

Counselling Experiences at Prince Albert Mental Health Services:

A Field Practicum Report

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Abstract

The following is a report providing a reflection of my practicum experience at Prince Albert Parkland Mental Health Out-Patient Services. The purpose of the practicum was to gain practical social work knowledge and experience in clinical counselling with individuals, in group settings and through application of Internet Cognitive Behavior Therapy (ICBT). To achieve these goals, I worked with clients with diverse issues, such as: anxiety, depression, panic disorder, change of life, post-partum depression, sexual abuse, post-traumatic stress disorder and grief and loss. I enhanced my knowledge in various therapeutic approaches and utilised them to assist clients during counselling sessions. These approaches included a strengths-based perspective, cognitive behavior therapy, and solution focused therapy, within a client centered philosophy of practice. As part of my goals, I also worked with ICBT clients, providing support and encouragement throughout two eight-week sessions and co-facilitated dialectical behavior group therapy sessions with numerous participants. As a result, my counselling skills have improved and I gained insight into the role of mental health counsellor. I conclude with discussing challenges, values and ethical considerations that arose during my practicum placement.

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Chapter One: Introduction

The purpose of this report is to provide a critical reflection of my field practicum placement as part of the final component for my Master's degree in Social Work. I completed my practicum placement with the Prince Albert Parkland Health Region at the Out-Patient Mental Health Unit. The impetus for choosing this particular practicum stems from a desire to increase my professional capacity in clinical counselling. Working as a clinical counsellor allowed me the opportunity to enhance my skills to work individually with patients and clients, as well as in group facilitated sessions.

My previous career background included working in corrections, child protection and young offenders. For the last 13 years I have been employed as a Community School Coordinator. My current work has a primary focus on community development and engagement initiatives, while also acting as a school liaison to assist needy families and students with attendance issues. Although this work has been fulfilling I was still left with the feeling that I needed to develop further skills in the area of counselling. I felt that in order to be a more well-rounded and skilled social worker, it was necessary to increase my knowledge and abilities by working with clients in a clinically capacity.

In order to meet my career objectives, I concluded that working for the Prince Albert Parkland Health Region (PAPHR) in the Mental Health Out-Patient unit would provide me with the learning opportunities that I was searching for. One of the exciting things about social work, which first propelled me to completing my Bachelor's Degree, was the flexibility in the type of work that social workers are employed to do. Being able to advocate for the disadvantaged, empowering individuals to realize their strengths and capacities and helping those in crisis make positive changes, are all extremely important and worthy actions. Working in the capacity of a

counsellor at Mental Health Services would allow me to have a more rounded clinician's experience in a different work environment and to serve clients with diverse needs.

Included in this practicum report is a review of the major components of my field practicum with PAPHR in Prince Albert. I will describe the agency placement, the services available and intake process. I will discuss the practicum activities and the counselling theories that I utilized and became familiar with. I will also describe how my learning objectives were achieved and the skills that I learned throughout the process. Lastly, I will present some of the personal challenges, values and ethical considerations that I experienced during the practicum. I will first begin with looking at my own experiences with mental health.

Personal and Professional Experiences with Mental Health

In 2014, the World Health Organization described mental health “as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community” (WHO, 2014, para 1). The Mental Health Association website states that mental illness can indirectly affect all Canadians at some point in time in their lives through a family member, colleague or friend (Canadian Mental Health Association, 2014). The incidence of mental illness justifies the continuous need for mental health services, and prevention and awareness strategies across the globe.

In my own life, my personal experiences with mental health have definitely influenced my professional interest over the last two decades. In 1999, some life changing events erupted in my family. Within 3 months both my husband and I were injured in workplace accidents that would dramatically change the paths of our life at that time. My husband was injured in a serious chemical accident on the worksite leaving him incapable of working. Besides the

physical injuries from the accident, he also suffered with post-traumatic stress disorder. Three months later, while I was working at the women's correctional centre, I was physically assaulted by an inmate. I was pushed, punched, choked, scratched and kicked in the stomach. At the time of the assault I was 6 months pregnant with our third child. Months following the accident I too was diagnosed with post-traumatic stress disorder.

As a result of our incidents, we both sought mental health counselling to try and begin to deal with our personal issues. It was a challenging time for our family. As parents of three young children we had a difficult time trying to support each other as we were both suffering and attempting to deal with our own separate issues. It was with the help of counselling that we were able to learn to deal with the challenges we were facing. Following these events, I decided not to return to my job with corrections and began seeking out other employment. It was at this time that I started to think about going back to university and social work seemed like a good fit. I recalled the counselling sessions that my husband and I both had and how we benefitted from it and thought that this line of work was admirable.

I completed my Bachelor of Social Work degree in 2004 and began working as a Child Protection worker for Social Services and also went on to work as a Community Homes Youth Worker, with young offenders. Working in this capacity, and with my previous years in corrections, it became evident that there were many mental health needs in the community of Prince Albert. However, even though I had a desire to work in the area of mental health, a position of community school coordinator at the school in my neighborhood where my children attended became available. I chose to work in this position as this was a good fit between my family and career and I enjoyed community development work. My work was close to my home which meant that I could be available to my husband and children if needed.

Working within all of these different environments demonstrated to me that there are individuals suffering with anxiety, grief, and depression in all kinds of settings. Even in my own personal life obstacles continued to challenge our family. In 2006 my husband had open heart surgery due to an unexplainable aortic aneurism and then most recently in 2013, he suffered a hemorrhagic stroke, a complication that resulted from a staph infection. This stroke has tragically left him legally blind at 41 years of age. Once again these events led me to seek mental health support for my husband and this strengthened my desire even further to enhance my skills in clinical counselling. A practicum at Mental Health Services seemed like a good direction to take in order to enhance my practical social work knowledge and skills in counselling.

Practicum Objectives and Activities

My field practicum placement at Prince Albert Parkland Health Region Mental Health Out-Patient Services took place from May 2016 through August 2016. Even before the beginning of my career in the field of social work I have always had an interest in counselling. Excited to take on this challenge I was looking forward to partaking and facilitating different activities within the mental health unit. My learning objectives were constructed to encompass opportunities for me to enhance and learn different skills in a clinical social work setting. The learning objectives at my practicum placement were comprised of five main goals.

The first and primary objective was to gain practical social work experience in the area of clinical counseling in a mental health setting. Becoming familiar with the mission statement of Mental Health Services at PAPHR, their policies and intake process would all be a part of this process. Understanding the multidisciplinary team approach and services offered in conjunction

with Mental Health Services would provide me with a greater understanding of the entire agency and their goals.

The second goal was to further develop clinical skills in both individual and group counselling sessions. Taking on my own caseload of 16 clients for the purpose of individual counselling would allow me to gain experience in this area. As well, co-facilitating Dialectical Behavioral Therapy (DBT) group therapy sessions with 18 participants would provide me with valuable experiences to reach my objectives. In addition to group and individual counselling, my third objective was to enhance my skills in delivering Internet Cognitive Behavior Therapy (ICBT). Working with the Health Region I was able to facilitate ICBT sessions with 10 clients. Providing therapy over the Internet may address treatment barriers and clients who are uncertain about their need for psychological treatment, it is a safe method for accessing services. The Prince Albert Parkland Health Region extends across numerous rural and remote communities, thereby making ICBT a viable option for many individuals. Becoming proficient in delivering ICBT was an important goal in order to provide mental health options to individuals in my home community.

The fourth objective was to learn about concerns commonly affecting those seeking counselling and become familiar with the treatment methods and protocols used at PAPHR Mental Health Services. The final objective was to gain further knowledge of and to utilise various counselling theories, such as Cognitive Behavior Therapy (CBT), Solution-Focused Therapy and Strengths-Based Theory. While trying to attain these goals, the principles, values and ethics outlined in the Canadian Association of Social Workers Code of Ethics (CASW) were of utmost importance, in order to protect the clients, to promote their well-being and to guide my own conduct (CASW, 2005). The next chapter will illustrate the services and strategies in place

at PAPHR Mental Health Out-Patient Services, where I completed my practicum placement in order to address my learning objectives.

Chapter Two: The Agency

The Prince Albert Parkland Health Region Mental Health Out-Patient Services is located at 2345 10th Avenue West, in the lower level of the Victoria Square building. This facility is conveniently located on the same property as the Victoria Hospital in Prince Albert, Saskatchewan. The mandate for the PAPHR Mental Health Services Program is derived from *The Mental Health Services Act* (2008). Section 3 of *The Mental Health Services Act* empowers the Minister of Health to “do anything pursuant to this Act that he considers advisable for preventing circumstances that lead to mental disorder and distress and for promoting and restoring the mental health and well-being of the people of Saskatchewan” (2008).

According to the PAPHR Mental Health Services Manual their vision is to have “Healthy Living in Healthy Communities” (PAPHR, 2009a). Included in their mission is having, “People, Families and Communities Working Together Toward Improved Health in Prince Albert Parkland Health Region” (PAPHR, 2009a). As set out in their manual their guiding principles include: (1) promoting the dignity, rights and freedoms of each individual; (2) providing service based on need with priority given to the most needy; (3) shared responsibility between health care providers and the individual; (4) service proximity and accessibility; (5) individualization for clients which is sensitive and responsive in each unique case; (6) quality assurance; (7) promotion and prevention awareness of mental health; and (8) knowledge and competence of professionals (PAPHR, 2009a).

The agency functions as a multidisciplinary practice involving numerous team members from multiple professions working together to meet the mental health needs in Prince Albert. Jessop (2007) describes the multidisciplinary approach, as one in which a team of individuals from different professions work independently with the individual and then share information via

case notes or case conferences. This mirrors the practice at the Prince Albert Mental Health Unit. The Out-Patient Mental Health team is comprised of social workers, psychiatrists, psychologists and community mental health nurses. This team of professionals work together to best meet the needs of the clients at Mental Health, guided by the services that they provide.

Agency Services

Within the Mental Health Out-Patient Unit there are five major program components that operate to fulfill the needs of the clients. These programs include: child and youth Mental Health Services, adult and forensic Mental Health Services, psychiatric rehabilitation and residential care, psychiatry and inpatient psychiatric. Although my practicum was with out-patient services, it is important to highlight each program since they operate within a multidisciplinary team providing services to clients and their families. Each program will be briefly discussed next.

The child and youth program provides services to individuals under 18 years of age and their families. This program is divided into two areas of service, developmental services and counselling and psychology services. Developmental services offer autism support, speech and language support, cognitive disability strategies and occupational therapy. A staff of 11 manage this program, which include a physician, occupational therapist, language pathologist, support workers and two social workers.

The other component of the child and youth program is the counselling and psychology services. There are 11 team members who work within this program, which include 9 social workers and 2 psychologists. Each member specializes in particular areas such as: eating disorders, anxiety, depression, emotional regulation, residential school survivors, trauma, grief counselling, sexual abuse, gender/sexuality issues and cognitive disabilities strategies. The

multidisciplinary approach of this program is valuable when offering services to both the child and the family. The supports are located within one building, making it easy to direct clients to the services they need, thereby limiting barriers of access to these services.

The second major program operating within the mental health outpatient clinic is the adult and forensic mental health service. The team working in this unit consists of 10 social workers and three psychologists. The services provided include: walk-in counselling, group skills training for anxiety and depression, counselling for female inmates of Pine Grove Correctional Centre, counselling for eating disorders, domestic violence, anger management, geriatric psychotherapy, post-traumatic stress disorder, survivors of abuse, ICBT, and adult cognitive strategies. This unit also facilitates assessment and diagnosis, testing and health psychology. The forensic services include court ordered assessments of offenders, youth and adult, sex offender treatment and risk assessments of violent recidivism.

The psychiatric rehabilitation and residential program provides support to those with long-term psychiatric disorders. There are 11 community mental health nurses, one community social worker and 6 psychiatrists on the team. The community health nurses and psychiatrists serve the Prince Albert area and at least 31 surrounding communities within this health region, and the two local correctional centres. The team takes a proactive community-based care approach and utilises a community partnership model to treat clients with long-term psychiatric disabilities. This community partnership model includes utilising services within local communities and third party arrangements with independent community services to meet the need of their clients.

The last two Mental Health programs operated as part of the PAPHR Out-Patient Unit are inpatient and out-patient psychiatric services. These programs are facilitated by 6

psychiatrists with services including: a psychiatric consultation clinic for children and youth, and adult psychiatric treatment and assessment. Assessments can be initiated following a referral from Out-Patient Mental Health Services, family physicians, court order, police, schools, family members and self-referrals. For 24-hour inpatient care, admission can be voluntary or involuntary, and admission is determined by the client's psychiatrist or on call psychiatrist.

These mental health programs above employ 41 staff with 20 of these positions held by social workers. All of these programs are overseen by the regional director of Community Mental Health Services, a manager of mental health out-patient services and a manager of rehabilitative and residential/community mental health. It is interesting to note that two of the positions were held by women with masters in social work and the other, by a woman with a masters in nursing. Typically, nursing and social work professions have been dominated by females, while managerial positions are occupied by males, which can leave women feeling devalued and powerless (Sands & Angell, 2002). Having administrative positions held by women with a MSW helps maintain the influence and importance of social work values and ethical principles that are outlined in our CASW Code of Ethics (CASW, 2005).

During my practicum it was interesting to observe and note how these programs were organized and delivered using the multidisciplinary approach. Having all of the team members and programs housed in one building certainly added to the effectiveness of the approach. The social workers, community mental health nurses, psychologists, physicians and 3 of the 6 psychiatrists who work within the mental health programs described above, maintained a working office space within the Victoria Square building. This provides the continuity and accessibility of services not only to the client, but to all of the practitioners as well. I was able to observe the benefit of this approach as a few of the clients that I was working with were also

receiving psychiatric care. On several occasions I was able to consult with their psychiatrist to discuss strategies for my clients and to ensure that both myself and the client's practitioner were focused on the client's goals.

Client Demographics

The goal of PAPHR Mental Health Services is to promote and support the mental health of all residents in the region, while making services universally accessible in the timeliest manner. Access to these services is based on non-discriminatory practice and is inclusive of all persons with respect to ethnicity, religion, gender, disability, age, sexual orientation or family status (PAPHR, 2009b). Provision of services is also assessed according to need, with priority given to those in greatest need. The services offered at PAPHR Mental Health are provided at no cost to the client.

The clientele that receive services from Prince Albert Mental Health Services is very diverse and includes: adult, youth, incarcerated individuals, high school students, seniors and individuals with physical disabilities, and learning disabilities. Clients can contact PAPHR Mental Health Services on their own by phone, or in person, and they can be referred by physicians, by court order and/or referred by other agencies for counselling. There is also a walk-in program at Mental Health Services called "Open Access." It is available to all clients who wish to seek mental health services and feel they are in crisis or are simply requesting to see a counsellor without a prior appointment. Individuals can access this service from Monday to Friday from nine in the morning until noon and then again at one in the afternoon until four. The evolution of walk-in clinics has come about as the demand for mental health services increases, while funding and resources continue to be stretched (Bloom & Tam, 2015). Walk-in counselling services help to address the stigma of mental health as well as reduce costs and the

impact on health care systems (Bloom & Tam, 2015). The “Open Access” program is a valuable service and is utilized from a variety of clientele. I have brought former elementary students in crisis to this program and they were able to see a counsellor and have services set up on that same day. The “Open Access Program” helps to address clients who are at risk and need to be seen with the 24-hour time period. The 2014-2015 Community Program Profile reports that, “Since 2012-2013 outpatient wait times have significantly improved, with 85% of patient being seen within the identified benchmarks” (Government of Saskatchewan, 2016, p. 4).

According to the 2014-2015 Mental Health Profile for the Prince Albert Parkland Health Region the total active mental health clients served during this timeframe was 3832, with 2145 new and reopened registrations (Government of Saskatchewan, 2016). A look at national statistics indicate that 1 in 5 Canadians, at some point in their life, will personally experience a mental illness and eight percent or nearly 3 million Canadians, will experience major depression at some time in their lives (Canadian Mental Health Association, 2014). In Saskatchewan, “from 2010-2011 to 2014-2015, demand for mental health services increased by 19%, whereas the overall Saskatchewan populations increased by 7%” (Government of Saskatchewan, 2016). These numbers depict the rise and frequency of mental health incidences within Saskatchewan over a relatively short period of time.

As described earlier in this paper, all services are provided at the Victoria Square location other than the depression and anxiety group meetings and the skills training groups, which meet at an alternative site centrally located in the city. As part of their objectives, the staff at PAPHR Mental Health Services also provide public education, prevention and supportive services to individuals, groups and communities within Prince Albert, aimed at promoting mental health and preventing mental illness (PAPHR, 2009a).

Intake and Screening Process

At PAPHR Mental Health Services two social workers are assigned as intake staff in order to facilitate client calls, written referrals and emergency/walk-in clients. These intake workers then screen and prioritize each client's level of risk and need for appropriate services. The PAPHR policy deems each level of risk and the required time necessary to see each client (PAPHR, 2009b). Clients classified as emergent level of risk or very severe is a life threatening condition or one that requires immediate assessment or treatment. Clients in this category are to be seen within 24 hours to 5 days. Moderate risk is classified as a client having significant impairment in functioning and these clients are to be seen within 20 working days. Elective level of risk or mild risk is where a patient has requested services and such will depend on program availability. Clients at this level of risk are to be seen within 30 days.

The initial intake psychosocial assessment and screening process forms used at PAPHR Mental Health are universal for each client that is seen by either a physician, psychologist or social worker. All clients must first give informed consent to receive services and treatment and involuntary clients will be assessed as per *The Mental Health Services Act* (2008) and/or *The Youth Criminal Justice Act* (2003). Once completed the assessment is then placed on file and is a valuable tool to utilise for other practitioners working with that client and to review the clients progress. The psychosocial assessment contains vital information required to best address the client's concerns, and identifies recommendations or requests for additional services and/or programs. Assessments include the following information: contact numbers, next of kin/family, living arrangements, social history, childhood delays, presenting problems, psychiatric history, suicidal thoughts or plans, current medications, resources or supports, and motivation for change. The psychosocial assessment completed with each client at Mental Health Services is far more

complex than simply observing individual manifestations of behavior. Prichard (2006) argues that the psychosocial assessment, “considers external factors as the influencing etiology of individual behavior, and to address social, political, and economic factors as contributors to individual distress” (Prichard, 2006, p. 23).

Following the initial assessment, information is then gathered to determine how soon the client needs to be seen and what type of program would be most appropriate. Such as, psychiatry, counselling or the anxiety/depression group. Each practitioner specializes in particular program areas and therefore, clients can be set up with individuals who can best assist them with the program applicable to the clients. I found this arrangement of having social workers specializing in particular areas of client interests beneficial. Not only was this beneficial for the clients but also for the practitioners, as they could become more knowledgeable in their area of focus as opposed to seeing all clients. A treatment plan for each client would be developed with their practitioner once all of the necessary information is gathered for their assessment (PAPHR, 2009a). Social workers at PAPHR Mental Health Services develop this treatment plan based on the specific goals that clients choose to work on or accomplish. Developing the treatment plan is a collaborative effort between counsellor and patient and feedback is elicited from the patient (PAPHR, 2009a). Timelines are also included in the treatment plan which would include identifying plans for termination of counselling services when appropriate.

Once clients are assigned a social worker, psychiatrist or psychologist, every client is informed of their rights to receive service and their rights to confidentiality between client and practitioner. Clients are also informed when and why that confidentiality could ever be broken. This process parallels the confidentiality practices that are outlined in the CASW Code of Ethics,

“Social workers demonstrate transparency with respect to limits to confidentiality that apply to their professional practice by clearly communicating these limitations early in their relationship” (CASW, 2005, p. 8).

Following the discussion of confidentiality with each client, a suicide screen and suicide risk assessment is completed with every individual aged 6 and over (PAPHR, 2009b). The suicide screen and risk assessment is another universal strategy and integral tool used in the delivery of service to the clients. The suicide screen and risk assessment has shared use among the mental health team of practitioners and is completed or updated each time the client is seen. This multidisciplinary approach allows for a continuum of services and for all parties to be knowledgeable about the client’s current status. In my opinion, I found this tool to be invaluable especially when clients were involved with more than one mental health program. For example, I had more than one client who was seeing psychiatry as well as counselling; utilising the same assessment tool allowed all practitioners to have a clearer and consistent image of the client. It also allowed practitioners to share or indicate any concerns. This could be done either through communication of client notes on the individuals file or through a personal consult with the other practitioner.

Part of the intake worker’s role is also to facilitate walk in clients from the Open Access Program. As mentioned earlier, this is an emergency walk-in program for individuals who are in crisis or feel that they need to see a counsellor on that particular day. In this program, clients are seen on the given day that they appear and a brief screening and initial assessment is completed. It is common for clients who come in to use this service to be rated at an emergent level of risk. Therefore, the suicide risk screen is completed for all clients. If at any time it is determined that there is an imminent risk of suicide, the psychiatrist on call is consulted and would see the client

on that same day. The psychiatrist would then be able to assess client safety and provide necessary treatment or mental health inpatient admission, if required.

The final stage of the intake process is being assigned to a clinician, at which time a treatment plan is developed in collaboration with each client. A more detailed examination of the initial assessment is completed and identified client concerns are brought forth. The treatment plan and/or strategy includes: establishing treatment goals, identifying how those goals would be monitored or evaluated, defining goals for discharge planning and identifying the most appropriate therapeutic environment for services (PAPHR, 2009a).

Agency Perspective

Historically, the field of mental health has operated under the perspective of the medical model in which there is a preoccupation with looking at the client as a diagnosis rather than an individual (Carpenter, 2002). This medical view, which focuses on client deficits and symptoms, fails to recognize the strengths of the individual nor to engage these strengths (Deegan, 1996; Rapp, 1998). Historically, mental health agencies have employed professions who are more likely to adopt the medical model, such as psychology and psychiatry (Norman & Peck, 1999). The medical view or ideology directly conflicts with social work values and ethics, where the client is viewed from a strengths perspective. Miller (2002) adds that in the medical model, clients are seen as passive and recipients of the “expert” recommendation of professionals. Rather than a view of diagnoses, pathology and treatment, the social worker views strengths and weaknesses of the client in terms of their environment (Bland & Renouf, 2001; Miller, 2002). Social work often approaches clients in the psychosocial model, from a person in environment context (Bland & Renouf, 2001). It can be a challenge when working with different professions within the same team, like at PAPHR Mental Health, where there are social workers,

psychiatrists, physicians and psychologists, as part of the multi-disciplinary team. According to O'Brien and Calderwood's (2010) research study, in Australia, the United Kingdom and the United States, they identified the need for more social workers to be engaged with clients with mental illnesses and identified great significance in social workers' use of approaches that can empower clients and their families.

Social workers recognize that an individual's mental health is influenced by many factors including: family relationships, social networks, community and society (Carpenter, 2002). Carpenter (2002) suggests that social workers who practice from a person-in-environment perspective are readily situated to support clients by helping them to connect or reconnect with invaluable resources. Prichard (2006) reports that the person-in-environment perspective, "considers environmental and relational influences as central to individual distress, and presents social issues such as oppression as being primary contributors to individual behavior and distress" (Prichard, 2006, p.7). The person-in-environment perspective or person-centered model, acknowledges that additional factors like: resilience, culture, housing, socio-economic status and stability, employment, gender, age, support systems, and stress factors, as well as strengths, influence mental health. This person centered approach is the philosophy utilised among social workers at PAPHR Mental Health. This philosophy is recognized by the other practitioners as well, however, the medical model philosophy still operates in tandem as the diagnosis piece remains a focus in their treatment of clients. I would agree with Carpenter's (2002) statement that social work and mental health care have evolved considerably and, "the profession has consistently provided an invaluable contribution to the multi-disciplinary field and the field, in turn, has helped define social practice and its domain" (Carpenter, 2002, p. 86). This is reflective of my practicum experience at mental health services. The intake strategies and

assessment forms for treatment, planning and goal setting, are used universally by all practitioners, which highlights the strengths perspective with each and every client, as these forms take into account client support networks and existing resources. Having covered the agency perspectives, demographics and services, the following chapter will highlight my practicum activities at PAPHR Mental Health.

Chapter Three: Practicum Activities

During my practicum placement at Prince Albert Mental Health Out-Patient Services, I was able to participate in a number of different activities and roles. My practicum placement started in May 2016 and I completed all of my activities in October 2016. As mentioned earlier, my goals were centered on gaining clinical counselling experiences in individual sessions, and group settings and to further my experience using Internet Cognitive Behavior Therapy (ICBT). While fulfilling these roles I hoped to be able to enhance my knowledge and practical applications of counselling theories like cognitive behavior therapy and gain understanding of current client concerns. The following paragraphs will highlight the three areas, ICBT, Dialectical Behavior Therapy (DBT) group sessions and clinical counselling, in which I worked during my placement period.

Internet Cognitive Behavior Therapy

My interest in ICBT began when I completed the Online Therapy User Training and Operations Course (2014), in June 2015, at the University of Regina, as part of my master's degree. The Online Therapy USER Unit for Service, Education and Research, developed an online Wellbeing Course that utilises CBT strategies to treat anxiety and depression (Online Therapy USER, 2014). This program was developed in response to the prevalence of depression and anxiety illnesses in Canada. The Mental Health Commission of Canada stated that in 2014, the cost for providing treatment, care and support service, for people with mental health problems and illnesses was about forty-two billion dollars (Mental Health Commission of Canada, 2014). The online therapy option would not only be cost effective, but could also improve access to services to those in remote areas, provide clients with anonymity, offer convenient and flexible options and also be effective for clients' utilisation.

The Online Wellbeing Course was developed by Dr. Heather Hadjistravropoulos with researchers from the University of Regina and the University of Saskatchewan. The program was modelled after a program being offered at the eCentre Clinic in Australia (Online Therapy USER, 2014). The aim of the online therapy unit was to develop ways to improve access to evidence-based care for people with anxiety, depression, and other health conditions, by making evidence-based ICBT broadly available. The website was created in 2011 and in 2012 there were 206 clients participating in online therapy for treatment of depression, anxiety and panic disorders. In 2013, the online Wellbeing Course was adapted to assist cancer survivors with anxiety and depression. The year following, adaptations were made to add a Pain Course for individuals diagnosed with fibromyalgia, a course for those with cardiac conditions and an After Cancer Course for cancer survivors (Online Therapy USER, 2014).

Therapists trained to facilitate the Online Wellbeing Course consist of psychologists, social workers, or psychiatric nurses. The success of the online CBT therapy is evident in current research reporting that, “Guided ICBT has been found to be effective for a range of anxiety disorders with sustained effects over time” (Andersson, 2015, p. 107). Additional studies conclude that this form of treatment is both effective and acceptable to patients and clinicians and generates positive and clinically significant outcomes (Andrews & Williams, 2015; Mewton, Wong, & Andrews, 2012). It has also been noted that ICBT for anxiety disorders may be as effective as face-to-face CBT, provided that: clients are deemed suitable, that content coverage and pedagogical structure is sufficient, the webpages are user friendly and that there is some form of minimal therapist support (Andersson, 2015; Andersson, Calbring, Berger, Almov, & Cuijpers, 2009).

Therapist-assisted ICBT presents patients with the same psychoeducation and cognitive and behavioral strategies received in traditional face-to-face cognitive behavior therapy (CBT), but the information is offered through structured modules over the Internet (Hadjistavropoulos, Alberts, Nugent, & Marchildon, 2014). The cognitive behavior model posits that the way people perceive their experiences influences their emotional, behavioral, and physiological reaction (Beck, 2010). In CBT, correcting misperceptions and modifying unhelpful thinking and behavior brings about improved reactions (Beck, 2010). Therapist-assisted ICBT utilizes the cognitive behavioral model within their structured modules online. As part of therapist-assisted ICBT treatment, patients communicate with a therapist by email or phone, which is typically done once a week, as well as work on the scheduled modules and assignments (Hadjistavropoulos et al., 2014). There are some limitations to this approach regarding computer access, language and computer skills, close monitoring of patient safety and privacy (Hadjistavropoulos et al., 2014).

As part of my practicum I started working with four ICBT clients in May of 2016 for the Prince Albert Parkland Health Region. Working with these clients consisted of following a highly structured eight-week program. Each client participating in the program was pre-screened to assess suitability and the program was offered to only those individuals who reported mild to moderate symptoms of depression, panic, social phobia and generalized anxiety (Online Therapy USER, 2014). As part of the program clients agreed to fill out a generalized anxiety (GAD) questionnaire and a depression (PHQ) questionnaire each week, in order for therapists to get a clearer understanding of their emotional and mental status (Online Therapy USER, 2014).

As an e-therapist, I had weekly contact with each of my clients by email and sometimes by phone. Each week clients had homework or lessons to work on and exercises to complete,

corresponding to the lessons. The lessons were structured so that they were completed in sequence with clients getting access to additional lessons once the previous one was completed. Clients were encouraged to apply the exercises to their particular circumstances and then invited to discuss their progress by writing about any concerns or questions in their weekly emails. Three out of the four participants finished all 8 weeks of the course as well as all of the modules within eight weeks.

I completed an additional round of ICBT therapy with six more clients that finished in October of 2016. Five of these clients completed the course and one client had not finished by the twelfth week. Once the client and e-therapist structure time period is over, clients continue to have access to the lessons and resource material on the website, as well as contact numbers or email contacts if they have any further questions or concerns. This is a helpful feature for clients as sometimes individuals can have time conflicts with the highly structured schedule of the ICBT program. This allows them the time to finish at their own pace and reread the lessons, notes and emails from their therapist. All of the clients that I worked with, except one, were satisfied or very satisfied with the Wellbeing Course and materials. The one client who was less satisfied, shared that he would have rather had weekly phone therapy sessions instead of email contact with his therapist, which was not the premise of the program. This particular client was encouraged and redirected to access other services in his community for the additional counselling that he was requesting.

The ICBT Wellbeing Course was helpful for people in rural communities and for those who expressed concern over the stigma of accessing mental health services. Clients were also appreciative of being able to complete their lessons and emails on their own time and having access to it whenever it was convenient. It was an interesting and sometimes challenging process

to build rapport through emails, especially if clients had short responses. Once rapport was established, it was very genuine. Coming from a community like Prince Albert, where there are numerous small rural and northern communities which have challenges with regards to access to services, ICBT could certainly address these needs. In addition to facilitating ICBT sessions during my practicum, I also took part in DBT group counselling, which will be discussed next.

Dialectical Behavior Therapy Group

Dialectical Behavior Therapy was originally developed by psychologist Dr. Marsha Linehan in order to treat patients who were chronically suicidal (Linehan, Armstong, Suarez, Allmon, & Heard, 1991). This treatment evolved into a comprehensive cognitive behavior based therapy for bipolar disorder that specifically targets emotion dysregulation (Linehan, 1993a, Linehan 1993b). In DBT, emotion dysregulation is understood as a consequence of emotional vulnerability coupled with maladaptive or affective modulation strategies (Linehan, 1993a). Individuals with emotional dysregulation experience stronger than usual emotions and have trouble trying to control their emotional behavior. For example, dysregulation can be a direct cause of mood swings, problematic anger behavior, can prompt self-injurious and suicidal behavior and impulsivity (Koons, 2008). Therefore, a main overarching goal of DBT is to stabilize the clients in order to help them achieve behavioral control.

DBT has since been adapted to use as a therapy model in other populations to reduce symptoms such as, aggression, depression, attention deficit disorder, problem drinking and incarcerated women with histories of trauma (Eisner et al., 2016). Some of the components that DBT teaches is mindfulness, as well as interpersonal effectiveness, emotional regulation and distress tolerance skills (Eisner et al., 2016). Developing these skills helps to reduce vulnerability to negative emotions and to maladaptive coping behaviors that are associated with

strong emotions. Koons (2008) further explains the three foundations of DBT which include behaviorism, “Zen” and dialectics. Behaviorism represents the means for change, where the client and therapist seek to understand how maladaptive behaviors are learned and then address how to replace these maladaptive behaviors with more skillful behaviors. Zen provides the means for acceptance, and emphasizes the intrinsic wisdom in each and every individual. This translates into “Wise Mind,” a synthesis of information gathered from facts and emotions. Therefore, in “Wise Mind” one acts on facts, emotion, intuition and wisdom combined, to make the best mindful choices (Koons, 2008).

Dialectics represents the third component of DBT, which refers to finding the balance between acceptance and change. Dialectics are dissimilar to the dichotomous thinking which is characteristic of individuals with bipolar disorder. Dialectics see everything connected to everything else, and looks at opposite thinking, which can provoke a more thoughtful search of the truth. Ultimately, the dialectical struggle is that clients must identify and change behaviors that are destroying their lives and to accept their situation as it is.

Linehan (1993a, 1993b) has further developed her DBT methods in order to facilitate it as an intense group therapy skills program. Group skills training consists of three modules which were developed to target emotional regulation: (1) mindfulness, (2) emotional regulation, and (3) distress tolerance. Mindfulness is completed as the first module where participants learn skills to increase awareness of thoughts, emotions, physical sensations and actions without criticism or judgement. Using “Wise Mind,” participants are taught to label and identify current emotions. In the second module, emotional regulation skills are modelled to help participants cope with overwhelming feelings in new and effective ways. The importance of emotions is

discussed along with reducing vulnerability to negative emotions and choosing to act opposite of an emotional urge.

The final module introduces distress tolerance skills so clients can address impulsive behaviors which may occur due to an inability to tolerate intense emotions. These skills teach individuals coping strategies to tolerate distress and to accept things as they are at the given moment. Additional skills include crisis survival skills and reality acceptance (Linehan, 1993, Linehan 1993b). As part of the distress module clients were taught reality acceptance skills, which explained that “Radical Acceptance” was accepting things all the way with mind, body and heart (Linehan, 1993, Linehan, 1993b). This group model was the basis for the DBT group which I co-facilitated as part of my practicum.

The Dialectical Behavior Therapy group that I participated in at PAPHR Mental Health was a pilot project that was put in place to try and address some of the needs of the client population in Prince Albert. The eighteen clients who participated in the group were diverse, but shared a common denominator of all previously having been involved in counselling or some type of therapy for at least two or more years. Many of the clients had been diagnosed with a bipolar disorder and others had been involved with mental health services for several years and were still actively seeking additional services. In addition, all of these clients had previously participated in the anxiety and depression group skills therapy sessions. As per Linehan’s (1993) suggested requirements, participants wanting to engage in this program were required to have a high level of commitment with regards to attendance, participation in group discussions and agreed to complete homework assignments.

The goal of the DBT skills group was to offer these clients new strategies and skills that they could try applying in their daily life. Having learned these new and additional skills another

goal of the DBT group therapy was for clients to be able to learn to self-regulate emotions in hopes of learning to better cope with life's emotional obstacles. With success in attaining these new coping abilities, clients could potentially have: a decrease in suicidal acts, a decrease in therapy-interfering behaviors, decreased depression and substance abuse, and increased emotional regulation, mindfulness, and self-management (Linehan, 1993b).

The DBT group skills sessions that were offered at PAPHR Mental Health Services were held on Wednesday evenings from 6:30 to 8:30, at the Victoria Square building where mental health services are provided during the day. The DBT group sessions were set up as three separate modules running six weeks at a time, with a one-week introduction at the beginning, for a total of 19 weeks. The sessions were facilitated as described above, with the first module being focused upon mindfulness, then emotional regulation and lastly distress tolerance (Linehan, 1993, Linehan, 1993b). I began co-facilitating in May at the start of the module which started with a review and then introduced emotional regulation. At the beginning of each session all the participants completed a brief self-reflection exercise on how they were feeling about themselves. At the end of each session they filled out an evaluation of the group presentation, material and whether or not they felt it was applicable to their situation. This provided important material to evaluate the effectiveness of the pilot project and to determine whether it was applicable for the target audience of this particular group.

My experience with the DBT skills group sessions during my practicum resulted in a valuable learning experience. Not only did I get to experience group therapy sessions, but I was also offered the opportunity to learn an additional practical counselling theory and skill strategies to use with mental health clients. Examples of these skills include the "Stop Skill" and "Thinking Pros and Cons" (Linehan, 1993a). Using the "Stop Skill" participants are taught the

meaning of the acronym and to do the following: (1) stop and do not react on your emotions, (2) take a step back and breath, (3) observe what is going on inside and outside you, and (4) proceed mindfully and with awareness using “Wise Mind” (Linehan, 1993, Linehan, 1993b). Participants modelled the use of the pros and cons skill when having to decide between two courses of action and to recognize when to act or resist crisis urges (Linehan, 1993a). I continued to use these two particular skills with other clients during individual therapy sessions.

Co-facilitating the group sessions allowed me to see the capacity building among the clients within their sessions and I was able to witness how they empowered each other to try to make changes in their lives. Part of the program included small group work, in which facilitators sat with clients while they practiced validating each other. This small group work provided a unique demonstration of the strengths of group work. The participants would practice the skills that they learned by validating each other and it was evident that they were ultimately empowering each other as they did it. It was also valuable to see how participants viewed or interpreted the material differently and then witness the diverse applications of their newly learned skills. The participants of the DBT skills group appeared to thoughtfully listen to each other, even though there were strong opinions within the group. Participants quickly built a strong group camaraderie with each other as the sessions progressed.

One of the limitations that I could identify with the DBT group was that some clients struggled with the language or terminology used in the modules. We worked through these issues utilising group discussions and modelled examples. In addition, there were components of the distress tolerance skills that applied to addictions; however, some of the clients participating did not share this experience, and therefore did not find the material applicable. All of the clients except one, who was pregnant and lived out of town, completed all three modules or 19 weeks of

sessions. As well, all of the participants indicated that they found the sessions helpful and wished to continue learning and practicing DBT skills.

The DBT pilot project needs to be evaluated further in order to determine the feasibility of continuing to offer the program in the future. Decisions around what parameters would need to be put in place such as: adjusting program terminology, group size, client suitability, whether or not it should be offered to solely to participants with a bipolar disorder and how long the program should be, are just some of the areas that need to be addressed. The information gathered from the participant evaluations indicated that the clients felt they benefitted from the program. I found myself incorporating many of the skills into individual counselling sessions. The concept of using wise mind is something that I continued to use in sessions in combination with cognitive behavior therapy. The use of “Wise Mind”, which is an integration of the emotional mind and the reasonable mind, somewhat compliments the concept of realistic thinking or evidence based thoughts used in CBT. In addition to the DBT group sessions, individual counselling sessions were also completed as part of my practicum placement.

Clinical Counselling Sessions

The Prince Albert Parkland Health District Mental Health Services runs five days a week from 8am to 5pm. Social workers schedule and book their own clients once they are pre-screened and assigned to them. The expected workload measures for social workers is to have 15 to 20 face to face sessions per week, which would include: phone calls, collateral contacts, correspondence, completing assessments/client notes, record keeping, travel (if required), and attending meetings (PAPHR, 2009b). This would account for 80 to 85 percent of the workload. The remaining 15 to 20 percent of the time is to be allocated to program consultation,

community and resource development, public education, promotion and prevention, professional education and research, committee involvement and program evaluation (PAPHR, 2009b).

Counsellors at PAPHR Mental Health Services would typically see four to five clients a day and some saw more. I started out with a heavier client load, four to five a day, in order to meet with more clients as my time to spend with clients was only over a seven-week span, bringing me to the end of my practicum. Each social worker is encouraged to use the theories and strategies that they are most comfortable with, but also to keep in mind a fundamental focus on client-centered therapy. Client-centered therapy takes a non-directive approach and encourages and motivates clients. The client is seen as the expert in their own lives and that he or she possesses the innate ability to find their own answers (Rogers, 1961). With self-direction having an integral role in client-centered therapy I was very comfortable with this perspective as it parallels my own ideology, from a strengths perspective. My ideology emphasizes discovering the strengths, capacities and abilities within each client. This aids to develop their self-awareness and empower them to guide and direct what their goals are and how to overcome them. From my experiences talking with co-workers, Cognitive Behavior Therapy seemed to be the most common therapy used among clinicians.

As previously discussed most clients are assigned to clinicians who are best suited to meet their needs for service depending on what clients identified as concerns. I wanted to have the experience of working with a variety of client issues, so I did not set any particular restrictions. I was assigned female and male clients, as well as youth clients. I also worked with female inmates from Pinegrove Women's Correctional Center. I was a bit hesitant at first at the thought of working with a female inmate, due to being assaulted by one in the past, but I was surprised at how smoothly things went working with these clients. I actually felt like I had a

greater understanding of what their correctional experiences may have been like, having worked in that specific jail as a guard in previous years. When a woman from the correctional center would come in and refer to certain programs or protocol they had to follow, I clearly understood what they were referring to. I was also able to direct a few clients to follow up with their case managers at the center to enquire about specific programming opportunities that could be beneficial for them to participate in during the rest of their sentence.

During my practicum my supervisor informed me that the client no-show rate at PAPHR Mental Health Services was around 50 percent (PAPHR, 2009a). Unfortunately, due to the stigma attached to seeking mental health services many individuals struggle with seeking help. The Mental Health Commission of Canada (2014) reports that 60 percent of individuals with a mental health problem or illness will not seek help due to the fear of being labeled. This was reflected in my caseload, as I started out having 23 clients and ended up with only 16 clients (13 women, 3 men and 1 youth) and after the first session 3 clients did not return for any additional appointments. Of these three clients, one client continued seeing a psychiatrist, one informed me that she was going on a holiday but would try to make it back and the other client seemed ambivalent about future sessions, but had booked an appointment.

Before seeing any clients, I first reviewed the names scheduled to my caseload and ran into my first ethical barrier, personal relationships with clients. Three of the client's assigned to me were individuals that I knew, with one being my daughter's friend. Prince Albert is a small community and therefore, the chance of this happening could not be avoided. The PAPHR Mental Health Policy (2009b) addresses this issue for counsellors and provides direction for clients to be moved to another clinician for treatment if personal boundaries are an issue (PAPHR, 2009b).

As I started to meet with clients I quickly learned that there were a few things that I had to be extremely cognizant of during client sessions. The first issue was with regards to time. I initially thought that an hour was plenty of time to conduct a session, but swiftly learned that it was necessary to be mindful of the length of time spent during each session. For most clients, when they started talking they had a great deal to say. I discovered that time management was a big undertaking during sessions. Managing time was necessary in order to allow the client time to express their concerns, as well as to collect the required information on the client assessment form. During clinical supervision, time management was discussed with my supervisor and as a result, I made alterations to my office in order to clearly see the clock at all times. This small change also helped to keep better track of time.

The second thing that I became aware of was directing client conversation. One of the ways I was able to work on this area was through the client assessment form. Each clinician is required to complete this form and it was a great tool for guiding discussion. This assessment form worked well to assist in redirecting conversation, as well as to generate conversation in order to discover more about the client's motivation for seeking therapy and identifying their goals. Using the assessment form I was able to readdress specific areas of conversation in order to focus on providing the details necessary to complete the form and fulfill the goals of the sessions.

Part of my supervision during clinical placement included taking audio recordings and reviewing them. This is where I learned something else about myself, which was that I often asked two questions at once or back to back questions. Through this review process, I learned that when I asked multiple questions at the same time, I was only getting half of the information I was seeking. Concentrating on one question at a time was more direct and less confusing for

the client, thus providing me with the information I needed. The audio recordings were also helpful to review my tone of voice during sessions and allowed me to constructively review and reflect on making appropriate changes for future meetings with clients. Some of these changes in future sessions included: writing down specific questions to ask a client (in order to avoid asking two at once) and working on my tone of voice by paying more attention to and varying my pitch, intonation, volume and tempo, in order to better communicate with my client.

The clients that I saw at mental health services had a variety of issues, but in my experience it was most common for clients to have either prominent depression and/or anxiety, coupled with other issues such as: anger, frustration, paranoia, low self esteem, problems with appetite and motivation, grief and loss, a history of trauma, and physical symptoms like nightmares, body sweats or nausea. A frequently used resource with social workers at PAPHR Mental Health was *The Burns Depression Checklist* and *The Burns Anxiety Inventory* (Burns, 1989). The depression checklist consists of 15 questions around feelings, changes in behaviors and suicidal thoughts. The anxiety inventory consists of 33 questions about anxious feelings, anxious thoughts and physical symptoms. The clients would rate themselves as “not at all, somewhat, moderately or a lot,” for each question. The results were tallied and then an indicator of the degree of their depression and/or anxiety was recorded. These were great tools to use with clients to assess their emotional and physical states. These checklists also provided an opportunity to highlight to clients that their thoughts and/or how they were feeling could have an impact on their physical body. This impact on their physical body can result in physical symptoms, which can lead to unhelpful behaviors, an example being avoidance. The checklist was repeated again towards the end of sessions to see how the client was progressing with

addressing their symptoms. Once the checklist was repeated it was helpful to reveal the progress made by clients in particular areas or to identify additional areas to work on.

In addition to symptoms of anxiety and depression, clients that I provided counselling to at mental health services had a range of diverse issues including: anger, paranoia/fears, post-traumatic stress disorder, sexual abuse, self-harm, post-partum depression, attention deficit hyperactivity disorder, relationship issues, bipolar disorder, addictions, grief, loss and change of life. The screening intake form allowed me to prepare myself and seek information for each case, in order to better assist my clients. I did this through research of resources and literature available at PAPHR and by consulting with other practitioners who shared current resources, like Dialectical Behavior Therapy (Linehan, 1993a).

I had an interesting case load of clients with a variety of experiences including being kidnapped, witnessing a murder in the workplace and childhood sexual abuse, to name a few. The client who was kidnapped was an inmate from Pine Grove Women's Correctional Center. She shared her story of how her divorce led to drug use, which led to gang involvement and credit card fraud. She was kidnapped and held against her will for three days, by friends of her drug dealer ex-boyfriend. Fortunately, this client had "reached rock bottom" after her incarceration and started dealing with her issues by addressing her sobriety and reconnecting herself to former positive relationships outside of jail. During our sessions her focus was on her fear and anxieties. She utilised CBT strategies to examine how her negative thoughts impacted her feelings and behaviors.

Another client had witnessed a murder, seeing it happen through a window while at work. She observed a man shoot another man. She then proceeded to perform CPR and first aid on the victim once the perpetrator had fled the scene. This particular client was suffering from post

traumatic stress disorder and was taking medication prescribed by her psychiatrist. The focus of our sessions was working on her physical symptoms of anxiety and depression, employing CBT strategies.

The third example I noted was the client who had suffered sexual abuse as a child. It was only in the last two years that my client had acknowledged and started to deal with her childhood abuse. She had been abused by the teenage son of her elementary school babysitter. My client had repressed her abusive memories for many years and then finally revealed them to her mother. My client shared that her mother had known about the abuse all along and had attempted to get her help. The mother had informed my client that when brought for help, “the professionals” told her mother that her daughter was young enough and would likely forget. My client shared that she struggled for numerous years with issues of self-harm, anorexia, and suicidal ideations. She shared that she was angry with her mother for not helping her by addressing what she felt (the abuse) was the reason for her self-destructive behaviors. Since revealing her abuse, my client has been seeing a psychiatrist and sexual abuse counsellor. This client was assigned to myself only temporarily while her counsellor was on holidays. Our time together was spent working on addressing her anxieties resulting from her fears, negative maternal relationship, and poor coping mechanisms. We utilised both dialectical behavior therapy and CBT strategies such as, “Wise Mind” and the “Stop Skill” (Linehan, 1993, Linehan, 1993b).

One of my other clients was a mother who was suffering with post-partum depression. Zauderer and Davis (2012) report that approximately 13 percent of new mothers’ experience hopelessness, anxiety, desolation, and fatigue, all of which are indicators on the spectrum of PPD. It is also reported that 14 to 23 percent of pregnant women will experience depression

during pregnancy (Zauderer & Davis, 2012). After childbirth, 5 to 25 percent of women will develop post-partum depression (Zauderer & Davis, 2012). Having no previous experience working with mothers with post-partum depression issues, I was expecting my client to share with me feelings of depression and possible suicidal ideations. I was caught off guard when my client shared with me that she wanted to “kill her baby.” For most of the clients that I saw, a suicide screen was completed and often a safety plan was developed to keep that person safe. In this case, a safety plan was developed for the infant at risk. Fortunately, this client was already seeing one of the psychiatrists’ at PAPHR Mental Health. I was able to consult with her psychiatrist to confirm what plans and treatment were in place to ensure the safety of my client and her infant child.

Through consultation with my supervisor I became familiar with the EPDS or Edinburgh Perinatal/Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987). The EPDS is a screening tool that is being used universally for expectant and new mothers in hospitals, in therapy and by physicians to identify possible signs of depression. Santos et al. (2007) report, “The EPDS is the most widely accepted screening scale used worldwide in the perinatal period” (Santos et al., 2007, p. 2). It is used in Canada, United States, Netherlands, Japan and Spain to highlight a few examples (Santos et al., 2007). The purpose of this tool is to identify women who may benefit from follow up care, such as a mental health assessment. Being a mother of three children and recognizing the challenges and struggles of being a new parent, I found I was extremely interested in learning more about what resources and suggested treatments were in place to work with this type of clientele. I became extremely interested in the possibility of working more in-depth in this area of practice. After reflecting on the reported the incidence of PPD, in which possibly 25 percent of new mothers could experience post-partum depression, it

alarms me that there is not more awareness of this issue (Zauderer & Davis, 2012). If given the opportunity in the future, I would like to work with women who are experiencing post-partum depression. I would like to create awareness about PPD and identify what services are currently available and discover what else could be implemented within my community.

One final piece of the clinical counselling sessions which is worthy to note is the diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, which is required by the social worker or clinician for each client (American Psychiatric Association, 2013). After meeting with each client and completing the primary assessment piece, a clinical diagnosis is required. The DSM was created to enable mental health professionals to communicate using a common diagnostic language (Prichard, 2006). However, I found that this diagnostic piece was reflective of operating under the medical model rather than from a social work perspective. Prichard (2006) adds that using the DSM is a “pathology-based, deficit approach to diagnosing psychiatric conditions and psychopathology” (Prichard, 2006, p. 7). In addition, Prichard (2006) notes that there is concern for social workers continuing to be trained in assessment and psychopathology using a classification system, such as the DSM, that is seriously restrictive. Ultimately, I felt like I was placing a label on the individual when usually there was a more complex history of events that the client was trying to deal with, instead of the one assigned label. During my clinical supervision and by consulting with other social workers I was able to get a better understanding of the DSM diagnostic process. The counselling theories that I used within my counselling sessions will be discussed in the next chapter.

Chapter Four: Counselling Theories

The goal of Mental Health Services is to assist clients in defining their strengths and helping them work towards independence rather than fostering dependency. These goals align with the CASW Code of Ethics (2005) where, “the profession has a particular interest in the needs and empowerment of people who are vulnerable, oppressed, and/or living in poverty” (CASW, 2005, p. 3). I would describe my personal theoretical framework for practice as an integrative approach. Depending on what each individual client’s needs are determines my approach and what I think would work most effectively to support their therapeutic goals and their ability to achieve them. Although, if I had to choose one approach, my professional approach is that of a strengths perspective. I would describe myself as a “cup is half-full” type of person and as a result of my own personal experiences I apply this type of thinking to most situations. Highlighting individual strengths and the positive aspect of every situation is an empowering approach.

In this chapter, I will discuss the following counselling theories that I utilised during individual sessions with clients at Mental Health Services: Strengths-Based Practice, Cognitive Behavior Therapy, and Solution Focused Therapy. Having already highlighted ICBT and DBT I will focus this section on theoretical frameworks not previously discussed. As noted earlier, my previous counselling experience was limited due to the types of employment I had held. Therefore, enhancing my working knowledge and practical application of additional approaches was as essential piece to fulfilling my learning objectives. Providing counselling sessions to individuals and groups as a mental health counsellor and learn of concerns commonly affecting clients would also address my practicum objectives.

Strengths-Based Approach

The strengths-based approach or perspective is contradictory of traditional psychotherapy models which tend to focus on personal deficits, defects and disease (Min, 2011; Saleebey, 1992). Rather than draw attention to weaknesses, limitations and failures, the strengths-based approach embraces the ideology that focuses on an individual's strengths and instinctive coping mechanisms (Cohen, 1999; Min, 2011; Saleebey, 1992). Within the strengths-based approach, the emphasis is placed on a person's strengths as a resource, in order to solve their own problems. The strengths perspective does not diminish or refute the client's problems or challenges, rather it brings attention to the positive attributes of the client's abilities in order to empower that individual (Cohen, 1999). This process is achieved through information and knowledge exchange between therapist and client. Min (2011) shares that everyone has the gifts, capacities, resources and inherent skills that they can use to address their own problems. These strengths can be in the form of life experiences, personal attributes, coping abilities, environmental resources, personal motivation and social skills and capacities (Min, 2011).

Saleebey (1992) further adds that adopting a strengths perspective is using the strengths and resources of the client, their family, their community and professionals to cope and overcome their problems. This approach affirms the client's problem solving capabilities and encourages self-determination, through the process of a collaborative relationship between therapist and client, rather than a hegemonic relationship (Tong, 2011). This perspective aligns itself with the values of the Canadian Association of Social Workers Code of Ethics (2005), whereby there is an intrinsic importance placed on respecting the client's self-worth and dignity, through empowerment and encouragement. Using this approach allows clients to begin to think of themselves in a more positive reference and encourages them to think of themselves as not

being the problem. During my client sessions I would consistently draw upon the strengths-based approach.

It was evident to me while working with individuals, that when their strengths were highlighted they appreciated the recognition. Many clients struggle with their negative thoughts and are critical of themselves. When presented with the positive aspects about themselves that I brought forward from our conversations they often seemed pleasantly surprised and uplifted. Some clients had a harder time accepting the recognition, while others stated that they had failed to recognize those qualities in themselves and did not see themselves in that way. Focusing on each client's gifts and capacities can have a great impact towards empowering the individual and assist to increase their self-confidence and ability to achieve their goals. Highlighting their supports and resources, whether environmental or emotional, parallels nicely with the perspective utilised at Mental Health Services.

However, there are some limitations to the strengths-based approach, such as when clients refuse to see the strengths or capacities in themselves. Some individuals refute these qualities or minimize their strengths, which can prevent them looking past the problems or mistakes they have made. In addition, Saleebey (1992) argues that this approach is more of an orientation to practice as opposed to specific theoretical approach with specific guidelines. In light of these limitations, I still feel, as a therapist, that having a strengths-based perspective remains to be invaluable way for a therapist to help empower clients to see their self-worth and dignity, in order to motivate them to reach their goals.

Cognitive Behavior Therapy

Cognitive Behavior Therapy (CBT) was developed by Aaron Beck and Albert Ellis, two pioneers who brought together their backgrounds of Cognitive Therapy and Rational Emotive

Behavior Therapy. Throughout my time spent at PAPHR Mental Health Services cognitive behavior therapy was the most commonly used therapeutic approach used by social workers. It was also my experience that many clinicians take an integrative approach to therapy sessions, bringing in other forms of therapy where appropriate, so in addition to CBT, many other approaches were practiced. The evidence available that supports the efficacy and effectiveness of CBT for depression is abundant and has been well established (Butler, Chapman, Forman, & Beck, 2006; Cuijpers et al., 2013; Tolin, 2010). Chambless et al. (1996) reports that CBT is considered an empirically supported treatment approach and is endorsed by both the Division 12 Task Force of American Psychological Association and the National Institute for Health and Care Excellence (NICE) in the United Kingdom (Clark, 2011; Waltman, Creed, & Beck, 2016).

Beck (2011) reports that cognitive behavior therapy has been one of the most researched treatments for depression and anxiety and it has also been found effective for a variety of other psychiatric issues. CBT is based on the cognitive model which suggests that a person's behaviors, emotions and physiology are influenced by how they perceive events (Beck, 2011). This theory suggests that dysfunctional thinking, which can lead to altered behaviors and moods, is at the root of all psychological disturbances (Beck, 2011). Examples of dysfunctional thinking can include overgeneralizing, mind reading, personalizing, jumping to negative conclusions and filtering (Edelman, 2007). Cognitive behavior therapy aims to stop the cycle of unhelpful thoughts, maladaptive behaviors and unwanted physical symptoms, from continuing to impact each other as they are all interconnected.

In CBT the therapist works with the client to educate them about unhelpful thoughts and beliefs and how these can attribute to their distress. Edelman (2007) states that the focus of CBT is to help clients develop realistic thoughts in order to reduce their experiences of negative

emotions. Beck (2011) adds that important components of CBT include helping clients solve problems by encouraging them to identify and evaluate their negative thinking patterns about themselves, their environment and their future. By helping the client identify their unhelpful thinking and their unrealistic beliefs, they can begin to replace these with healthier thoughts. This approach is based upon the idea that: if you change how people think, you can change how they behave.

CBT is guided by several principles one of which is to create a strong therapeutic alliance (Beck, 2011). Trust is built between client and counsellor through empathetic statements, active listening and reflection. Another important principle of CBT is the emphasis on collaboration between therapist and client and active participation (Beck, 2011). The client takes on an active role in their therapy by completing agreed upon homework and activities. One example of these activities includes thought challenging or thought monitoring, where the client is asked to find realistic evidence of their unhelpful thoughts or beliefs. Another homework exercise is graduated exposure, where clients choose activities that make them uncomfortable or create anxiety, and then try to expose themselves to that uncomfortable situation in small amounts, until they are no longer anxious.

I found that this therapy was useful and practical in working with clients at Mental Health. CBT incorporates homework activities for clients which encourages collaborative work between the client and therapist when homework is reviewed in subsequent sessions. Although I am a strengths-based therapist at heart the strategies and skills taught in CBT were tremendously useful and easy to apply while working with clients. My experience with clients was that they come in with distorted thoughts and self-defeating feelings of failure, which makes CBT an efficient tool to use in order to explain to clients the cycle of symptoms. CBT provides some

education to clients about their unhelpful thoughts, behaviors, and physical symptoms. It was also helpful to illustrate the CBT triangle, so clients could visualize and further comprehend how their thoughts, behaviors, and symptoms, are all interconnected. This process allows clients to identify their unhelpful thinking patterns and beliefs and CBT provides the tools and exercises to work on them.

The process of CBT is also aligned well with the philosophy of PAPHR Mental Health Services in which clients are asked to identify their social history, presenting problems and goals, as part of completing the Primary Assessment. CBT requires an evaluation in order to formulate a case and conceptualize what is happening for the individual you are working with and then plan treatment. Therefore, the process of CBT and the expectations of Mental Health Services complement each other in an effective way to assist clients. It was my experience that many clients were eager to, in some way, address or work on themselves between sessions. CBT provided many strategies/homework activities to share with clients that they could utilise on their own time. In addition to depression and anxiety, I found that CBT was effective in working with clients who were experiencing grief and loss, relationship issues, PPD, bipolar disorder and PTSD.

However, like any other approach there may be limitations and for CBT it can be argued that the approach focuses on the here and now and therefore, does not help those individuals who want to focus on issues from the past. Another limitation of CBT is that an individual may feel that they are the problem, as the focus is on an individual's distorted beliefs (Min, 2011). CBT can also be seen as inflexible due to the active participation required by clients to complete homework, challenge their thinking and complete activities. This inflexibility was something that I encountered in my work with ICBT clients, as the lessons were planned out and scheduled.

A few of my clients had a hard time with the pace of activities of the program and how they moved along to new concepts. The ICBT Online Therapy USER program is structured with specific lessons and timelines. Before clients begin they are aware of these timelines, but are not always able to keep up with the pace set out by the program. Fortunately, the online program is designed for clients to continue to have access to the material for an additional three months and clients can also print off the resources for their own personal use. With these measures in place it gives clients additional time to go over the CBT concepts and finish out their program at their own pace.

Solution-Focused Therapy

Another therapeutic approach I utilised during my placement at PAPHR was Solution-Focused Therapy or Solution-Focused Brief Therapy. This theoretical approach is based upon building and creating solutions to client problems, rather than focusing on the problem itself. Utilising this approach, it is believed that people already possess the skills and resources they need to resolve their problems (Nichols, 2014). Nichols explains that as people become engrossed in their problems it hinders them from recognizing their abilities, resources, as well as any successes, where the problem did not exist or where the problem was solved at one time. Instead of looking at the details of the problem, the focus is placed on exploring and highlighting what aspects contribute to fixing the problem. Focusing on the solutions proves to motivate people to concentrate on maintaining behaviors that will continue to solve their problems.

Using the solution focused approach the therapist's role is to highlight the client strengths and then assist the client to realize that they have the innate capacity to be a change agent rather than a victim of circumstance (Walsh, 2010). This approach is short term and goal focused and with it, the belief is instilled that rapid change is possible, even with a single session (Nelson,

2005). Staying future focused, the miracle question is proposed to the client and asks “if by a miracle you woke up one morning” and their problem was gone, what would be different (DeJong & Berg, 1998). This approach enables the individual to start thinking about what types of changes they would like to see happen in their lives and forecast what the future could look like. The focus then remains on the future instead of concentrating on the problem.

Dolan (2014) offers a description of some of the techniques used in solution focused therapy as follows: looking for previous solutions, using compliments, inviting clients to do more of what works, asking the miracle question or the exception question (when the problem did not exist), using scaling questions (rating from 0 to 10, best to worst), and asking the coping question of how they have managed to go on.

I found solution focused therapy useful when clients were focused on a particular problem area. It is similar to the strengths-based approach in which it focuses on strengths and moving forward. Through collaboration with the client to find solutions, it aids to empower the client to achieve their goals. My experience has been when highlighting success with clients, they appear to have a great sense of self-worth and leave more optimistic about their future. As clients are encouraged to find solutions they are seen as the experts and the tone of the sessions are set in a positive tone, which is helpful in maintaining engagement and motivation in therapy sessions. Like the strengths-based perspective this particular approach aligns well with the social work values of a client’s right to self-determination (CASW, 2005).

However, there are a few limitations with this theoretical approach where it is not successful for all types of clients, especially those who have suffered trauma, who may need to revisit the past to understand the problem (Shebib, 2011). The same would apply to clients who need to revisit the complex past, like in a situation involving childhood abuse, in order to move

forward and would require longer term counselling. In addition, Nichols (2014) shares limitations that point to a lack of empathy or understanding when clients are prevented from telling their personal story, as the focus is primarily on building solutions. Having discussed this third and final therapeutic approach used in counselling sessions at Mental Health Services, the next section will highlight how I achieved the learning goals set out in my practicum proposal.

Chapter Five: Achievement of Objectives and Skills

My practicum placement at the Prince Albert Parkland Health Region in Mental Health Services was a great fit with the goals set out in my original learning objectives. This placement provided me with many opportunities to fulfill my goals and provided additional learning opportunities. The objectives that I chose to focus on during my practicum placement were: (1) to gain experience in the area of clinical counseling, as well as in group counselling; (2) to gain further knowledge in and utilise various social work and counselling theories; (3) to enhance my skills in ICBT; and (4) to learn about concerns commonly affecting those seeking counselling and become familiar with the treatment methods and protocols used at PAPHR Mental Health. I will provide an overview on how I believe these objectives were achieved, as well as the skills that I developed throughout the process.

Increased Competence in Clinical and Group Counselling

During my placement at PAPHR I was able to facilitate both individual and group counselling sessions. I felt that I experienced tremendous personal growth in individual counselling. My skills in this area were refreshed and renewed, increasing my confidence in assisting clients. The skills that were essential to achieve this were: active listening (asking questions, paraphrasing), reflection, focusing (redirecting conversation), respecting confidentiality, relationship building and above all developing a strong therapeutic rapport through positive regard, genuineness and empathy. I found that keeping social work values and standards at the forefront of all sessions provided the guidance to always act in the best interest of the client and to encourage self-determination (CASW, 2005). Core social work value number one, “respect the inherent dignity and worth of persons” was a central focus when working with clients (CASW, 2005, p.4). For my own personal conduct, following the

Saskatchewan Association of Social Workers Standards of Practice principle of competence was vital: “Social workers shall be competent in performance of services and functions that they undertake on behalf of the persons they serve” (SASW, 2012, p.13).

During the group sessions all of the same skills were applicable, but building rapport was developed differently during group counselling. Due to the group setting some clients appeared to be slightly resistant to share and be open, but the small group breakout sessions provided the atmosphere for the clients to get to know me better as a therapist. Within those smaller groups the relationship building began by engaging clients, building their trust and redefining the purpose of the group therapy (Shebib, 2011). In addition, I was able to build relationships and trust with clients when I prepared, presented and modelled the material for the group sessions. When I led the sessions, as my fellow co-facilitators had, this increased the rapport and sense of confidence I had with the group participants. I feel that I was attentive and empathetic to the stories, concerns and fears that clients shared, both one on one and in group therapy.

During counselling sessions, I also enhanced my interviewing skills with clients while completing the required assessments and working with clients to set goals. Goal setting helps clients define, in measureable terms, what they hope to achieve from their counselling sessions and provides direction and motivation for the client (Shebib, 2011). In some instances, clients came in and were not completely sure what their goals were. This required deeper exploration of what the client was not fully expressing or was only hinting at (Culley, 1991). By digging deeper at the hints or patterns the client shared, I was able to gain a better understanding of what the client’s struggles were and then helped them to redefine what their goals could be. My competence in group and clinical counselling has increased as well as my practical and working knowledge of various theoretical approaches.

Enhancement of CBT and other Theoretical Approaches in Practice

During the individual and group counselling sessions the application of theoretical approaches also became more fluid and comfortable for me. I frequently utilised the strengths-based approach when working with clients, so it was essential for me as a clinician to enhance my experience with other approaches. Application of cognitive behavior therapy was an effective choice for most clients. Being able to apply this therapeutic approach with a variety of different issues, like anxiety, panic disorder and post-partum depression, helped to solidify my confidence in using cognitive behavior therapy. I also utilised solution-focused therapy, usually with shorter term clients, and gained more confidence in this method.

Through placement in this practicum not only did I enhance my knowledge and practical skills in using CBT, I also was provided with the opportunity to learn an additional therapeutic approach, which was dialectical behavior therapy. I was not expecting to utilise this approach going in to my practicum, but I was extremely pleased to gain and learn a working knowledge in dialectical behavior therapy. It was helpful to work alongside two other facilitators for the DBT skills training. As well, it was also helpful hearing the group discussion from participants as they were introduced to the terms and practiced the skills. The DBT skills training experience has prepared me for future group sessions, by gaining a better understanding of group dynamics and the role of the facilitator. The next section discusses the use of CBT in online therapy.

Increasing Capacity of ICBT

During my practicum placement I was able to utilise cognitive behavior therapy both in person and online, as part of the Online Wellness Program. My practical experiences with CBT has further solidified my working knowledge of this approach. The use of internet cognitive behavior therapy has an important place in our society today. This is evident by the number of

different programs that are being offered online and the range of issues that are being treated. ICBT is now being researched for possible use in the treatment of other issues like, post-partum depression, tinnitus, irritable bowel syndrome, and headaches (Hedborg & Muhr, 2011; Hunt, Moshier & Milonova, 2009; Pugh, Hadjistavropoulos, Hampton, Bowen & Williams, 2014; Weise, Kleinstauber & Andersson, 2016). The range of issues being treated online further illustrates the significance and depth that ICBT can serve to clients in need and for clients who live almost anywhere. Carrying a caseload of 10 clients over the course of my practicum has strengthened my belief in the value of ICBT, especially for clients who live in rural communities. Individuals who live out of urban centers have an additional barrier to accessing services, as they would have to travel to see a counsellor face-to-face. Offering online CBT services could help to address this barrier and improve access to mental health services. During my practicum, at least half of the clients I treated through ICBT were from smaller communities, most of whom commented that they appreciated being able to access mental health services from home.

One of the key points of ICBT as an e-therapist is developing a genuine rapport with clients. Establishing this rapport with clients through emails was a challenging process. Developing rapport through email requires being able to reflect empathy, genuineness, emotion and understanding in the written word. For clients who did not email each week or sent short emails, building rapport was more challenging. Continued sessions aided in increasing my skill capacity in building genuine rapport during these internet therapy sessions. At the end of each eight-week course, I had several clients thank me for being their therapist and for my encouragement and assistance throughout the course.

Fulfilling the Role as a Mental Health Out-Patient Counsellor

Actively participating in the role of the mental health counsellor was a thought-provoking and complex process. This process required case management skills, constant reflection, critical thinking, increased awareness, and consultation. These areas were reviewed during clinical supervision on a bi-weekly basis. Learning the role of the mental health counsellor involved becoming familiar with the PAPHR's policies, practices and expectations. The expectation of the mental health counsellor is to maintain a client-centered perspective and adhere to the guidelines set out in the policy, while upholding the dignity and the right to self-determination of the client (PAPHR, 2009b). Reviewing the procedures and case management/paper work necessary for each client was an in-depth process, but appropriate in order to best meet the needs of the clients. The paper work, assessments and client notes are vital to continue to productively serve clients, as the information that is gathered is available to all practitioners for present and future use if necessary. Especially important is the suicide protocol work, so that clients at high risk have access to services as soon as possible. All of this work was done as part of my role as mental health counsellor during my practicum.

In addition to the case management, I believe that critical thinking and constant reflection is necessary as a mental health counsellor. Reflection is a cumulative process that equips practitioners with the ability to build and store knowledge from which they can draw (Bulpitt & Martin, 2005). Reflection was part of my daily routine during my practicum and I participated in biweekly supervision session with my supervisor as well. Critical thinking and reflection on what was working well in sessions, what needed more work, preparation or research that needed to be done to be more effective, and how things could be done differently were important areas of focus for professional and personal growth.

Awareness and consultation were extremely important in this new role, as I did not readily have all the information or resources necessary to work with clientele with particular issues, like post-partum depression and attention deficit hyperactivity disorder for example. Being able to consult with other social workers, psychologists and psychiatrists was extremely helpful. It was also reassuring that this consultation was well received within the multidisciplinary team and that the client-centered approach was embraced by all members of the mental health team, regardless of their position. Heightened awareness of the incidence of issues like PPD made a definite impression upon me as a social worker, as did the importance of continuing to be invested in mental health trends and keeping abreast of current mental health concerns. The Canadian Association of Social Workers states that social workers must adhere to value four of the Code of Ethics; competence in professional practice (2005). After completion of this placement, I am pleased to say that it has renewed and rejuvenated my social work values and ethics.

Chapter Six: Challenges, Values and Ethics

In this chapter I will examine some of the personal and professional challenges that I experienced as a result of my practicum. In addition, I will discuss personal values and ethical considerations of being a mental health counsellor. Following this I will provide a conclusion for my practicum report.

Personal and Professional Challenges

During my placement at PAPHR I experienced some challenges throughout the practicum both personally and professionally. When I arrived on the very first day of my practicum I was advised that my professional supervisor was away due to a family emergency and unfortunately, she did not return for over two weeks. I thought my learning opportunity was in jeopardy, but fortunately, the multidisciplinary team approach of practitioners at PAPHR assisted me in settling in to the role of counsellor. I became adept at asking for guidance and assistance throughout the unit, which allowed me to get to know many of the staff. This independence proved to be essential and effective in learning the expectations of my role. Although my supervisor was away, I was still provided with the supervision necessary and was able to consult with others on issues and concerns.

Another professional challenge that I struggled with was the 50 percent no show rate for appointments of clients seeking mental health services. This statistic surprised and saddened me. I had no previous comprehension of the rate of attendance for mental health appointments. The fact that 500,000 Canadians, in any given week are unable to work due to mental health problems or illnesses, is unsettling and even more unsettling is the fact that only 40 percent of that 500,000 will ask for help (Mental Health Commission of Canada, 2014). When it comes time to attend the appointment, the history of the rate of attendance at PAPHR illustrates that

likely only half of those will show. As a clinician, this is frustrating and unfortunate to see, that due to stigma, illness or whatever the cause may be, individuals who crucially need the service do not attend. Awareness of these factors is a driving force for mental health professionals who are trying in many different venues and formats to support activities that are integral to improving mental health. PAPHR is committed to enhancing the awareness and understanding of mental illness through public education in the community and surrounding areas: thereby, working towards reducing stigma (PAPHR, 2009b). Collaborative work is consistently being done in the region to increase health promotion, prevention and early intervention strategies.

One more challenge to this line of work that I quickly became aware of was the sense of crisis or high emotion that is involved in working with clients who are experiencing a high level of risk, distress or trauma. Compared to my previous line of work with community development this was a dramatic change. Bride (2007) relays that listening to clients' complex traumas can induce symptoms of burnout, as well as secondary traumatic stress. Sometimes as practitioners we can put ourselves in a vulnerable emotional position as we engage with clients. As we build a connection to our clients and develop rapport we can leave ourselves susceptible to traumatization, as we "take on" others peoples pain (Dombo & Gray, 2013). It is essential in the role of social worker to recognize that people have the ability to heal themselves and that we can share empathy and compassion without taking away from one's self (Dombo & Gray, 2013).

Therefore, the identification of self-care is an important piece when working with people who are in crisis to help avoid some effects of traumatization. The importance of maintaining boundaries, being cognizant of professional limits and practicing mindfulness, are key items to self-care being a social worker in the counselling role. I am happy to share that during my time at PAPHR Mental Health Services the awareness of self-care amongst the team members was an

important factor. Each week during Monday morning meetings small personal successes and triumphs (like the birth of a grandchild or going on a weekend getaway) were shared among all practitioners highlighting the importance of our lives beyond the office and deeper personalization of each individual. In addition, there was an opportunity for team members to participate in a brief walk each day during the afternoon coffee break, if schedules allowed. This was a valuable opportunity to practice some self-care, by leaving the office, getting fresh air, some physical exercise and being able to talk with fellow co-workers. The challenges that I incurred during my placement were worthy to note and address, as I am sure that there are similarities that can be drawn across working in other capacities as social workers.

Values

Values are personal beliefs that can be formed through the influences of life experiences, family, society, friendships, religious beliefs, culture, socioeconomic status and racial or ethnic backgrounds (Miller, 2007). These values place importance on our individual beliefs and guide us in decision making and actions. In the role of social work, our professional values are listed in the CASW Code of Ethics (2005). These values include the respect for the inherent dignity and worth of persons; service to humanity; pursuit of social justice; integrity in professional practice; and confidentiality and competence in professional practice (CASW, 2005). My own personal and professional values and those of PAPHR were aligned and I was pleased to learn that this agency upheld the same beliefs of the core social work values (CASW, 2005). There was a focus on self-determination and assisting the client to identify their needs, concerns and goals for the future.

However, there were some brief moments where as a clinician I did feel like my own personal values surfaced, but was pleased that they did not in any way impact my clients. In one

instance I was working with a client who was an inmate at the Women's Correctional Centre. As indicated earlier in my report, I was assaulted by a female inmate while working at this same correctional institution. During our sessions, I did not feel that I was in jeopardy because she was an inmate, nor did I fear that I would be harmed. I felt as though the relationship was completely different, as I was in a position to advocate for my client rather than be in position of power or authority. My personal belief that I did not condone the crimes that the inmate committed also surfaced, but the focus remained on her plans for the future and the goals she had set for our therapy sessions, without any mention of the crimes she committed.

One other instance where I believe that my personal beliefs and values were tested, was when I worked with the mother who had post-partum depression. When the mother shared with me that she had thoughts of wanting to "kill her baby," I reserved any personal judgements. Being a mother of three children it was hard for me to imagine having those thoughts, but my concerns quickly turned to compassion for this young mother. I had not understood up until that point how traumatic this disorder could be for a new mother until I personally met this woman and heard her story. It made me reflect on how easy it was to judge someone and how debilitating that can be to that individual. I personally believe that more research and public awareness needs to be done to reduce the stigma for mothers and to assist those women who struggle with PPD. As social workers, we have the unique capacity to stand up and advocate for our clients and I was reminded of how important our profession is to those in need.

Ethics

My professional ethics, values and personal morals guided me through my work as a mental health counsellor in this practicum placement. As mentioned earlier, social workers are guided by the CASW ethical standards and values (2005). In addition to these guiding principles

the expectations set out in the policies by Mental Health Services and the client centered/strengths perspective helped to uphold a focus on maintaining the best interest of the client and the right to client self-determination (CASW, 2005; PAPHR, 2009b). These guiding principles were also prevalent while facilitating the various therapeutic approaches such as, cognitive behavior therapy, solution-focused therapy and the strengths-based approach. Using these collaborative therapeutic approaches during sessions to define treatment goals and direction, exemplified upholding a client's right to self-determination.

In addition to self-determination another significant component at PAPHR Mental Health Out-Patient Services is the importance placed on service to humanity and social justice, through access to programs and services. It is appropriate that one of the guiding principles of the PAPHR Mental Health Services program is, "To promote mental health and enhance awareness and understating of mental illness through public education, thereby, to work towards reducing stigma" (PAPHR, 2009, p. 2). The concept of access and inclusivity for all those in need is a central focus for Mental Health Services. This is illustrated by no fee services and implementation of the "Open Access Program" for clients, which helps to eliminate additional barriers of access and promotes inclusivity. I believe that working with my own core values which are aligned with social work values and maintaining the *Standards of Practice for Registered Social Workers*, I was able to serve clients in an ethical manner while upholding the expectations and policies of the Prince Albert Parkland Health Region (Saskatchewan Association of Social Workers, 2012).

Conclusion

The learning objectives that I aspired to achieve during my practicum placement were met during my time spent with PAPHR Mental Health. I wanted to challenge myself to new

experiences, directly resulting from facilitating individual and group counselling as well as internet therapy. The agency and staff provided a supportive and excellent venue for learning and achieving my goals, all of which embraced the values of social work. I was able to participate in a number of different activities all the while, being provided with guidance, encouragement and access to ample resources. I appreciated being able to be a part of the multidisciplinary team and was able to consult with other practitioners about clients' needs and various issues. The diversity of clients that I assisted allowed me to embrace and broaden my awareness and knowledge working in the area of mental health. Working in-depth with clinical therapeutic approaches enhanced my confidence and ability to use them effectively.

Reflecting on this experience has left me with a few thoughts on ways to impact mental health services. Coming from a school environment I think there could be a substantial positive benefit if a mental health counsellor could be available in each elementary school for 4 or 5 days per week. Mental health counsellors in the school setting could help reduce the stigma of accessing care and eliminate one of the barriers of access to mental health services. I am aware of mental health services offered in high schools, but this service is offered only in a limited capacity in elementary schools. The increased presence of mental health counsellors in schools could serve as an opportunity to engage youth and families to promote change, awareness and acceptance.

I also believe that ICBT is a valued service option for clients given that it is facilitated by professionals. The increase of the different areas that ICBT can serve is a direct reflection of its effectiveness. There is a need for awareness of this service as well as training for facilitators and new areas of application. I also believe that being able to offer some type of an interactive online therapy program through Skype would be well received by clients.

This paper provides an in depth reflection of my experiences at Prince Albert Parkland Health Region Mental Health Out-Patient Services. Overall, this placement provided me with a positive learning experience and allowed me to gain invaluable knowledge working with clients in group and individual sessions. It has renewed my beliefs and passion in the work done by social workers and the importance of the values and ethical professionalism that guides the work we do. I would sincerely like to thank my supervisors and all of the practitioners who I was able to work alongside, for this valuable experience. As a result of this placement, I have become a more skilled and well-rounded social worker.

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