information on services provided to illustrate the concerns in hopes that in the near future these psychosocial issues will be addressed in a manner consistent with those visions.

Value 6: Competency in Professional Practice

“Social workers uphold the right of clients to be offered the highest quality service possible”

(CASW, 2005).

This practitioner was aware, in undertaking this practicum, that services offered through a medical social worker would not be sustainable after practicum completion due to this Agency not having a designated funded position. This non-sustainability created ethical considerations for the practitioner. Is it ethical to provide a service, knowing the service will not be maintained? What happens to the individuals who have come to rely on the service and when withdrawn there is nothing to replace it? The practitioner struggled with the idea that she may be creating an

environment for failure. After ethical considerations, this practitioner believes that the best interest of the client was being met, and it is not the ethical concern of the practitioner to sustain a service; only to make the funding powers more aware of the lack of services.

Value 4: Integrity on Professional Practice

“Social workers demonstrate and promote the qualities of honesty, reliability, impartiality and diligence in their professional practice” (CASW, 2005).

In participating within this practicum the practitioner was aware that relationships within the community could produce conflict of interest issues for the practitioner. In rural communities, due to population size and generational relationships, the division between social and professional boundaries become blurred. It is important for the practitioner to use these relationships to establish rapport and communication but to ensure boundaries of practice are identified and maintained.

Skills

Throughout this practicum experience this practitioner was able to develop, increase, and enhance skills inherent with social work standards and practices.

Analysis

Analytic skill development was paramount within this practicum experience. As discussed, the practicum placement was not a designated position. Therefore, the practitioner had to use analytic skills in developing a process and application of service that met the needs of the clients, families, and Agency.

This practitioner also used analytic skills to compile statistical information on services provided and evaluation of services to assess the success of the services and practicum experience.

Awareness of Family Social Work

This practitioner developed family practice social work skills during the practicum placement. Family social work involves assisting the families in learning to function more competently while meeting the emotional and developmental goals of all members (Collins et al., 1999). Family social work is developed through reinforcing family strengths, education, and providing support (Collins et al., 1999).

Adaptation

As discussed earlier, adaptation was an imperative part of this practicum experience for both clients and professionals. Adaptation incorporated a generalist approach to meet the needs of the Health Center and to establish a better practice. This adaptation meets with Social Work Standards VI (Saskatchewan Association of Social Workers, 2005).

Knowledge

This writer was given the opportunity, through this practicum placement, to develop working knowledge of palliative care systems as well as those of coordinating agencies. This writer developed knowledge in the areas of planning and discharge, Home Care Services, surgical and psychiatric referrals and Oncology procedures and treatments. Enhancing and developing knowledge is consistent with Standard 4.1.3 (Competence) and Standard 7 provision 5 (Obligation of Health Care Facilities) of Social Work Practice (Saskatchewan Association of Social Workers, 2001).

Communication

Communication is imperative and the most important skill needed when addressing clients and families facing end of life decisions and death (Bowman, 2000; Howatt, 2000). It is

the belief of theorists and this practitioner that communication should be direct and open to assist the client and family in functioning well during and after death (Howatt, 2000).

The practitioner was open to the usage of tools such as ecomaps and genograms to assist in promoting and developing communication. These tools allowed the practitioner to ask open-ended questions to gather relevant information to assist in providing the best quality of service (Mattaini & Meyer, 1998).

Role of Mediator

Conflicts will arise due to choices, age, changing health teams, multitude of professions, conflicting perspectives, cultures, and death. Knowing that conflict may arise due to these factors, a social worker must be able to apply the skills of knowledge and empathy (Bowman, 2000).

It became apparent to this writer that, although a client is in palliative care, family dynamics still play an integral role in establishing and maintaining care. This practitioner found that mediation was required with several families to establish consistent and quality care.

Role of Educator

It is noted that one of the basic roles of the social worker is as an educator (Collins et al., 1999). This writer found this statement to be consistent with her experience within this medical health practicum. This writer found that working within a medical health setting the opportunity to educate is found with clients, families, and staff (Froelich et al., 2009).

This practitioner used education skills to assist clients and individuals in the following ways:

1. To increase awareness and recognition of feelings.
2. To provide information on support services.

3. To incorporate tools to adopt new skills to meet the challenges of acute and palliative care.
4. To act as a role model of support (Collins et al., 1999).

Education of the inter-professional team was paramount in the success of this practicum. As discussed earlier, the Agency was lacking awareness and knowledge of the services and potential benefits of a medical social worker. The practitioner increased the knowledge of staff through consultations, identifying services available through social work, and working as a collaborative team member. This practitioner believes the best way to educate is to work as a unit and therefore the services and benefits are relayed through practical usage.

Advocacy

The ability to advocate was paramount within this practicum experience. As noted earlier within this paper, advocating began at the onset of this practicum.

Advocacy skills were used within the following areas:

1. Identifying a need for service in a community.
2. Advocating to the University to perform a practicum in a non designated position.
3. Advocating to Regina Qu'Appelle Health Region to perform a practicum.
4. Advocating for clients and families for best quality of service.
5. Advocating of equal service to rural residents.

This practitioner views the skill of advocacy as a necessary and integral part of any social work practice.

Compilation of Statistics

In co-operation with the Saskatchewan Association of Social Works Standards, a social worker must be able to demonstrate their practice (Saskatchewan Association of Social Workers,

2001). This writer maintained written client records but also documented statistical information of all clinical sessions within this practicum experience (see Appendix I). Statistics were identified to provide this writer with an overall view of services provided for the purposes of completing the practicum master paper required by the University of Regina and to provide statistical support for the usage of SEICC to identify the need for implementation of a rural medical social worker.

Evaluation

There is often confusion in regards to what social workers do in a health care setting and questions about whether those services can be supplied by other sources such as nurses, clergy, or volunteers (Thompson et al., 2001). This practitioner believes it is this lack of awareness and knowledge of social work practice that limits and reduces the incorporation of social work practice into all medical health settings.

As stated previously, this practicum placement did not occur within a designated position. This writer chose a non designated palliative unit to promote and demonstrate the potential benefits of social work within a health setting and also to evaluate the experience (see Appendix J).

During this practicum placement this writer distributed twenty-five evaluations to acute and palliative care team members. Of the twenty-five distributed evaluations, twenty-one were returned with ratings of very good to excellent. This writer believes the number of completed returned evaluations demonstrates the desire and need for a medical social worker on staff. In reviewing the feedback from team members several common themes emerged which also substantiates the need and desire for a medical social work designated position at the SEICC.

Common Themes

- The quality of client care was positively affected by the medical social worker role.
- The additional support enabled staff to better provide quality care to clients and families.
- The psychosocial and emotional needs of clients and families were positively affected.
- The client's and family's responses to the role were very positive.
- The resources developed would be useful and would be utilized.

Practicum Findings

Throughout the course of this practicum experience I was given a number of cases that corresponded with the material located in the literature review. The following case examples exemplify the overall knowledge and experience gained throughout this practicum.

In accordance with Canadian Association of Social Worker Code of Ethics (2005) the names used within the case studies have been changed to protect the confidentiality of the individual and their family.

Importance of Psychosocial Care

This writer addressed psychosocial care during the practicum by applying social work approaches that provided support and assisted in bridging the communication between the individual, the family, and the caregivers. This writer focused on communication to identify and address concerns, feelings and provide resource support. The purpose of these initiations was to involve, inform, and improve the emotional and psychological well being of the individual, family, and caregivers to reduce fear, anxiety, and personal concerns. The goal of addressing psychosocial care issues is to reduce distress and provide the best quality of life and therefore a meaningful death (Jeffery, 2008).

Guided Imagery - Case Example

Debbie is a 54 year old female who was diagnosed palliative. Debbie was experiencing high anxiety due to the sudden onset and diagnosis of cancer. This writer had worked with Debbie for several days discussing what she liked, her fondest memories, important people, and important places in her life. This information provided the writer with information on possibilities of where to direct Debbie if she struggled to create a vision of relaxation.

Several days after admission, I approached the topic of guided imagery with Debbie. With some encouragement, Debbie participated and started to create a vision of a Hawaiian beach she and her husband had spent time on several years before. I increased the image through questions of, “What does the sand feel like?” “What do you hear?” I found that after several prompting questions Debbie began on her own to describe the vision in great detail, from the clothes she wore to the feel of the sun on her face. The session with Debbie lasted for close to an hour with her taking the lead in visually describing her safe place. I encouraged her to maintain the vision as long as she wished and the session ended with Debbie’s direction. Debbie reflected to me that this session was a wonderful way to remember a time and place that brought her so much joy and happiness. I encouraged Debbie to apply the skill at any time when her anxiety increased or to distract herself from her current situation

Respecting Client Goals - Case Example

James is a 49 year old rancher who prides himself on independence and self-reliance. He stated to this writer on several occasions “You have to look out for yourself cause no one else will”. James was admitted to palliative care with progressive cancer. James had difficulty but would dress himself daily in his jeans, cowboy shirt, cowboy boots, and hat and visit the other patients. On the fifth day of his admission James stated to the practitioner that there was no one to visit and he was heading to the bar to meet some friends and play pool. The request was

unusual and concerns were raised in regards to alcohol usage and travel arrangements. The physician stated that he could see no medical reason why James could not go out as long as alcohol was not consumed. This practitioner was concerned about travel and discussed with James who would take him and that alcohol consumption was not recommended. James's friends picked him up and returned him to the hospital six hours later, he was content and happy that he had something to do and people to talk to.

Through this example the practitioner recognized that the individual is the best person to determine their abilities and that co-operation and promoting these abilities is the best way to achieve the best quality of life for the client. This example is consistent with Social Work Standard V 1.1.3 *“discuss the benefits and any foreseeable risks with clients before a service or particular intervention strategy is agreed upon. The client has the right to refuse intervention”* and V 1.1.4 *“recommend the least intrusive psycho-social intervention available to assist in the remediation of client problems while respecting the rights of clients to self determine”*.

(Saskatchewan Association of Social Workers, 2001, p. 7).

De-medicalizing Palliative Client Care - Case Example

Bert was a 52 year old bachelor admitted to palliative care with terminal lymphoma. Bert was a farmer his entire life and thirteen years prior had acquired a stray dog. As Bert's time increased in palliative care his anxiety and depression also grew. In discussions with Bert he explained that he was worried for his “partner” Abby who was alone on the farm. This practitioner believed Bert was referring to a human in the way he spoke of Abby.

This practitioner asked Bert if someone was caring for Abby and he stated yes but “I know I'm dying and I want to say goodbye to my friend”. It is not consistent with Agency policy

to allow animals into the hospital but within the rural areas, where person-animal relationships are viewed differently, accommodations are made (Castlelden, et al., 2010).

To reduce distraction and not to promote this activity on an everyday basis, these animal visits are usually scheduled later in the evening after visiting hours and clients are settled for the evening in their rooms. Abby was brought through the back door to Bert's room where Bert's demeanour immediately changed and he began to smile and laugh with Abby. All staff left the room and permitted Bert and Abby their time alone. Bert eventually signalled for the friend who brought Abby to take her home. Although Bert was emotionally drained he stated he was content now and his anxiety was reduced.

This practitioner believes in adjusting Agency policy as necessary to one that reflects the culture and lifestyle of the individual. Through this experience Bert's physical and emotional distress was addressed without the usage of medications. Therefore, this could be seen as being the least intrusive method to promote good quality care.

This writer notes that, in providing Bert with his request, the relationship between Bert and this writer became stronger and more personal. Sessions between Bert and the writer were more open and direct following this intervention, and Bert was more willing to discuss other personal aspects of his life.

Phases of Grief - Case Example

David is a 54 yr old rancher with deep roots within the community. He was diagnosed with terminal cancer in March 2010. I was acquainted with David for several years prior to his diagnosis and admission to palliative care. In my first professional meeting with David, he was uncharacteristically quiet and reserved in his communication. David had difficulty in speaking as

he was experiencing extreme bouts of crying and long periods of quietness (anticipatory grief stages phase 1).

In visiting David over the period of two weeks it was difficult to find time to speak with him as his room was constantly filled with friends and family. During this time several of his children and friends spoke with me in regards to David's level of pain, his eating habits and his general behaviours (anticipatory grief stages phase 2).

David called me one day and asked to discuss funeral arrangements and plans he had in regards to his ranch and wife after his passing. David also became increasingly anxious about one of his grandchildren who is a child of recent divorce. David worried that this child would have the greatest difficulty with his dying and wanted to develop a plan to assist the child. I introduced David to the Child Mental Health Worker and we discussed the situation and made plans to have the child begin therapy. This plan eased the anxiety David was feeling and he stated, "At least I know I did what I could" (anticipatory grief stages phase 3).

In knowing David for several years I was aware that he had a strong faith and support from fellow worshippers. However, David had never spoken to me about his faith or religion. During our next few discussions David initiated discussions which focused on describing to me his faith and his spiritual beliefs (anticipatory grief stages phase 3).

David's youngest son, a father of two young children contacted me. Brett's concern was that his children aged 2 and 2 months would never know their grandfather. Brett felt cheated that his children would not benefit from the wisdom and time that their grandfather could provide. I encouraged Brett to work with his father to develop a memory journal or autobiography in which David could write thoughts, information, or advice to leave his grandchildren. In this way,

information could be passed on and a connection could be maintained between grandfather and grandchild (anticipatory grief stages phase 4).

Eventually, David was released from palliative care and died at home a short time later. While attending David's funeral I was taken aside by the son Brett who informed me that David had developed a memory book that described his life, his wishes for his grandchildren and stories he wanted to relate to future generations. Brett stated that the book provides great comfort to himself and to his family. Brett also informed this writer that his sister's son had also began therapy with the child and youth Social Worker and the therapy appeared to be assisting the child relate his feelings about his grandfather's death.

Due to this writer's awareness of the phases of anticipatory grief, suggestions and services were implemented in a timely manner in order to assist the clients in meeting their needs, addressing concerns and reducing anxiety.

Summarization of Theories

It is important to note the similarities between all theorists; they all provide stages or phases of grief that an individual is expected to experience. This writer believes that in providing the grieving individual with stages or phases of expected feelings and behaviours the individual is more aware and can recognize that their feelings and behaviours are not out of the ordinary realms the of normal grieving experience. Although there is no empirical evidence to support that grief is processed through stages or phases, this writer found that providing information on the stages and phases of grief did appear to provide comfort as described in the following case study.

Case Example

Marlene is a 52 year old second time widow. Marlene contacted this writer as she was

experiencing extreme feelings of depression. In meetings with Marlene, she described her state to the writer as “I feel like I’m going crazy, some days I am so damn mad at him, and on others I’m waiting for him to walk through the door.” Given that this writer was only available for one more session with Marlene, copies were provided of both Kubler-Ross’s theory of grief and Worden’s stages of mourning. At the last meeting Marlene stated, “Seeing my feelings in writing helped me understand I’m not crazy.” Although Marlene was not experiencing all of the stages or phases, the information provided her with comfort and affirmation of normal grieving experiences.

Assisting a client consists of more than opening the lines of communication. It is important for clients to have the perspective of the practitioner but also of others in the field of concern. In providing further information the clients may identify their experience with those of others. This inclusion of other perspectives may enable the client to recognize, mobilize and incorporate ways they may continue change on their own.

Generalist Perspective - Case Example

It is this writer’s experience that applying a generalist perspective is a necessity within a rural palliative setting due to the various concerns and issues within a rural setting as demonstrated in the following case study.

A referral for service was received by Adult Mental Health Services requesting a consultation. Adult Mental Health Services contacted the writer and asked for cooperation with the referral as mental health issues were noted with identified contributing factors of a palliative spouse.

Wendy is a 76 year old British Citizen who recently married Ted after 6 years in a common-law relationship. Wendy was living in Canada on a Visitor’s Visa. Wendy had been

a widow for several years before meeting Ted, and her daughter and siblings still reside in England.

Ted is a 78 year old British Immigrant who moved to Canada at the age of 70 to farm. He was recently widowed before moving to Canada with his eldest son and his wife and children.

Ted met Wendy on a return trip to England to visit family. Wendy joined Ted in Canada shortly after and they have been in a 6 year common-law relationship. Their income is derived from the farm production of grain and cattle.

In early 2008, Wendy returned to England as required by her Visitor's Visa. During her travels she became sick and was hospitalized in England for 5 months and convalesced with her daughter for 2 additional months. During this time Ted's health had deteriorated and he was unable to visit Wendy in England. Wendy was notified in October that Ted had been diagnosed with terminal brain cancer and was due to have surgery. Wendy, still weak from her illness, returned to Canada to be with him. Wendy was with Ted during and after surgery where the prognosis for Ted was palliative.

Upon returning home the following issues evolved:

1. Ted's son had Ted declared incompetent.
2. Ted's son took control of all assets and finances.
3. Ted's son declared the common-law relationship between Ted and Wendy void due to their lengthy separation.
4. Ted's health deteriorated and he was unable to leave his bed.
5. Wendy was unable to access any finances to pay for food or essentials (medication or heating of the home).
6. Ted's prognosis was a one year survival.

7. Home Care was stopped due to non-payment of service.
8. Ted and Wendy married in December 2009.

This is the point that Mental Health Services had been contacted and, together with the medical social worker, a home visit was initiated. In assessing the situation, it became apparent that a generalist approach was needed to address the individual and caregiver client systems due to numerous concerns and issues. This writer's assessment and practice follows a palliative approach with a generalist perspective.

Ted's Goal

Upon initial assessment with Ted, this writer asked Ted what his goals were. Ted identified he wished to be able to get out of bed and have a meal with his wife at their table and to be able to go onto his deck for coffee with his dog.

In attempting to meet Ted's goal this practitioner worked as a mediator between Home Care Services and Ted to provide needed services with limited financial cost. Home Care Services were co-operative and provided information and services that fell within the limited funds available.

This writer then advocated with Occupational Therapy for a lift that would allow Ted to be transferred from his bed to a wheel chair where he could meet his goals of attending meals and having access to his deck. Occupational Therapy provided a lift that was capable of transferring Ted but was difficult for Wendy to manage on her own. Further advocacy efforts for a more user friendly lift were unsuccessful. The lift necessary was unavailable on a full-time basis and required structural changes to the home and ceiling. This writer provided the information to Ted and Wendy for them to consider.

Wendy's Goal

In assessing Wendy, it was evident that she had many concerns and issues in attempting to care for Ted. The stress and depression she was experiencing was being addressed through Mental Health Services. This writer identified required support for financial, legal, and medical concerns.

This writer and Wendy prioritized the concerns and issues and came to the belief that financial concerns needed to be first addressed as they were the common factor in meeting the other issues. This writer, with Wendy's permission, contacted a local lawyer and had them consult with Wendy and Ted in regards to the declaration of incompetence, seizure of assets, and Immigration Visa. The writer also contacted a Cancer Advocate to assist Ted and Wendy with resources and information.

This writer proposes that this situation, although unique, is quite representative of the varied work and situations experienced by a rural medical social worker. A generalist approach is advantageous as it provides the practitioner with guidance but also the freedom to work in several client systems, agencies, and roles to provide the best quality care for the individual.

Solution Focused Brief Therapy - Case Example

Mel is a 42 year old transient whose last address was Alberta. Mel attended the outpatient services for assistance with fractured ribs. Mel sought out this writer and requested a meeting. In conversation with Mel he indicated that he was unhappy, depressed, and had no home or family that he was in communication with. I asked Mel on a scale of 1-10, 1 being the lowest and severely depressed and 10 being happy and content, where would he designate himself. Mel stated he was a "four". In speaking with Mel, we identified he had been a transient for the past 10 years, staying with friends and family for short periods of time. Mel admitted to

drug and alcohol addiction and had attended treatment several times during the past 10 years. Mel had left Alberta and was hitchhiking to Manitoba to attend the Union Gospel Mission.

This writer asked Mel about what he did to cope and Mel stated he had no family, no resources, no money, and no home. He relied on himself, social assistance, and handouts from people.

I asked Mel the miracle question “Suppose something happened tonight while you were asleep and the problem you are having disappeared. When you awoke what would be the first thing you would notice that would begin to tell you a miracle had happened?” Mel stated he would be at the Union Gospel Mission, he had lived there for a year several years back and while there he had a warm place to sleep, food, worked in the kitchen, and had received assistance with his addiction problems.

The Plan

Through assessing Mel this writer was able to identify that Mel was an individual who had limited resources, but had the strength of determination to attend the Union Gospel Mission. Mel also had the strength of acknowledgment that the Union Gospel Mission had been a successful environment for him where he had felt comfortable, accepted, and supported.

In developing a plan with Mel, this writer consulted with the physician who had attended Mel and found there was no medical reason for Mel not to travel but concerns were raised in regards to hitchhiking. This writer also consulted with a Social Assistance Worker and the RCMP. The writer obtained a bus ticket to Winnipeg for Mel and transportation to the bus would be provided through the RCMP. This writer also contacted the Union Gospel Mission and notified them when Mel would be arriving.

Prior to Mel leaving I asked Mel to scale his problem again using 1 as severely depressed and 10 as happy and content. Mel scored himself at a “seven”. This writer believes that using solution focused brief therapy was beneficial within Mel’s situation. The practitioner had a limited time to address Mel’s difficulties; the miracle question allowed Mel to envision his preferred future and mobilization was able to be accomplished quickly.

Criticisms of Solution Focused Brief Therapy

This writer finds that solution focused therapy provides a baseline to identify where the client is at but questions if the individual has been experiencing a problem for a long period of time, will they become trapped within the problem? Further to this, will the client be unable to identify possible strengths or solutions and therefore remain unable to create new alternatives and mobilize themselves?

Individuals are largely resistant to change and will often repeat patterns in life that are both adaptive and maladaptive. It is essential to gauge an understanding into the willingness of a client to change and why ‘this time’ is more important. Without the full co-operation of a client, change will not occur and patterns will continue to repeat.

Ecosystem Perspective - Case Example

Susan is a 54 year old married woman with two grown and married daughters. Susan was admitted for severe depression and suicidal ideation. As with most people, Susan had various environmental interactions within her systems. I asked Susan if it would be alright if I jotted down the various people and interactions she was discussing with me and in the end I would share this with her. I informed Susan that she was the expert of her life and that everything she relayed to me was of importance to devise her ecomap (see Appendix H).

The Plan

Susan was experiencing a loss of attachment due to her psychiatrist's retirement and her minister's leave of absence. She stated these individuals provided her with feedback and support on a regular basis.

Susan was informed that there were no other psychiatrists available in her area, but that she could access psychiatric services out of Regina. This was not possible for Susan as she rarely drove in the city. The alternative option for Susan was access to Mental Health Services within her home area which could be provided on a regular basis.

Susan had also identified that the loss of her minister had created concerns for her. Susan was not comfortable in attending another church so another individual within the church to assist with support was identified.

Susan also stated there was a strong interplay between herself and her daughters. The daughters had offered assistance to Susan, but Susan had refused stating, "They have their own worries and don't need mine". Through discussion Susan began to understand that the assistance offered through her daughters was made with love and concern and that she should attempt to accept their help and this would provide her with emotional support.

It was also identified that Susan felt lonely and abandoned as her husband Roy was away for work several times a week. There was no alternative to changing Roy's schedule, so adaptations for connection were made. Through confirming it with Roy, he agreed to phone nightly for a few minutes to inform Susan where he was and that all was fine. This nightly contact also provided Susan with a time where she could voice concerns and not have them build until Roy returned home on the weekend.

To address providing purpose for Susan, it was recommended medically that she remain unemployed. Susan liked to be busy and experience accomplishment, so she herself suggested

volunteering at the church where she could designate the times and availability, and still feel useful.

An ecomap can serve as a means for change because every avenue of a client's life is addressed. It is through this visual representation that both strengths and weaknesses are assessed for how they contribute to the client and current situation.

Criticisms of Ecosystem Perspective

This writer finds the ecomap extremely useful in identifying environmental difficulties and interplay. The one difficulty that this writer has noticed is that, in some situations, there are so many interactions the client becomes overwhelmed with the visual ecomap of their situation and expresses concern at the massive undertaking for change.

It is beneficial for the practitioner to clarify the process of the ripple effect and the idea that change creates other changes, so not each individual interaction will have to be addressed singularly.

This writer questions if the ecosystem perspective is an actual beneficial perspective. I find this perspective is more a tool of assistance that helps within assessment and then leaves the practitioner with the opportunity to apply a perspective based upon the ecomap assessment.

In starting where the client is at, a practitioner can build on understanding and identifying specific supports to address the remaining needs of the individual. In working together to create an ecomap with the client, an action plan can be created that works with the previous experiences of the individual but also aids in adaption to new positive changes.

Crisis Intervention - Case Example

John is a 29 yr old married man of two young sons. John presented as an emergency

admission to the Health Center for suicidal ideation. In meeting with John upon admission, he was visibly shaking and crying uncontrollably. John's sister Thelma was present and stated that John had attempted the night before to overdose on cocaine and meth. Thelma also stated that John's wife Jane had recently filed for divorce and refused to let John see his children. It was also relayed to this writer that the financial situation was unstable and bankruptcy was discussed. Thelma stated that the majority of John's problems had derived from a serious car accident three years prior that had left John disabled in one leg and with limited use of one arm. All information was confirmed with John who agreed through nodding.

John was in a safe location within the hospital and had been medically provided with a sedative. To ensure the safety of John it was requested by this writer that the sister or another family member stay with John until a plan of action could be developed. It was also established that the wife Jane and John's children would not be allowed to visit until John was stabilized. These actions were designed to reduce the physical and psychological dangers while providing direction for John and his sister. This writer also inquired if there were any other supporting individuals that were available to help John. The sister identified their mother and father and a friend of John's named Bill. The writer encouraged notification of these individuals.

This writer consulted with John for several hours communicating to him that he had many friends and family who cared for him and that he had overcome much adversity in his life. John was admitted for five days to the crisis unit and during this time the practitioner connected with John several times a day for five days.

It was discussed with John that addiction treatment was a priority. It was discovered that the wait time to attend "dry out" or addiction treatment would be approximately eight weeks. This writer, in knowing the practicum placement would soon end, wanted to establish a Mental

Health Services contact for John. It was also discovered the wait list for Adult Mental Health Services was twelve weeks long. Through discussions with John and family it was mutually agreed upon that none of the other concerns could be addressed until John was detoxified and sober.

In looking for alternatives this writer was made aware that John had worked several years with a pipeline company and his benefits were substantial. This writer contacted the insurance company to investigate the possibility of private rehabilitation. The investigation was not successful. This writer tried to make arrangements for a psychiatric consultation but there were no working psychiatrists available in the area.

The Plan

This writer consulted with John's physician and a referral was made to Wascana Rehabilitation Center in Regina. As such, John was immediately taken on case load. Through the Wascana Treatment Center John would receive psychiatric assessment, continued mental health support, and treatment for addiction. Wascana Rehabilitation Center would also supply therapeutic treatment for John's physical impairments. This writer also worked with the family to provide continued support for John and his return home. Legal contact information was provided in order to assist with bankruptcy and divorce proceedings. A referral was also made for Adult Mental Health Services within John's home community. This writer also assisted the family in filing for Disability Benefits through John's insurance company to provide an influx of money to John to assist with maintenance of his children.

Criticisms of Crisis Intervention

Although crisis intervention can be extremely successful for individuals, this writer acknowledges that success is dependent upon the individual's want and willingness for change, strength of strong support systems, and available resources.

Confidentiality in Professional Practice - Case Example

Albert is a 62 year old divorced father of three daughters and two sons. Albert was admitted for spinal surgery that resulted in him becoming a quadriplegic. This writer was initially addressing concerns of anxiety and depression due to the results of Albert's surgery. Through these discussions Albert relayed to this writer that his two sons had not been involved in Albert's life for several years due to personal and financial conflict. Although this information may have assisted the physicians and discharge committee with a more comprehensive plan for after care supports it was felt that the information if released should be provided through Albert or the daughters.

Respect for the Inherent Dignity and Worth of Persons - Case Example

Don was a 48 year old husband and father of two school-aged children. Don was admitted into palliative care with an extremely short life expectancy. In speaking to Don and his wife Bernice it was identified that Don did not have a personal Will or a Health Care Directive. This practitioner explained to Don and Bernice the importance of having legal documentation in regards to personal affairs and designated medical treatment. Although the importance of the situation was explained, this practitioner was met with resistance "I can't get to a lawyer" or "Bernice knows what needs to be done". This practitioner offered the name of a lawyer who provides assistance to hospitalized clients. This suggestion was also met with resistance and frustration towards the practitioner. It was then that this practitioner had to draw back from the situation and allow Don and Bernice to manage their own affairs in the way they saw fit.

Integrity on Professional Practice - Case Example

Mary is 86 and was a neighbour and friend of this practitioner since childhood. This practitioner discovered that her relationship with Mary and her family created numerous expectations for the practitioner. Mary and her family requested that the practitioner be with the family during all physician consultations, the family requested the practitioner “check on Mary” at times when the family was not available, and that the practitioner report to the family any concerns of care. This practitioner explained to Mary and the family that Mary was receiving the best care possible and the practitioner believed it was unethical to report back to the family on daily activities. The practitioner believes the expectations were understandable in view of the relationship and rural environment but limits of professional and ethical boundaries have to be established and maintained.

Mediator - Case Example

Bob is a 67 year old father and husband who was admitted to palliative care directly from his home. Bob had been ill for several months but the diagnosis and prognosis was a complete shock to Bob, his wife and family. Upon admission Bob was placed in palliative care but due to bed shortages Bob was relocated to Long Term Care the next day. This relocation to another unit caused distress and confusion for the family as they did not comprehend if Bob was palliative or long term. Due to this confusion, Bob’s children became quite irritated and demanded their father receive a second opinion on his condition. The children became suspicious of staff and made requests inconsistent with Agency mandates. This conflict between family and staff was creating an increasingly stressful environment for Bob and his wife.

This writer consulted with Bob’s wife and children and asked them about their concerns

and if they could write them down in point form. The practitioner clarified the relocation situation and provided them with a written diagnosis report from the physician stating Bob's condition. The practitioner then consulted with nursing staff to address other concerns stated by the family.

To conclude, this practitioner reported to the Agency that mediation was successful and both family and Agency had resolved the conflicts noted. Mediation was required due to lack of information and communication between Agency and family.

Understanding Your Team Boundaries

This writer also believes that, although this was an educational experience for the members of the SEICC team in regards to social work benefits and practices, it was also a learning experience for this writer. Through participation within nurse's briefings, physician consultations, and consultations with home care personnel and administration, this writer began to understand the roles and relationships that are established within a multidisciplinary team. Although it is classified as a palliative team approach there are specific roles and skills assigned to each member. Through understanding and becoming aware of individual team roles this writer began to understand the connection and fluidity between professions to implement the palliative approach.

The palliative approach incorporates the skills of each team member but boundaries of professions are established. For example; this practitioner would not offer comment or advice in regards to medication or physical symptoms. The palliative approach is a collaboration of various professions with professional understanding and boundaries to provide the client with the best quality of life. This understanding and awareness is consistent with Social Work Standard IV, 2.1 *"The limits of professional competence, and transfer cases that are beyond the level of*

expertise, experience, or personal ability of social workers to manage” (Saskatchewan Association of Social Workers, 2001, p. 6).

Visions

Personal Visions

As I have identified within the introduction to this report, it was difficult for me throughout my education and work experience to identify an area of practice that matched with my personal and professional values. In reflection, I believe that my life experiences have directed me towards medical social work. It is within this environment that I find great personal and professional satisfaction.

These feelings of both personal and professional satisfaction have been met in the following ways; I was able to work and assist individuals in need in my own community, and professional and client feedback was positive reaffirming my belief that medical social work was needed within the Care Center and community.

Although I have supplied the Regina Qu’Appelle Health Region with statistical information and evaluation results of the practicum experience, at this time there is no funding designated to provide a medical social worker to the Health Care Center.

It is the hope of this writer that the Regina Qu’Appelle Health Region will recognize the need for a medical social worker and provide consistent services that reflect the philosophy of the Region. Until then, this writer will continue to advocate for those needing social work services and continue my education through specialization into the area of Oncology.

Social Work Visions and Social Change

This writer believes there are three main areas of social concern that will directly affect

medical social work and how the services of social work are applied. The first social concern is that of our increasing aged population. This writer identified that throughout Canada, North America, and Europe the population aged sixty-five and older is increasing at an alarming rate (Husebo & Dahl, 1998). This specific population increase has caused concern for all people despite, age, location, gender, ethnicity, or economic standing. This is a global issue with global concerns (Husebo & Dahl, 1998).

The second social concern is that of the direct correlation between the increase in the aging population and the lack of available resources. As this specific segment of the population increases there is a significant strain felt on the resources available. All resources are affected from a strain on government funding due to an increased lack of professionals and caregivers available to provide service to this population (McGrath et al., 2007).

The third social concern is the apparent viewed lack of value in addressing or providing psychosocial services to this population. This writer proposes that, due to this lack of recognition of addressing psychosocial issues of this population, individuals are not receiving the best quality of care, and are therefore not experiencing the best quality of life (Passik et al., 2002).

This lack of recognition, or addressing of concerns, is in direct conflict with the visions of the World Health Organization, Canadian Hospice Palliative Care Association, and the Regina Qu'Appelle Health Region. All three organizations state, through their philosophy or visions, that psychosocial issues will be addressed equally with physical issues (Regina Health District, 2002; WHO, 2010).

This practitioner believes that, as the aging population continues to increase and the availability as well as quality of resources decreases, a social revolution of health care will take place. It is through this social revolution that this writer proposes that social work will be

ethically driven to take a leading role in addressing the concerns of this population and meet the increasing needs of this country. Social work will be instrumental in providing information and education to the Government and the public. Social work will also become a strong advocate for equal and fair distribution of available resources to meet the new needs of the population.

Social Work Ethics Value 2: *“Social workers uphold the right of people to have access to resources to meet basic human needs. Social workers advocate for equal treatment & protection under the law and challenge injustices, especially injustices that affect the vulnerable and disadvantaged. Social workers promote social development and environmental management in the interest of all people.”* (Canadian Association of Social Workers, 2005).

CONCLUSION

I found this practicum placement within the South East Integrated Care Center to be a positive and empowering experience. I believe I had the opportunity in a very limited time to encounter a wide variety of psychosocial issues that are presented within a rural medical health setting on a regular basis. This variety of issues has provided me with a larger knowledge base than expected and a better understanding of generalist social work practice.

This practicum experience within the South East Integrated Care Center allowed me to comprehend the importance and necessity of palliative care within a community. Through this awareness I was able to gain a better understanding of grief, bereavement and response to loss. This awareness allowed me to enhance my theoretical skills through applying various social work models and perspectives to meet the individual concerns and issues of the clients, the families, and the caregivers.

I believe this practicum experience also provided me with several unexpected benefits. This experience provided me with the opportunity to reconnect with my community through a

professional role, reflect upon my personal values of life and death, and presented an area of practice that met both my personal and professional values and goals.

In closing, I would like to share a prayer that I feel demonstrates the impact of grief and bereavement and reflects the beliefs of palliative care.

We remember them
In the rising of the sun and in its going down,
We remember them;
In the blowing of the wind and in the chill of winter,
We remember them;
In the rustling of the leaves and the beauty of autumn,
We remember them;
When we are lost and sick at heart,
We remember them;
When we have joys we yearn to share,
We remember them;
So long as we live, they too shall live,
For they are now part of us
We remember them.

From Gates of Prayer, Reform Judaism Prayerbook
Source: Remembering With Love (Levang, & Ilse, 1992)

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Proposal for Master of Social Work Practicum

Student Name: Marnie McMullen (BSW, RSW)
Program of Study: Master of Social Work (MSW)

Academic Supervisor: Nuelle Novik (MSW, PhD, RSW)
Academic Committee Member: Miguel Sanchez (MSW, PhD)

Professional Associate: Sandra Dobra (MSW, RSW)
Practicum Setting: South East Integrated Care Center
Moosomin, Saskatchewan

Period of Practicum: January 2010 to April 2010

Practicum Objectives: The purpose of this practicum is to gain graduate level social work counselling skills and knowledge of rural palliative health care issues and relevant resources.

Learning Goals:

1. To explore counselling theory and its application to individuals with palliative health care issues.
 - Gain an understanding of one or two counselling approaches and apply them to individuals and families with palliative health issues.
 - Identify and explore the counselling approach used in the agency.
 - Increase knowledge and application of strengths based counselling approach.
 - Completion of a literature review with a focus on both theories under examination and study.
 - Both theories would be applied while working with clients.
2. To gain an understanding of issues related to and resources available to rural palliative care individuals.
 - Examine the common concerns and stressors experienced by individuals with palliative care issues.
 - Research the availability of assistance and resources for rural palliative care individuals.
 - Explore the role of the rural medical social worker in regards to palliative care services.
3. To gain knowledge and skills required to work within a multidisciplinary team.
 - Work collaboratively with other professionals who provide palliative care services.
4. To gain experience with group work
 - Research group work as relevant to rural palliative health care.
 - Assist with the planning and facilitation of rural palliative care groups.

MEMO

Referrals accepted from January 12, 2010 - April 2, 2010

TO: Sharon Wood – Facility Manager (SEICC)
 Dr. E. Crouse, Dr. R. Kerkhoff, Dr.M. Plewes, Dr. E. Roets, Dr. W. Roets,
 Dr. S. VanderMerwe, Dr. M. VanJaarsveld
 Shelley Taylor – Patient Care Coordinator (SEICC)
 Celine Stolz – Care Coordinator – Moosomin Home Care

FROM: Sandra Dobra

RE: STUDENT PRACTICUM – PALLIATIVE CARE

Marnie McMullen, Master of Social Work candidate (University of Regina) will be doing a practicum at the South East Integrated Care Centre from January to mid April, 2010.

Her goals include:

- Gaining knowledge and skills in individual and family counselling in relation to palliative care/oncology.
- Facilitating the use of community resources relating to palliative care and developing relevant educational and resource materials which will be sustainable after the practicum.

Marnie is accepting referrals from Jan. 12 – April 2, 2010. Referrals will be accepted from Moosomin Family Practice Center, Shelley Taylor (Patient Care Coordinator), Home Care (Moosomin area), and Mental Health. Referrals will be prioritized according to level of distress. A referral form is attached.

Support and information could include:

- Palliative resource counselling (including caregiving resources, financial aid and legal issues, advance health care directives)
- Client advocacy
- Palliative care information and education
- Individual and family counselling relating to psychosocial and emotional needs, anticipatory grief and bereavement (**counselling will be time limited due to the practicum time limitation of three months**).

At the end of the project, we will no longer have the availability to refer clients but we will have access to the resources developed. Marnie will be working out of the Community Services Area. She may be reached at **435-6277**. Fax number: **435-2386**. As Practicum Supervisor in the Faculty of Graduate Studies and Research, I will be providing supervision to Marnie. Please join me in welcoming Marnie as she volunteers her time towards this learning experience.

Sandra Dobra, M.S.W., R.S.W.

Enc. (1)

c.c: Heather Dorgan/Blair Sirup DATE: 24 March 2010

**REFERRAL FOR PALLIATIVE CARE SOCIAL WORK
MARNIE MCMULLEN – STUDENT PRACTICUM
(UNIVERSITY OF REGINA)**

REGINA-QU'APPELLE HEALTH REGION

Date: _____ HSN: _____ D.O.B.: _____

Name: _____

Address: _____ Ph. No. _____

_____ Postal Code _____

Next of Kin: _____

Referral Source: _____

Relevant Information/Diagnosis/Presenting Problems:

Consent: _____

Goal For Services Requested: _____

**SOUTH EAST INTEGRATED CARE CENTER
PALLIATIVE RESOURCE QUICK REFERENCE**

✓ **Children and Palliative Care**

Presentation Resource
Marj Phenix
Children and Grief
Gordon F Kelly School
Carlyle, Sask
SOC ORO

Children's Wish Foundation
www.childrenswish.ca

✓ **Financial Information**

Canada Pension Plan Benefits: <http://www.hrsdc.gc.ca>

Includes: Canada Employment Benefit
Caregiver Benefit

Palliative Care Coverage: <http://www.health.gov.sk.ca/pspalliativecare.html>

✓ **Professional Aids:**

www.pallium.ca The palliative pocketbook the palliative project

✓ **First Nations**

Fort Qu'Appelle Healing Center:

Karen Schmidt

kschmidt@fhqtc.com

All Nations Healing Hospital website <http://www.fortquappelle.com>

National Forum Cancer Control for First Nations Inuit and Metis in Saskatchewan

Cheryl Whiting

Cheryl.whiting@saskcancer.ca

✓ **Funeral Planning**

Organ donation - Saskatchewan Transplant Program

St Paul's Hospital

1702-20th Street West

Saskatoon, Saskatchewan

S7M 0Z9

306-655-5054

Cremation - <http://www.virtualhospice.ca>

✓ **Funeral Homes and Planning**

Carscadden G. R. Funeral Chapel
Wawota, Sask
739-2992

Carscadden Funeral Chapel
Moosomin, Sask
435-2513

Matthews Funeral Home
Whitewood, Sask
735-2335

Peter Carscadden Funeral service
Esterhazy, Sask
745-3304

✓ **Grief Centers And Support Groups**

Canadian Hospice and Palliative Care Association
www.healingjourney.ca

Cancer Advocate
1-800-939-3333
www.cancer.ca

Greystone Bereavement Center
Conexus Resource Library and Grief Support Groups
Contact Marlene Jackson
766-6947
Regina, Sask

Sask Palliative Care Association
766-2300
Sandra Hubenyk
<http://www.saskpalliativecare.org>

✓ **Informational Websites:**

Allan Blair Center: <http://www.saskcancer.ca/allan-blair-cancer-center.aspx>
Alan. D. Wolfelt Center for Loss and Life Transition: www.centerforloss.com
Alzheimer Society of Canada: www.alzheimer.ca

Canadian Hospice Palliative Care Association: <http://www.chpca.net>
Canadian Network of Palliative Care for Children: <http://www.cnpsc.ca>
Canadian Virtual Hospice <http://www.virtualhospice.ca>
Cancer recovery Foundation of Canada: 1-866-753-0303

Dougy Center for Bereaved families: www.dougy.org
Dr. Bill Webster: griefworks.com

Health Canada <http://www.health.gc.ca>
Hope Air, tickets for medical travel: West Jet: www.hopeair.org
Hospice Foundation of America: <http://www.hospicefoundation.org>

Griefworks <http://www.griefworksbc.com>
Griefworks Chat line: (604-875-2741)

Lou Gehrig's disease: www.alsa.org

National Cancer Institute <http://www.cancer.gov/cancer>

Public and Guardian Trustee <http://www.pgt.gov.sk.ca>

Sask Transportation Company (medical travel) 1-800-663-7181
Services for the blind: www.cnib.ca

Virtual Hospice: www.virtualhospice.ca

Youngwidow.com: Online support/groups/books and resources

✓ **Legal Information**

Public Legal Information for Everyone
Saskatoon, Saskatchewan
(306) 653-1868 or fax (306) 653-1869
email: plea@plea.org

✓ **Music**

<http://www.gracefulpassages.com>

✓ **Professional Aids**

The palliative pocketbook the palliative project: www.pallium.ca

✓ **Professional Education**

Cancer Education Webinar
Sponsored by
Sask Cancer Agency and Cancer Care Manitoba.
Series@yourside.ca

✓ **Self Help Books**

***Note that the Book and Brier Patch offers discount to palliative clients and families.**

1. A Friend In Hope
- 2005
2. A Grief Observed
- C.S. Lewis
3. A Terrible Thing Has Happened
- 2000 - ISBN: 1-55798-701-7
4. Badgers Parting Gifts
- 1984 - ISBN: 0-00-662398-0
5. Blessed Grieving
- 1994 - ISBN: 0-88489-304-9
6. Chester Raccoon And The Acorn Full Of
- 1992 - ISBN: 1-878076-12-4
7. Chicken Soup For The Grieving Soul
- 2003 - ISBN: 1-55874-902-3
8. Crazy Sexy Cancer Tips
- 2007 - ISBN: 1-59921-231-9
9. Creative Interventions For Bereaved Children
- Liana Lowenstern
10. Death In A Nutshell
- 2005 - ISBN: 1-84507-277-3
11. Death: The Final Stage Of Growth
- 1975 - ISBN: 0-671-62238-2
12. Dying Well
- 1997 - ISBN: 1-57322-657-2

13. Emma's Question
- 2009 - ISBN: 1-58089-145-5
14. Father Loss
- 2001 - ISBN: 0-7868-8449
15. Final Journey's
- 2008 - ISBN: 0-553-38122-1
16. Final Gifts
- 2008 - ISBN: 0-553-37876-4
17. Finding The Right Words
- Wilfred Bockelman
18. For One More Day
- Mitch Albom
19. For Parents And Teenagers
- 2002 - ISBN: 0-06-000799-7
20. Gentle Willow
- 2004 - ISBN: 1-59147-072-4
21. Good Grief
- Ganger Westberg
22. Grandpa's Boat
- 2008 - ISBN: 1-84270-755-5
23. How To Survive The Loss Of A Parent
- 1993 - ISBN: 0-688-13791-1
24. I Don't Know What To Say: How To Help And Support Someone Who Is Dying
- Dr. Robert Buckman, 2005 - ISBN: 1-55263-696-8
25. I Miss You: A First Look At Death
- 2001 - ISBN: 0-7641-1764-0
26. I Tell You A Mystery: Life, Death And Eternity
- Joan Christoph Arnold, 1996 - ISBN: 0-87486-083-0
27. Language Of The Heart: Rituals, Stories And Information About Death
- Carolyn Pogue, 1998 - ISBN: 1-896836-17-8

28. Lifetimes: A Beautiful Way To Explain Death To Children
 - 1983 - ISBN: 0-553-34402-1
29. Living With Grief
 - 2007 - ISBN: 1-893349-08-7
30. Love You Forever
 - 2008 - ISBN: 0-920668-37-5
31. May I Walk You Home: Courage And Comfort For Caregivers Of The Very Ill
 - Joyce Hutchinson, 1999 - ISBN: 0-87793-670-6
32. Meditations for the terminally ill and their families
 - Judy Osgood, 1989 - ISBN: 0-916895-05-x
33. Memories
 - 2009 - ISBN: 1-933718-29-3
34. Moonshadows Journey
 - 2009 - ISBN: 0-8075-5273-5
35. Nothing Left Unsaid
 - 2001 - ISBN: 1-57324-565-8
36. One You Love Is Dying: 12 Thoughts To Guide You On The Journey
 - James Miller, 1997 - ISBN: 1-885933-23-1
37. Parting: A Handbook For Spiritual Care Near The End Of Life
 - Jennifer Sutton Holder, & Joan Aldredge Clanton, 2004
 - ISBN: 0-978-1-55455-087-6
38. Sam's Story
 - 1988 - ISBN: 0-921450-00-1
39. Saying Goodbye
 - 1992 - ISBN: 1-878076-12-4
40. Step Into The Light
41. The Art Of Dying: Honouring And Celebrating Life's Passages
 - Salli Rasberry, & Carole Rae Watanabe, 1989
42. The Fall Of Freddy The Leaf
 - 1982 - ISBN: 0-943432-89-2

43. The Invisible String
- 2000 - ISBN: 0-87516-734-3
44. The Last Gifts
- 2008 - ISBN: 0-7407-7704-2
45. The Last Lecture
- 2008 - ISBN: 1-4013-2325-7
46. The Needs Of The Dying: A Guide For Bringing Hope, Comfort And Love To Life's
Final Chapter
- David Kessler, 2007 - ISBN: 978-0-06113759-4
47. The Next Place
- 1997 - ISBN: 0-931674-32-7
48. The Problem With Hair
- 1996 - ISBN: 1-56123-009-5
49. The Purple Balloon
- 2007 - ISBN: 0-375-84146-0
50. Tuesdays With Morrie
- 2007 - ISBN: 0-7679-0592-3
51. What Cancer Cannot Do
- 2006 - ISBN: 0-310-81184-8
52. When Dinosaurs Die
- 1996 - ISBN: 0-316-11955-9
53. What Dying People Want: Practical Wisdom For The End Of Life
- Dr. David Kull, 2004 - ISBN 0-385-65883-4
54. What's Heaven
- 1999
55. When A Parent Is Sick: Helping Parent's Explain Serious Illness To Children
- Joan Hamilton
56. When Someone Very Serious Illness
- 1991 - ISBN: 0-09620502-4-4

✓ **Alan D. Wolfelt**

- A. A Child's View Of Grief Bedside Journal And Legacy Workbook
- B. Butterfly Blessings
- C. Creating Meaningful Funeral Ceremonies A Guide For Families
- D. Healing A Friend Grieving Heart 100 Practical Ideas
- E. Healing Your Grieving Body
- F. Healing Your Heart 100 Practical Ideas
- G. The Handbook For Companying The Mourner
- H. The Journey Through Grief: Reflections On Healing
- I. The Lighthouse
- J. To My Daughter Or Son With Love
- K. Understanding Your Suicidal Grief
- L. Wolfelt's Grief Guiding Model

*Further information and hard copy resources are available through the Adult Mental Health office. An overview of information may be obtained through requests through Community Services. Contact 435-6277

**Palliative Care
Hard Copy Resources**

✓ **Adolescence And Grief**

My Book Of Feelings

Teen Grieving Workbooks
Teenage Perception Of Death

✓ **Caregiver Information**

Caregiver's Guide
Caregivers Planning Ahead

Living With A Serious Illness

Widow Information And Support

✓ **Children And Grief**

Child Grief Worksheets
Child: How Do I Feel (Workbook)
Children's Questions About Death
Communicating With Children

Developmental Ages And Reaction To Death And Illness

Explaining Funeral And Cremation To Children

Goodbye Grandma (Booklet)

Kids And Anticipatory Grief

Talking With Children About Serious Illness

Waterbugs And Dragonflies (Child Booklet)
When Dinosaurs Die (Child Booklet)

✓ **Client Information**

Alternatives To Burial: Cremation/Organ Donation
As Life Comes To An End: Handout

Butterfly Blessings: Reading

Caring For Yourself: Handout
Comfort For Patients: Handout

Easing The Hurt: Handout

Home Death Information
Hope And Denial: Handout
Hope For People Facing Cancer: Guidebook

Journey's End: Handout

Living Day To Day
Living With Limited Time: Handout

Planning Ahead: Pamphlet, Information On What To Expect In Palliative Care
Palliative Care Catalogue
Palliative Care Drug Plan
Palliative Care Guidelines
Programs For Greystone Bereavement Center

Regina Care Patients Lodge: Information
Regina Private Palliative/Hospice Agencies

Saskatchewan Hospice Care Resource List
The Sacred Soul: Reading

✓ **Crisis Information:**

Suicide

Traumatic Loss

When Hello Means Goodbye (Loss Of Child)

✓ **Cultural**

Aboriginal Palliative Care Resource List

Culturally Diverse End Of Life

✓ **For Parents**

Helping Your Children Grieve

✓ **For Teachers**

Coping With Loss

✓ **Grief**

A Death In The Family

Finding Your Way Through Grief

Grief And The Holidays

Grief In Times Of Celebration

Guide To Grief And Bereavement

Information On Bereavement

Living With Your Loss

Living Without A Loved One

Personal Grief Timeline Worksheet

Ten Stages Of Grief

Ten Things To Know About Grief

Understanding Grief

✓ **Personal Information**

Canadian Cancer Society Advocate

Financial Information (CPP, Caregiver Benefits, Veteran Benefits)

Health care Directives

Wills

✓ **Spiritual Information**

Spiritual Book Resource List

Spirituality And Disease

Rituals For Patients

✓ **Teachers And Grieving Children**

Abuse Of Older Adults – Pamphlet
Aboriginal Palliative Resource List
A Death In The Family – Handout
Adolescences – My Book Of Feelings
Alternatives To Burial
Anxiety Resource
As Life Comes To An End – Pamphlet

Bereavement – Handout
Bipolar Resources

Canadian Cancer Society Advocate
Canadian Virtual Hospice – Handout
Caregiver – Info Package
Caregiver’s Guide – Handbook
Caregivers Planning Ahead – Info
Caring For Yourself – Handout
Certificate Of Incompetence
Child Grief Worksheets
Child – How Do I Feel Workbook
Child Waterbugs And Dragonflies
Children Developmental Stages
Creative Listing And Communication – Handout
Comfort For Patients – Handout
Communication With Children
Coping With Loss – Teachers
CPP Benefits
Culturally Diverse End Of Life

Depression Resources
Developmental Ages And Reaction To Death And Illness
Distress Tolerance Handout

Easing The Hurt – Handout
Elderly Grief Response
Explaining Funeral And Cremation To Children

Finding Your Way Through Grief – Handout
For Parents – Helping Your Children Grieve

Good Bye Grandma – Child
Greystone Bereavement
Grief And The Holidays

Grief At School A Self Study Tool Kit For School Professionals

Grief In The Times Celebration

Guide Books: Hope For People Facing Cancer/Butterfly Blessings/The Sacred Soul

Guide To Bereavement And Grief

Health Care Directives

Home Death

Hopeair

Hope And Denial – Handout

Hope For People Facing Cancer – Guidebook

Info On Alzheimer's

Information On Bereavement

Information On Widows

Journey's End – Handout

Journey's End...A Guide To Understanding Final Stages Of Life

Kids And Anticipatory Grief (Package Contains: Understanding Needs, Development, Talking)

Living Day To Day Info

Living With A Loved One – Handout

Living With A Serious Illness – Handout

Living With Limited Time – Handout

Living With Your Loss – Handout

Loss Of Sibling – Info

Managing Difficult Behavior

Organ And Tissue Donation

Palliative Care And Mental Disabilities

Palliative Care Catalogue

Palliative Care Drug Plan

Palliative Care For The Community And Caregiver (Booklet)

Palliative Cancer Greystone Books

Palliative Care Guidelines

Personal Affairs – Package

Personal Grief Timeline

Planning A Funeral

Planning Ahead – Pamphlet

Planning Ahead...An Information And Resource Guide To Palliative Care

Programs For Greystone Bereavement

Psychosis In The Elderly

Regina Care Patients Lodge
Regina Private Agencies
Rituals For Patients

Saskatchewan Hospice Care Resource List
Stress Management – Pamphlets
Spiritual Info – Handout
Spiritual Books – Resources
Spirituality And Disease: Finding Meaning During Health Crisis
Suicide – Info

Talking With Children About Seriously Ill
Teachers Guide To Grief
Ten Key Facts About Grief – Handout
Teen Grieving Workbooks
Teenage Perception Of Death
Ten Stages Of Grief – Info
Ten Things To Know About Grief – Handout
To Children About Death (Kid Questions)
Tools For Effective And Respectful Communication
Traumatic Loss – Info

Understanding Grief – Handout

When Dinosaurs Die – Child
When Hello Means Goodbye (Child Death)
Wills

Beck Depression Inventory

Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the **past few days**. Circle the number beside your choice.

1.	0 I do not feel sad. 1 I feel sad. 2 I am sad all the time, and I can't snap out of it. 3 I am so sad or unhappy that I can't stand it.	8.	0 I don't feel I am any worse than anybody else. 1 I am critical of myself for my weaknesses or mistakes. 2 I blame myself all the time for my faults. 3 I blame myself for everything bad that happens.
2.	0 I am not particularly discouraged about the future. 1 I feel discouraged about the future. 2 I feel I have nothing to look forward to. 3 I feel that the future is hopeless and that things cannot improve.	9.	0 I don't have any thoughts of killing myself. 1 I have thoughts of killing myself, but I would not carry them out. 2 I would like to kill myself. 3 I would kill myself if I had the chance.
3.	0 I do not feel like a failure. 1 I feel I have failed more than the average person. 2 As I look back on my life, all I can see is a lot of failure. 3 I feel I am a complete failure as a person.	10.	0 I don't cry any more than usual. 1 I cry more now than I used to. 2 I cry all the time now. 3 I used to be able to cry, but now I can't cry even though I want to.
4.	0 I get as much satisfaction out of things as I used to. 1 I don't enjoy things the way I used to. 2 I don't get any real satisfaction out of anything anymore. 3 I am dissatisfied or bored with everything.	11.	0 I am no more irritated by things than I ever am. 1 I am slightly more irritated now than usual. 2 I am quite annoyed or irritated a good deal of the time. 3 I feel irritated all the time now.
5.	0 I don't feel particularly guilty. 1 I feel guilty a good part of the time. 2 I feel quite guilty most of the time. 3 I feel guilty all of the time.	12.	0 I have not lost interest in other people. 1 I am less interested in other people than I used to be. 2 I have lost most of my interest in other people. 3 I have lost all of my interest in other people.
6.	0 I don't feel I am being punished. 1 I feel I may be punished. 2 I expect to be punished. 3 I feel I am being punished.	13.	0 I make decisions about as well as I ever could. 1 I put off making decisions more than I use to. 2 I have greater difficulty in making decisions than before. 3 I can't make decisions at all anymore.

7.	<ul style="list-style-type: none"> 0 I don't feel disappointed in myself. 1 I am disappointed in myself. 2 I am disgusted with myself. 3 I hate myself. 	14.	<ul style="list-style-type: none"> 0 I don't feel that I look any worse than I used to. 1 I am worried that I am looking old or unattractive. 2 I feel that there are permanent changes in my appearance that make me look unattractive. 3 I believe that I look ugly
15.	<ul style="list-style-type: none"> 0 I can work about as well as before. 1 It takes an extra effort to get started at doing something. 2 I have to push myself very hard to do anything. 3 I can't do any work at all. 	19.	<ul style="list-style-type: none"> 0 I haven't lost much weight, if any, lately 1 I have lost more than five pounds. 2 I have lost more than ten pounds. 3 I have lost more than 15 pounds. (score 0 if you have been purposely trying to lose weight)
16.	<ul style="list-style-type: none"> 0 I can sleep as well as usual. 1 I don't sleep as well as I used to. 2 I wake up 1 – 2 hours earlier than usual and find it hard to get back to sleep. 3 I wake up several hours earlier than I used to and cannot get back to sleep. 	20.	<ul style="list-style-type: none"> 0 I am no more worried about my health than usual. 1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation. 2 I am very worried about physical problems, and it's hard to think of much else. 3 I am so worried about my physical problems that I cannot think about anything else.
17.	<ul style="list-style-type: none"> 0 I don't get more tired than usual. 1 I get tired more easily than I used to. 2 I get tired from doing almost anything 3 I am too tired to do anything. 	21.	<ul style="list-style-type: none"> 0 I have not noticed any recent change in my interest in sex. 1 I am less interested in sex than I used to be. 2 I am much less interested in sex now. 3 I have lost interest in sex completely.
18.	<ul style="list-style-type: none"> 0 My appetite is no worse than usual. 1 My appetite is not as good as it used to be. 2 My appetite is much worse now. 3 I have no appetite at all anymore. 		

Scoring

- 1 – 10 These ups and down are considered normal.
- 11 – 16 Mild mood disturbance.
- 17 – 20 Borderline clinical depression.
- 21 – 30 Moderate depression.
- 31 – 40 Severe depression.
- over 40 Extreme depression.

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me much	Moderately - it wasn't pleasant at times	Severely - it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or light-headed	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / light-headed	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____.

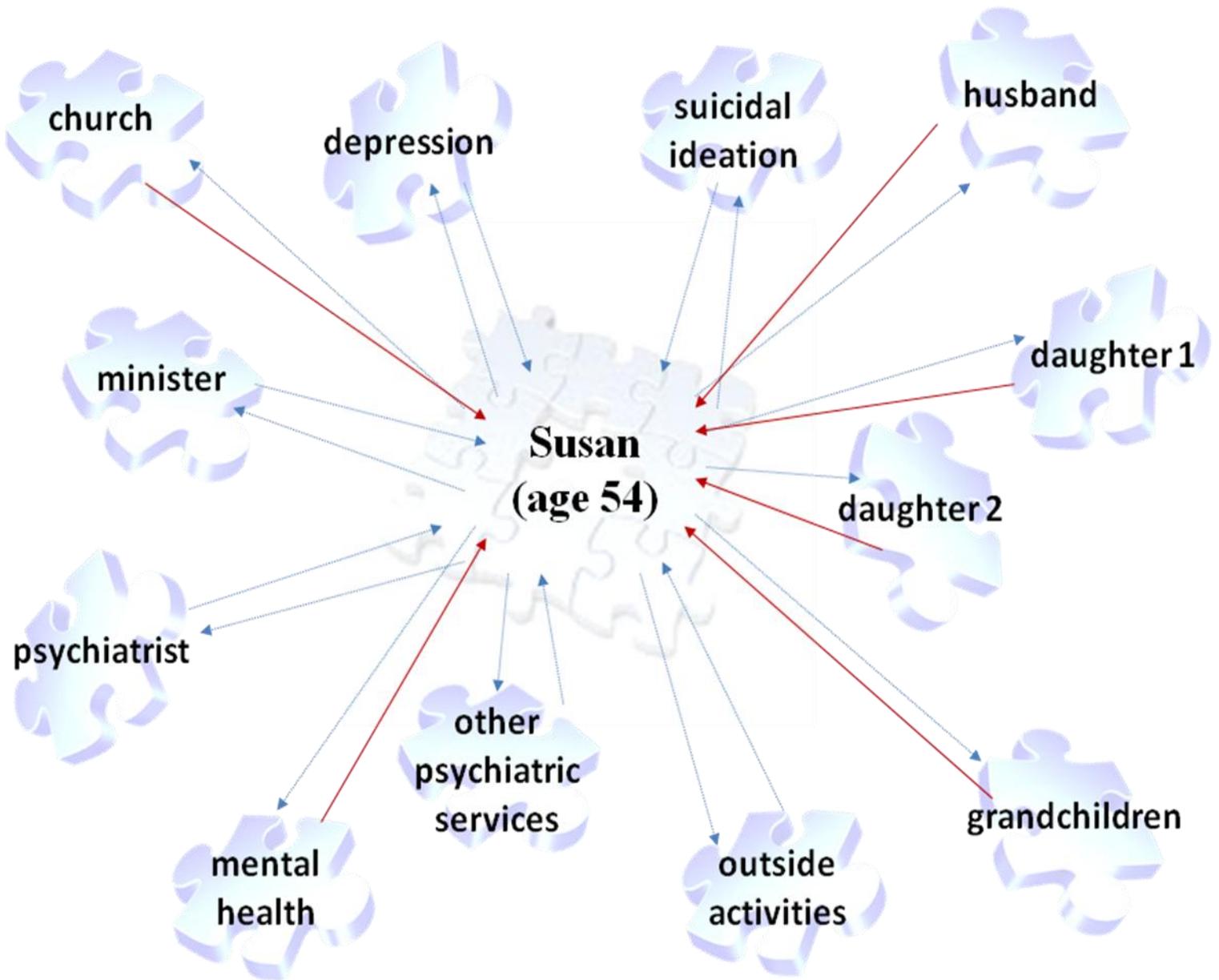
Interpretation of the Beck Anxiety Inventory Scores

A grand sum between **0 - 21** indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to "mask" the symptoms commonly associated with anxiety. Too little "anxiety" could indicate that you are detached from yourself, others, or your environment.

A grand sum between **22 - 35** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not "panic" time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a physician or counselor if the feelings persist.

Eco Map



Key:▶ (broken line) negative interactions
————▶ (solid line) positive interactions

January 6, 2010 - April 1, 2010

#	Age	Gender		Counselling		Referral/Consult									
		Male	Female	Individual	Family	Mental Health	Addictions	Psychiatric Services	Home Care	Advocate	Assessment	Resources	RCMP	Social Services	Other (Insurance)
1	61		F		2										
2	82	M		4	3					1		1			
3	83	M		1	2										
4	88		F	1											
5	62	M		11	2							1			
6	89	M		4								1			
7	85		F	2	3										
8	79		F	6	1										
9	79		F	6											
10	85		F	7	3										
11	43		F	2			1								
12	59		F	5		2									
13	81		F	4											
14	78		F	1											
15	40		F	2		1	1								
16	48		F	1											
17	38		F	2			1								
18	17		F	1	1										
19	22	M		1	1	1	1								
20	48	M		2											
21	52	M		1	2										
22	80	M		1							1				
23	29	M		4	4	1	1	1			1				1
24	56	M		3		1									
25	28		F	3	1	1									
26	29	M		2		1	1								
27	46		F	2											
28	73		F	1											
29	78	M		1	4										
30	33		F	1											
31	78	M		4	4										
32	78		F	1											
33	49	M		2											

**Social Work Practicum Statistics
January 6, 2010 - April 1, 2010**

#	Age	Gender		Counselling		Referral/Consult									
		Male	Female	Individual	Family	Mental Health	Addictions	Psychiatric Services	Home Care	Advocate	Assessment	Resources	RCMP	Social Services	Other (Insurance)
34	6		F		1										
35	42		F	1	1										
36	54		F	3		1					1				
37	44	M		1		1					1	1	1	1	
38	72		F	1											
39	55		F	3							1				
40	89		F	4	4										
41	38		F	4											
42	88		F	4	2										
43	79		F	2							2	1			1
44	72	M		1	4				1						
45	70	M		2											
46	44	M		2							1				
47	38		F	1											
48	56	M		1											
49	14	M		1	2	1		1				1	1		
50	60		F	2	2						1				

These stats were compiled from a four-day work week (Monday-Thursday).

Physician and Patient Care Co-ordinator consultations not included, as consults were performed daily or as required.

TO: Dr. E. Crouse
Dr. R. Kerkhoff
Dr. M. Plewes
Dr. E. Roets
Dr. W. Roets
Dr. S. Van derMerwe
Dr. M. Van Jaarsveld
Sharon Wood – Facility Manager
Shelley Taylor – Patient Care Coordinator
Celine Stolz – Care Coordinator – Moosomin Home Care
Desirae Neville – Care Coordinator – Broadview Home Care
Nursing Staff

FROM: Sandra Dobra (Practicum Supervisor (Masters Student))

As you are aware, we have had the pleasure of having Marnie McMullen do her student practicum placement with us at the SEICC.

Marnie's goals were:

- To gain knowledge and skills in individual and family counselling in relation to palliative care/oncology.
- To facilitate the use of community resources relating to palliative care and develop relevant educational and resource materials which will be sustainable after the practicum.

Marnie's goals have extended far beyond her original plan, and she has played a valuable role as a medical social worker, encompassing many facets of client care.

I would ask that you please take the time to complete the enclosed questionnaire which is part of the practicum evaluation. This form may be returned to Shelley Taylor, who will, in turn, send the forms to me.

Thank you once again for your co-operation in providing a very rewarding and educational experience for Marnie.

Sandra Dobra MSW, RSW
Adult Mental Health
435-6277

Evaluation Form
Student Social Work Practicum - SEICC
January 6 - April 2, 2010

How would you rate this student practicum?

- Poor Average Above Average Excellent

Please rate the following questions according to this scale:

1 Poor	2 Average	3 Good	4 Very Good	5 Excellent
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To what extent do you feel the quality of client care was affected by the presence of a medical social worker?	
To what extent do you feel there was additional support provided, enabling you to better provide quality care to clients and families?	
To what extent did this practicum help SEICC achieve the RQHR's mission of providing holistic care?	
To what extent did the practicum enhance the ability to meet the psychosocial and emotional needs of clients and families?	
How would you describe the client's and family's responses to the presence of the medical social worker?	
To what extent did the practicum facilitate appropriate and effective linkage to community resources?	
A Directory for Palliative Care Services and resources has been developed and will be housed in the SEICC. To what extent do you feel this will be helpful?	

Comments or recommendations:

How could we have improved this learning experience?

Name (optional): _____

Thank you for completing this evaluation!!