COUNSELLING YOUNG PEOPLE INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM

A Practicum Report
Submitted to the
Faculty of Education
in Partial Fulfillment
of Requirements for
the Degree of
Master of Education
in
Educational Psychology

by

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June, 2017

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ABSTRACT

Counselling Young People Involved with the Criminal Justice System is a report on my practicum placement for my M. Ed. Psych. Practicum Route 2 program at the University of Regina. I worked at Child and Youth Services for the Saskatoon Health Region from May 1st to June 16th, 2017. I specifically worked with Mr. Shamus James, M. Ed. Psych., on the Young Offender team. Mr. James is also part of the Youth Sexual Offender team. This paper addresses topics that I learned about during my practicum, reflections on how my course work was applied to this practicum, as well as my personal goals of improving my counselling skills as I prepare to continue my work as a guidance counsellor for the Saskatoon Public School Division.

Key words: practicum, practicum report, forensic psychology, educational psychology, counselling
ACKNOWLEDGEMENTS

I want to acknowledge the support and assistance I received in the completion of my M. Ed. Psych. degree, my practicum, and this practicum report from: Dr. Angela Snowshoe (for teaching me about best counselling practice, Decolonization, and for being my faculty supervisor,) Mr. Shamus James, M. Ed. Psych. (for being a supportive professional associate during my practicum at the Saskatoon Health Region’s Child and Youth Services, Young Offender Team. I gained practical insight from talking with you about the unique issues related to forensic counselling. I appreciate all of the extra time you took to mentor me,) Dr. Ronald Martin (for teaching me three classes. Your sense of humour, positive feedback, and practical assignments helped me gain confidence,) Dr. JoLee Sasakamoose (for opening my eyes to societal changes that must take place in the world’s treatment of women, Indigenous people, and the benefits of group counselling,) Dr. Scott Thompson (for helping me focus assignments in Psychology of Learning to my end goal of becoming a full time guidance counsellor,) Dr. Gale Parchoma at the University of Saskatchewan (for being patient with my struggles taking ERES 800 online,) the many wonderful students I shared my nine courses with – I hope these friendships and professional collaboration will continue in future years; and the Saskatoon Public School Division (for granting me a half year Professional Development Leave. I would not have been able to complete my courses and my practicum without this gift from my employers, and the support of the Student Services team and the Administrators at Centennial Collegiate.)
DEDICATION

I would like to dedicate this paper to my supportive family – Mom, Dad, Michelle, and Craig – I cannot express how supportive you have been as I completed program in pursuing this next stage in my career as an educator. I love all of you very much!
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INTRODUCTION

My practicum placement was with the Saskatoon Health Region’s Child and Youth Services, specifically the Young Offender team. The practicum began on May 1, 2017 and ended on June 16, 2017. I will describe the work environment for this placement, my observations from working with my Professional Associate, Mr. Shamus James, and what I hoped to gain from this practicum placement. My focus for this practicum was twofold – to gain experience working with a psychologist and to learn about forensic psychology.

One goal for gaining experience was to build on the counselling microskills I learned about in Dr. Angela Snowshoe’s Deconstructing Counselling course by putting them into practice through counselling the youth who receive forensic treatment.

I also wanted to learn how different psychologists write their case notes. I have experience keeping notes from my two years as a high school guidance counsellor, but I wanted to re-examine how I have kept records through seeing other ways that professional psychologists write their notes and maintain their records. I was able to view different approaches to this through reading case files. My Professional Associate, Mr. James, keeps very thorough case notes (I feel that this is closer to my natural tendency,) but I also read another psychologist’s notes. This psychologist wrote concise notes that were more of a general overview of what is discussed in the session.

The third goal for learning about the work of a psychologist revolved around how to deal with ethical dilemmas – particularly dilemmas surrounding confidentiality. This goal overlapped with my aim to learn about forensic psychology since the youths who come to Child and Youth Services for treatment with this specific team are court ordered to attend their sessions. That means that they have more limits to confidentiality than someone who is
seeking treatment from a psychologist in private practice.

I learned about the informed consent process with the Saskatoon Health Region, which ensures that all clients understand what may or may not be shared with other parties – community youth workers, the court, parents/guardians, psychiatrists, and other members of the “circle of care.” Appendix A is the intake forms every client signs, as well as a suicide risk assessment that every psychologist is required to conduct during the initial treatment session. These documents helped me understand confidentiality and informed consent in a forensic context.

Forensic psychology is the professional practice of applying psychology to the law when assisting in legal matters (“Specialty guidelines for forensic psychology”, 2013). I had not learned about this type of psychology before my practicum. It is a major field in psychology, and requires different approaches with an adult population than with the young clients I worked with. The teenagers and young adults (older clients who were still finishing their youth sentence conditions) I worked with ranged from incarcerated clients who had committed violent offenses with current or former gang ties, to youth who had committed sexual offenses, as well as clients who had committed major property damage. I will describe treatment approaches that the young offender team uses in relation to clients who have committed different offenses, but I will also describe the challenges to these approaches with clients who struggle with poverty, have difficult home lives, and who struggle intellectually. The person’s basic needs often comes before the psychoeducation related to the crime. Mr. James and I would regularly discuss Maslow’s Hierarchy of Basic Needs (Harper, Harper, & Stills, 2003). Clients cannot take steps to improve their circumstances, and rid themselves of a procriminal
attitudes toward life if they are at the survival stage of Maslow’s hierarchy. We ended up addressing those issues quite often with clients. That said, the primary mandate of the Young Offender Team is to assess each client’s risk to reoffend.

I have learned a great deal about how forensic psychology is practiced with the young clients at Child and Youth Services. I also recognize the barriers to success with clients who are mandated by the courts to attend counselling – “no shows” for appointments are a regular occurrence. I have learned a lot about different approaches to conducting a session with a client – in particular, how to be more direct - and how the recordkeeping, notes, and paperwork involved with each client are handled. I have also learned how to use my personal counselling style in the context of this practicum, and how I will extend that growth and development into my future role as a guidance counsellor for Saskatoon Public Schools.

1. CHILD AND YOUTH SERVICES, YOUNG OFFENDER TEAM

The Saskatoon Health Region oversees Child and Youth Services. The team I worked with has offices on the second floor of the Youth Resource Centre building on 311-20th Street East in Saskatoon. On the first floor is the Day Program, which is a program that helps high school students who struggle with mental health issues develop life skills and transition back to regular attendance at school. The Day Program and the Child and Youth Services occasionally overlap since some students in the program may see psychologists on the second floor for treatment.

The Young Offender team is made up of five psychologists, and three forensic management workers. Of the five forensic psychologists, three psychologists specialize in
working with adolescents who have committed sexual offenses. One forensic management worker is in charge of the referrals from community youth workers and Kilburn Hall, the secured facility for youth who have committed criminal offenses in Saskatoon. This management worker has a MSW (Masters of Social Work) designate, while the other two forensic management workers are at the BSW (Bachelor of Social Work) level. There is also a Rural Consultation division that is in the same office, but they are not part of the Young Offender team. There are also several support workers who run the office, and who provide caretaking for the building.

The events that lead a client to receive treatment can vary, but the usual process is: a “young offender” aged twelve to seventeen commits a crime. The youth is arrested and is assigned to a Community Youth Worker. Before a sentence is imposed, the Court request an assessment from a psychologist on the Young Offender team. The judge then determines if the youth will be placed in a youth detention facility – secure custody at the previously mentioned Kilburn Hall or open custody with Yarrow which is housed in the same building as Kilburn Hall. The judge can also impose a community-based sentence, so several youth live in their own home if that does not pose a risk to reoffend.

Some clients who are not in secure or open custody live in youth group homes (Eagle’s Nest, John Howard Society, or private homes like JCL.) Those placements are arranged by Community Youth Workers.

Youth sentences vary in length. Often, with adolescents who commit sexual offenses, sentences can be twenty-four months long. Part of the youth’s sentence, typically, involves receiving counselling. A referral is sent to the Young Offender team from the Community
Youth Worker or youth detention facility, and a psychologist is assigned. In most cases, the psychologist who did the court assessment also becomes the psychologist who provides treatment. The referral suggests whether the client receives forensic treatment, substance abuse treatment, or treatment for sexual offenders. Mr. James is part of the Sexual Offender team within the larger Young Offender team, so many “SO” clients are given to him. The psychologist then contacts the client to make an initial appointment. Preparing for that meeting involves reading through the file, and there may be consultations with the client’s community youth worker. Occasionally, it can take some time to contact the client, but eventually the first session occurs. That is when paperwork is discussed – informed consent, outline of treatment, contact information, and a suicide risk assessment – as well as getting to know the client (reviewing conditions and discussing key relationships in the client’s life.)

The psychologist then has to complete an initial session note within three days, so a treatment file can be opened. The time between all of these steps is monitored by the Saskatoon Health Region, so they can assess the expediency of service from referral to contact with the client to the file being opened.

An example of how this process can sometimes be slowed down occurred with a new treatment client that Mr. James met with when I began the practicum. The client’s foster parents unexpectedly came to the appointment because they wanted to ask Mr. James about a family event that could put the client in a high risk situation. That situation had to be processed before the session could even begin. This meant that the timing for the initial session was limited since that paperwork needed to be completed. It shows that there is a process to be followed, but psychologists need to be flexible with clients, and their families.
Most of Mr. James’ clients attend a session weekly or biweekly. He has some rural clients who come every two weeks since it is difficult to travel to Saskatoon every week. A model client will arrive on time, Mr. James will do a check in then there will be some psychoeducation and work around reducing the risk to reoffend, and a plan will be made for the next session which may or may not involve some homework for the client. In reality, clients will sometimes forget about appointments. Disruptions to the routine of attending appointments can cause some clients who have cognitive challenges to genuinely forget when appointments occur. If the psychologist has to cancel or reschedule an appointment – or meet for a case conference instead of an individual session - these clients may get confused about when to return to the earlier routine. Other types of clients appear to miss appointments on purpose. Some clients will come to a couple weeks of counselling, and superficially participate in the process. They will then miss an appointment or two – giving various excuses for not showing up. The entire time, Mr. James informs the client’s Community Youth Worker about the missed appointments. If it becomes a pattern then the Youth Worker may discuss consequences such as a breach, or may issue a breach if there is significant examples of non-compliance with treatment or other conditions. That is when these client may start to regularly attend again. The goal for the professional is to promote regular attendance, and to have these clients engage in the sessions in a meaningful way. There is a risk that if the pattern of sporadic attendance returns with these clients they will reach the end of their conditions without receiving much benefit from treatment. There are reasons why clients may choose to not attend sessions, which could involve seeing the justice system as an oppressive force in their lives. Perhaps not having the advantages of those in a privileged position –
whether it is socioeconomic, being treated differently due to race or sexual orientation, or not growing up in society’s view of a “traditional” nuclear family - can lead clients to commit criminal offenses. The crimes may be committed for survival – referring back to Maslowe’s Hierarchy of Needs. Some clients may have joined a gang to gain belonging and acceptance (also part of Maslowe’s Hierarchy of Needs) in a surrogate family if their biological family did not treat them well. Some clients may need to regain some power in life. This need for gaining power when they feel powerless could materialize through absences from treatment sessions. There is always a reason why people miss appointments, just like there are reasons why high school students miss classes – and it is not always because they are being manipulative or difficult. They have to see that attending sessions is meeting their unique needs.

After each session, Mr. James writes a case note – as stated earlier, his case notes are thorough. He writes down if the client shows up on time, the client’s demeanor that day, topics that are discussed in the session, and what the next steps are when the client returns. Observing and then taking part in this process has been exceedingly valuable to me. I see connections between this process and being a guidance counsellor. While students are not court-ordered to see me, they do not always come to my office voluntarily. There are many students who try to minimize issues, put in the time, or tell partial truths to avoid dealing with barriers to their success. Seeing how Mr. James handles this has taught me that there is only so much we can do for clients. They ultimately have to want to make changes in their own lives. We cannot force anyone to show up for appointments, make them talk to us, or force them to complete the treatment work.
Working with clients in treatment is just one aspect of the job for psychologists on the Young Offender team. When I began my practicum, Mr. James was in the process of writing a court assessment report. These reports take approximately forty hours to complete, and need to be completed in a timely manner for the courts. The challenge, though, is to be able to contact everybody to gather all of the relevant information – the Crown Prosecutor’s office has to send a package of information about the charges to the psychologist and the Community Youth Worker may send information that could include a Judicial Interim Release (JIR) or a past Pre-Sentence Report (PSR) which helps the psychologist get background on the youth and the offense committed. To complete the court assessment, all relevant parties need to be interviewed. Just scheduling the assessment itself can take a long time if people do not show up for interviews and appointments, or if there are other scheduling conflicts. Information needs to start with the client (which may take up to four interviews.) Other people that the psychologists gather information from are the family, the school, addiction services, social services, and the secure facility. Gathering all this information and writing the report takes about forty hours. Once the report is complete then it is submitted to the Court, and to all relevant parties.

2. ADOLESCENTS WHO HAVE ENGAGED IN SEXUAL ABUSE BEHAVIOURS

In forensic psychology, sexual offenders are often viewed as model clients. While these clients may not be as compliant as members of the general public, they typically are more engaged in treatment than violent or gang-affiliated clients. The research suggests that the risk of re-offense is low if offenders are given psychological treatment. Romine et al., 2012,
conducted a study that suggests that a sexual re-offense is 13%, and that a re-offense of any crime from this population is 20%. It should be noted that these statistics related to sexual offenses by people of all ages. The statistics for adolescents are lower. Mackaronis, Byrne, & Strassberg (2014) suggest that only 7.08% of adolescents will reoffend. The ATSA (The Association for Treatment of Sexual Abusers) Adolescent Treatment Guidelines (2017) recidivism rates for youth who commit sexual offenses even lower than the Mackaronis, Byrne, & Strassberg study. The ATSA found that the potential of re-offense could be as low as 5%. Whether it is 5% or 7%, it is a much lower rate than with youth who commit other offenses.

Sexual offenders are closer in profile to the “perfect world” client for a few reasons. These clients tend to show up on time for appointments, they do not miss appointments (or they give plenty of notice if they have to miss,) they fully participate in treatment sessions, and they complete their therapeutic homework. This information was surprising to me. I have discovered that the general public has a lot of misinformation about people who commit sexual offenses.

I had several preconceived notions about sexual offenders before this practicum. It should be noted that sexual offenders is a term which is now considered inappropriate; the ASTA would prefer references to youth who commit sex offenses as “adolescents who have engaged in sex abuse behaviours.” The first preconceived notion was to lump clients who are pedophilic with all sexual offenders. Offenders cannot be diagnosed as pedophilic unless they are, at least, sixteen years old (Hall & Hall, 2007). For a youth to be given this diagnosis by a psychiatrist or a psychologist, emotional and sexual maturity has to be taken into account. The Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5) states that
clients have to have sexual fantasies, urges, or behaviours involving pre-pubescent children for at least six months, the individual has to act on these urges or the urges and fantasies have to cause marked distress, and the age requirement has the stipulation that there is at least a five year or more age gap if the client is sixteen or seventeen years old (Diagnostic and Statistical Manual of Mental Disorders, p. 697). So, labelling twelve to fifteen year old offenders as pedophiles is inaccurate and potentially dangerous. Due to the societal misconceptions about what a pedophile actually is, youths who are told that they are pedophiles may then see themselves as beyond help. This could lead to harmful consequences. Some youth could accept being a pedophile, which may lead to re-offense. For other youth, it could lead to suicidal ideation, suicide attempts, or completion to “cure” themselves of pedophilia and to protect future victims. Also, if people in the community view a youth as a pedophile then there could be bullying, psychological violence, and physical violence aimed at the youth. The reasons most youth commit sexual offenses is not related to an attraction to children, so it is comforting to know that the legal system and the DSM-5 will prevent the extreme consequences of being given the pedophilic label on youths fifteen years old and younger. It is also crucial that psychologists are thorough if they are to diagnose a sixteen or a seventeen year old as pedophilic. Other diagnoses must be ruled out first.

Before the practicum, I thought pedophiles and sexual offenders could not be cured – which is also the wrong way to think about treatment for youth who sexually offend. Therefore, I thought the likelihood to reoffend is high. The truth is that most youth who commit sexual offenses are not attracted to children, they choose victims for a variety of other reasons, and they are not always at a high risk to reoffend.
I was not aware that most offenses happen within families. Proximity to victims is a factor in why an offense within families is more prevalent. It is rare for these types of offenses to involve a stranger to the victim.

Another myth that was debunked for me came from reading a resource book called *Pathways* (the title serves as an analogy for all the paths that lead to offending) which suggests that more than half of all teenage sexual offenders were not sexually abused as children (Kahn, 2011, p. 213). I thought that there was a direct link between being a victim to becoming an abuser, unless there is treatment for the victim – which is difficult if the offense is never revealed.

One more myth is that sexual offenses are only about power more than sex. In Mr. James’ experience, adolescents who commit sexual offenses are rarely trying to gain power over the victim. The reasons often involve hormones, hyper-sexuality, loneliness, rejection from peers, having access to victims, viewing pornography, and other stresses involving family or school (Barbaree & Marshall, 2008). This suggests that there are a lot of myths about sexual offenses, and the offenders. Fortunately, there are great resources in learning more about this aspect of forensic psychology.

There are effective resources to guide the psychoeducational component of treatment, and give more factual information about this type of offense. The Sexual Offender team mostly uses the previously mentioned resource book, *Pathways* (Kahn, Fourth Edition, 2011). This is used both for individual and group treatment for adolescents who commit acts of sexual abuse. Unfortunately, during my practicum, there were not enough clients to form a group. Group counselling is particularly effective with sexual offenders because so many offenders think
they are alone with their crimes, and their sexual feelings. Once they know that there are others who have committed similar crimes then they are more able to take ownership of their offenses.

*Pathways* allows the psychologist to discuss with the client what the laws are around sexual offenses, examine what is true consent, the dangers of pornography, examples of being in denial, thinking errors, how to create boundaries and barriers to avoid reoffending, as well as working toward acceptance of responsibility and apologizing to the victim. Since many sexual offenses occur within families then family reunification rules are also worked through in *Pathways*. The book is certainly not designed to be a one chapter per session type of resource. There are too many obstacles that get in the way of making this type of treatment that straightforward.

In one session, the client was challenged by Mr. James to teach me about barriers to offending – motivation, internal barriers, external barriers, and victim resistance. The client did an excellent job of discussing these four barriers. However, I noticed that any reference the client made to sexual offenders was “they.” By using this plural pronoun, the client appeared to subconsciously remove himself from being in the same category as a sexual offender – people who act this way are “they.” It appeared that he could not see how he moved through the same barriers to offend that he was teaching me about in the session. Mr. James asked the client a question about his specific offense, and the client shut down for a moment. This is a barrier to treatment for a lot of youth. They are good “students,” but the leap from learning the psychoeducational concepts to taking responsibility for enacting the negative behaviours discussed in therapy is not easy. It is also possible for a client to avoid
taking responsibility before the conditions of the sentence expire. That said, the success rate is still quite high even if clients do not reach the point of writing a letter to the victim, which is the moment that clients take full responsibility for the offense.

Another client I worked with – he was one of the first clients I met with on my own – was an exceptional case. He is an adult now who lives outside of Saskatoon, and is married with three children. Reading through the file, there are some question marks about what actually took place on the night of the crime. There is the possibility that another person coerced my client into committing the offense. My client has low cognitive functioning, which has made him very susceptible to manipulation by other people. He committed another crime, which was not of a sexual nature, where someone told him to steal something. He did it, even though he knew it was wrong. The other challenge with this client is that the sexual offense took place years before it was reported. His ability to recall these events at the time he was accused was limited, and it is especially difficult for him to recall them now. Another challenge is his reading level. *Pathways* is a terrific book, but he would struggle to read through the lessons, and to complete the quizzes and homework assignments. There is also one more obstacle to traditional treatment. This client has a lot of responsibilities. He is unable to get a job due to social anxiety issues, and has other life obstacles that often need to be removed before psychoeducation can occur. I have learned a lot from working with this particular client about how survival needs, and basic life skills around finances and employment are an essential part of the whole treatment plan to truly prevent reoffending. One resource guide cannot address everything for every type of client.

I like how Mr. James approaches the psychoeducation when he works with an atypical
client who can handle the material in *Pathways*. He reviews the two main parts of treatment – this is discussed in the initial treatment session – psychoeducation (or as one client called it: “learning about stuff”) and processing (the tough part for clients, as evidenced by my earlier example of the “they” versus “I” language used to describe sexual offenders.) After reviewing these two purposes for treatment, he shows a clever video from YouTube called *Tea Consent* (‘Tea Consent’, 2015, Youtube.com). It is an animated video that is an allegory for true consent. The video shows why consent for accepting sex is similar to consent for accepting a cup of tea – in a concise manner, the video covers the black and white examples of consent that many young sexual offenders view as “gray” areas like someone who appears to consent while intoxicated or has previously consented. This is a great way to lead into the material from *Pathways*.

I was initially nervous about counselling adolescents who have committed sexual offenses since hearing about sexual crimes has triggered a negative response from me in the past. The key has been humanizing the clients. That is where reading case files was quite valuable. Learning about the person, as well as the offense, helped me to not allow judgment or preconceived ideas to cloud my ability to provide treatment. And, before this experience, I did not know how successful talk therapy can be with sexual offenders. The misinformation I had, likely from media and television shows, made me think the opposite was true. I now know that if clients are caught and given treatment (with court sanctions) the likelihood of future sexual re-offenses is less likely than with the other category of clients I worked with: violent offenders.
3. YOUTH WHO COMMIT VIOLENT OFFENSES

There are quite a range of offenses that are committed by the youth who receive treatment from the Young Offender team. There are gang members who have committed murders and attempted murders – and these clients do not wish to leave their gang lifestyle. Many of the clients who are serving time in Kilburn Hall appear to have a high risk of general recidivism according to the Level of Service Inventory (LSI) – several of these clients are referred to as level fives due to this diagnostic which is often referred to in Pre-Sentence Reports. If they do reoffend, and are over eighteen years old, they move from the youth system into the adult system, and will likely move from Kilburn Hall or Yarrow into the Saskatchewan Correctional System.

The first time that I met Mr. James to plan out my practicum, we discussed this issue. He said that in forensic psychology, a more directive counselling style if required. While a person-centred approach – Carl Rogers theory which emphasizes the intrinsic strength of clients desire to get better (Joseph & Murphy, 2012) – can be used in forensic psychology, forensic clients often are more extrinsically than intrinsically motivated. These clients respond better to rewards and consequences. For some clients, the focus may be less on developing victim awareness or empathy, and more on personally relevant goals such as not going to prison. The aim, therefore, is to focus more on what is relevant to the client.

The next level are offenders who have previously served time like the first client I met with on my own. This person is now in the community trying to avoid reoffending. The reason this client was incarcerated was not because of the specific crimes he had committed, but because he ran away from open custody. When I met him, he was trying to get away from a
criminal lifestyle. His challenge was educational. He was trying to get his Adult 12 so he could pursue more career options, but his confidence at school was quite low – and he wanted to quit because he was finding school difficult. So, he was trying to line up work since he either had to go to school full time or work full time. The focus of my early sessions with him was more about finding work and succeeding in school. Those life issues would usurp any discussion of empathy for his victims – the more sessions we had, the more life challenges from being out of jail emerged. However, he was a cooperative, polite client despite his violent past.

Then there were clients who had committed violent acts, but managed to stay out of Kilburn due to a lack of gang involvement, decent family supports, or minimal/no criminal record. These could sometimes be clients who are viewed by others, who may be less aware of the socioeconomic factors that lead to crime, as youths who “play the system.” One client had perpetrated crimes on those he perceived as weaker than himself, but who may have difficulties navigating the prison system. I perceived this specific client as quite intelligent, which meant that he would engage on a philosophical level in sessions, but appeared to not take ownership of his crimes. He would then make up excuses for not attending sessions. This may be the most frustrating type of forensic client because there is a potential lack of empathy like the more “hardcore,” gang-affiliated clients, but he can appear “normal” to a lot of people. These clients appear to know the boundary between which violations will get them breached and sent to secured custody, and which violations will get them a slap on the wrist. One hesitates to speculate about psychopathic or sociopathic tendencies among clients without administering a proper assessment, but this profile of a client could be one where people who fit that type of
psychopathology lie. Another explanation, though, could be his possible disconnect with society’s values due to not having an obvious connection to a positive male role model. He may have had to find ways to assert his own individuality and gain power in his world without knowing how to. Therefore, his apparent passive aggressive tendencies may not be a sign of psychopathology, but a need to find appropriate ways to navigate his world. The irony is that treatment sessions may help him achieve this goal, but he often chooses to exercise his power by avoiding the help he may need.

Other clients that I encountered, who did not fit into the categories of youths with sexual offenses or youths with violent offenses are ones who were deep into drug addiction who committed break and enters, as well as caused massive property damage. This appeared to relate more to clients who are younger, or clients with cognitive challenges who could be manipulated by others into committing crimes.

The question then becomes, how does one treat young clients who have committed violent offenses? Wong & Gordon (2013) discuss the Violence Reduction Programme (VRP). This is the way that psychologists on the Young Offender team approach treatment. It is a team approach that is goal-oriented since a “one size fits all” program does not work with clients who have committed violent offenses. The Violence Reduction Programme amalgamates several different, empirically-supported approaches to treatment. The Risk Needs Responsivity approach is central to the Violence Reduction Programme (Andrews, Bonta, & Wormith, 2011). The intensity of treatment is informed by the clients’ risk level. The “risk” to re-offend determines the intensity of treatment. A client assessed at a higher risk level needs a higher intensity treatment approach than a client at a lower risk level. The “need”
relates to the dynamic risk factors that are shown to contribute to risk or risk reduction. These can be treatment targets such as antisocial attitudes, spending time with prosocial versus procriminal peers, and anger management. Then the most individualized part of treatment is “responding” to the specific needs of each client – the delivery of the treatment must be consistent with the ability and learning style of the offender.

There is an extensive list of forensic therapeutic approaches that the Violence Reduction Programme employs. The majority of the approaches I will discuss are ones that I read about and discussed extensively with Mr. James. I observed Mr. James use elements of the Risk-Needs-Responsivity principle with clients who had a variety of different needs.

Since clients are court ordered to see psychologists, they are not always likely to be cooperative. That is why Motivational Interviewing can be employed early in treatment sessions with some clients – and this approach may take time with clients who resist treatment. The four key principles of Motivational Interviewing are expressing empathy, developing discrepancies, rolling with resistance, and supporting self-efficacy. The clinician must use reflective listening to express empathy for the client. Identifying discrepancies between the client’s current situation and the client’s hopes for the future is a key component of Motivational Interviewing. Rolling with resistance is noting that resistance is a signal of change in the client’s viewpoint of her or his situation, and that means that the clinician may need to change direction or listen more carefully to what the client needs. Supporting self-efficacy is finding hope, optimism, and an ability to make changes in the client’s story. It should be noted that clinicians should avoid arguments and direct confrontation when using Motivational Interviewing; any trust that is beginning to develop will be lost if arguments or
direct confrontations occur (Center for Substance Abuse Treatment, 1999). While Motivational Interviewing does not need to be incorporated with every forensic client, more guarded clients may gain some level of trust over time if Motivational Interviewing is incorporated. Mr. James and I used Motivational Interviewing with a new treatment client in the last two weeks of my practicum. I was able to get the client, who was not sure if he could trust us, to open up. I simply took a topic that the client was interested in discussing, and asked him to educate me about it. This led to him telling us about several procriminal experiences from his recent past. I can now see the benefit of Motivational Interviewing for earning a client’s trust because of this specific session at the end of my practicum.

Multisystemic Therapy is important when treating high risk youth because it requires outside positive social supports from family, home, and community within the youth’s environment – the idea is that treatment does not just occur during a once a week appointment; treatment occurs twenty-four hours a day, seven days a week which is paramount to success with clients who have a higher need for supervision. I saw Multisystematic Therapy incorporated through a variety of rounds meetings, case conferences, and visits to Kilburn Hall. The team approach is incredibly effective in helping youths avoid re-offending.

Aggression Replacement Training allows the client to develop new coping skills through modelling, role-playing, receiving performance feedback, and generalization training – those clients who struggle with stress or pressures from a group can potentially benefit from this approach to treatment. This is an approach I read about, but did not observe during my practicum.

Relapse Prevention (also used with clients who have drug and sexual offenses) is about
anticipating problem behaviours to better prevent a lapse or a relapse since feelings connected to these behaviours will occur again to a greater or lesser degree in the future – this approach can be helpful with clients who have anger management problems where little annoyances can turn to full-on rage. I observed Mr. James regularly use Relapse Prevention when helping clients anticipate situations that could be potentially problematic for them. I was able to take what I observed, and use it when seeing a client on my own. The client struggles with anger management, so we discussed daily situations where his anger could be triggered. Then we worked through more positive ways to deal with the anger – the examples the client came up with were taking a walk, getting fresh air, listening to music, or having a smoke. Relapse Prevention is an important approach in the work done by the Young Offender team – those regular check-ins were needed for the clients I worked with in almost every session.

Finally, the Transtheoretical Model of change is extremely important in forensic treatment plans – and can apply to any effort for an individual to make life changes (Prochaska, DiClemente, & Norcross, 1993). The first stage is pre-contemplation, which is not recognizing any need to change or any problem with one’s current lifestyle. The contemplation stage is recognizing that there is a problem, but there is an unwillingness to do anything to fix the problem. The preparation stage is where one begins to make a change, or inconsistently tries to make changes at different times. The action stage is where there is consistent evidence of daily behavioural changes. The last stage is maintenance, which means continuing to maintain the changed behaviour (Wong & Gordon, pp. 3-5). Mr. James used the Transtheoretical Model of change with several clients, and I saw the benefit of it both for forensic and non-forensic clients.

While the Transtheoretical Model of change is a nicely structured approach, clients can get
stuck or regress. They can continue to say they want to make a change in their lives, but never
move to the action phase, or they will give up when it gets too hard and decide that change is not
worth it. The contemplation stage may be where the client gets to by the end of her or his
conditions. I like this model of treatment because I can apply it in a school context, particularly
with students not doing homework, not attending class, experiencing challenges with peers, or
struggling with substance abuse issues.

The fact that the Violence Reduction Programme can borrow from all of these approaches
to treat individual needs makes it an effective treatment programme for clients who have
committed violent offenses. The assigned readings and discussions with Mr. James helped me
understand the Violence Reduction Programme intellectually. Seeing Mr. James use it with
clients showed me how to apply the theories in sessions, and then I had the opportunity to use
some of the theories in sessions where I took the lead.

4. ASSESSMENTS

A large part of the job on the Young Offender team is conducting assessments. Some
assessments that the Young Offender team, and the Sexual Offender team, as well as
Community Youth Workers implement are the Violent Risk Scale (VRS) for Youth, the VRS
for youth sexual offenses (they previously used the Structured Assessment of Violence Risk in
Youth – SAVRY), and the Level of Service Inventory (LSI) Youth edition (Webster,
forensicpsychiatry.ca, 2011). These assessments help psychologists create a report for the
Court to consider when matching youth sentences to the gravity of the offense, and the level of
current and future risk for recidivism and community safety. The factors to consider when
assessing the risk to reoffend for adolescents who commit sexual offenses are sex offense history, criminal history, compulsivity/impulsivity/psychopathy, degree of force/violence (sexual and non-sexual offenses), multiple paraphilias/deviant arousal (deviant/criminal sexual orientation), accessibility to preferred victims, past treatment involvement, level of honesty/denial, insight into own risk level, type of personal support, chemical abuse history, and being able to qualify for treatment (Rajlic & Gretton, 2010). Examining the information gathered from these categories through the assessments, and structured clinical judgment, is how a psychologist’s recommendation can be reached. Since the focus on my graduate program has been counselling and not administering formal assessments, I did not take the lead on conducting an assessment during my practicum.

As well as court assessments, the Young Offender team also gives cognitive and achievement assessments to help find the best way to treat clients. The assessments I was able to observe Mr. James administer during the practicum were Wechsler Intelligence Scale for Children – Fifth Edition (WISC-V) over two sessions and a Wide Range Achievement Test 4 (WRAT-4) in a third session to a client who appeared to struggle with communication, have long term and short term memory challenges, and difficulties completing the paperwork for informed consent. The WISC-V assesses general cognitive ability and in five composite domains (i.e., verbal comprehension, visual spatial reasoning, working memory, field reasoning, and processing speed) and grade level, and the WRAT-4 assesses current achievement in spelling, sentence comprehension, numbers, and mathematics among adolescents. There were initially no records of this client’s educational history, so the assessments were conducted to fulfill the “needs” part of the Risk-Needs-Responsivity
Principle. What does this client need, so that treatment will be most effective for him? This client had committed a crime, but it appeared that he could not remember from one moment to the next what was happening in his life. This is another client where psychoeducation is difficult to incorporate into treatment because he is a seventeen year old who may be operating at the cognitive level of a seven year old. My role was to observe the assessment then I debriefed with Mr. James. Mr. James also showed me how to score the WISC-V. I was given the chance to practice scoring under his supervision. I also assisted in writing the client background section of the report.

I learned quite a bit about conducting an assessment from observing Mr. James. He used sound judgment in the moment to determine that it would take more than one session to complete the WISC-V. If a client is unable to concentrate enough to complete all of the tests due to fatigue then pushing to complete them all in one sitting may impact the data that comes from the assessment. One notable behavior I observed in the client was how difficult the practice test questions (used to determine test item starting point) were for him. It would be interesting to observe this test conducted with other clients who may display higher ranges of abilities, as the test adjusts according to ability levels (e.g. longer testing period with more abstract and complex items.) This client’s scores were mostly in the 40s, which indicates that he has an intellectual disability.

One of the tasks I took on to help this client was to look at educational options if he were to attend a high school in the fall. The Functional Life Skills (FLS) program offered in three Saskatoon Public School Division collegiates is what I recommended to Mr. James. The final decision will be made this fall by the director of the client’s youth group home.
It was great to see how assessments are conducted from the psychologist’s point of view. It was also important for me to recognize how challenging the psychologist’s job is when the past school information – report cards, previous testing, and behavioural issues – has not been made available.

Once we received the client’s school records, they confirmed our diagnostic hypothesis: this client has an intellectual disability that has kept him years behind other students his own age. This appears to have been prevalent since his primary school years.

Assessments are essential for providing information that will inform the treatment plan – whether they are used to assess personality, psychopathology, IQ, or achievement levels. I was able to observe only a couple assessments that revolved around one client, but I learned that psychologists cannot treat a client by using concepts and information that the client will be unable to comprehend. The need for information from assessments is key to the responsivity part of the Risk-Need-Responsivity principle because assessments help the clinician provide the most appropriate treatment for the individual client’s level of understanding.

5. CASE CONFERENCES

I participated in three case conferences during my practicum. I was used to this type of meeting from my first year as a guidance counsellor. That year, I had a student living in a group home, and we would meet once a month. The conferences I attended during the practicum were ones that happen about every three months. There was also a case conference with an older client and his family that occurred at the Community Youth Worker’s office.
The latter case conference was scheduled because of a pattern of not showing up for appointments.

A case conference is where the whole team involved with a youth meet to assess the plan. This can involve the director of a youth home, the social worker, the psychologist, maybe someone from the youth’s school, the community youth worker, the youth, as well as family members. It was important for me to observe how Mr. James approaches these meetings, as well as one of the social workers who is a “down to business” professional. It is important to know what the goal of the case conference is, and to not get sidetracked. In one of the meetings, the goal was to discuss the youth’s plan for overnight visits with a parent, and to discuss plans for continued success during the summer months. There was some side conversations about technology use that steered the meeting off course. When that happened, the social worker returned to the main topic for the case conference. Observing and participating in this case conference will make me have a more valuable presence in future meetings as a guidance counsellor – I will stick to my purpose at the meeting (how is the youth’s school life going and how can I help the youth be successful?) and note other aspects of the youth’s life that will help me provide educational support. It is important to not get sidetracked, and find gentle ways to suggest that we stay on topic – for example, it helps to set time limits and goals at the onset of the meeting, and plan accordingly with the team members.

Overall, the three case conferences I observed were constructive, positive, and focused on helping support the youth make life changes. In the past, I have attended more negative meetings – it is amazing how one person has the power to turn a constructive meeting into one where the youth gets angry and defensive. With young people who struggle to trust adults,
that kind of a meeting can have detrimental effects. I do not want to be the person that impedes progress, even if I have to be honest in my observations. That is why it has been great to observe Mr. James – he was an exemplar model of how to be direct and honest in these meetings in a way where young clients still feel respected. It is my goal to approach meetings with, and about, students in that same manner.

In the meetings, I took notes then would write the case note afterwards. I did contribute information when I felt it was valuable. One client has recently come out as homosexual to his family and to the team. When the team was discussing camp options for him, I suggested Camp fYrefly because there may be issues discussed at that camp which will help him live his life as a person who identifies as LGBQT that other camps may not address. In the other case conference, I had met with the client on my own, so I offered information that I felt would help his new Community Youth Worker find the best way to help him to be successful.

6. SUBSTANCE ABUSE

Having worked for most of my fourteen years as an educator in high schools, I am familiar with the way that drug abuse can harm a young person’s life. Certainly marijuana has been a drug of choice for a lot of students I have taught and counselled. I have also learned a lot about the use of cocaine, ecstasy, and psychedelics as a guidance counsellor. However, I did not have much personal experience working with youth who regularly use crystal meth, heroine, or crack cocaine. From the youth whose files I read, and the clients I ended up working with, they identified crystal meth as the most prevalent and destructive drug that they had used. I did not see any clients who were in the midst of detoxing – one client used meth a
lot, but had been sober for a long time due to being in secure lock up. Others clients had stopped using a few months earlier. I learned quite a bit from listening to these clients talk about how they used meth to prevent feeling negative or uncomfortable emotions. This connects with Vaughn & Long, 1999, who write about how an inability to tolerate emotions can lead to drug and alcohol dependency. Numbing emotions means that clients would not have to deal with painful feelings, especially sadness and anger.

I also see how returning to the community after detoxing from drug addiction, and feeling the pressure to stay away from a life of crime would be difficult. Life would slow down and appear – a favourite word among clients – “boring.” The danger of this thought pattern is that the risk to use again, or to reoffend, becomes strong. Clients may want to get high to avoid the boredom of an ordinary life. To be able to afford the drugs, they would have to return to committing break and enters, or armed robberies. That is why continuous forensic and substance abuse treatment is so important to prevent using again, and avoid recidivism. Of course, there are a myriad of other reasons why adolescents abuse drugs. The feelings of hopelessness due to living in poverty, or feeling discriminated against, relate to the need to numb those painful feelings. Since buying drugs becomes financially prohibitive, crime becomes a way to afford to feed the addiction. One client described a path to crystal meth that involved snorting cocaine until he could not afford it. Then he used, what he called, fishscale which is a mix of cocaine and crystal meth. He then could only afford crystal meth – and that became the drug that controlled his life. He was trying to escape from difficulties with his emotional regulation, and family challenges, by using which unfortunately got him into greater trouble with the law. It is worth noting that he is strong enough to talk about these challenges,
which is a struggle for many other young people.

Several clients I worked closely with were at the stage of their conditions where they were trying to survive in the outside world by trying to go back to school or get a job. I saw how their boredom, and the discouragement from not being able to handle school or get employment plus dealing with a world where they have not had the advantages of others, could be a sign that recidivism might occur. Life and its responsibilities would be hard to deal with while sober, especially if there is not a strong support system from friends and family. There is evidence to support the efficacy of professional supports in helping clients reduce substance use to maintain sobriety and reduce the risk of returning to a life of crime.

7. WAYS OF PROVIDING TREATMENT FOR INDIGENOUS CLIENTS

I took three classes from Dr. JoLee Sasakamoose (Counselling Girls and Women; Group Counselling; Multicultural Healing,) and one class from Dr. Angela Snowshoe (the previously mentioned Deconstructing Counselling.) These courses were both Decolonized and Indigenized. My eyes were opened to the ways that traditional psychology can be inadvertently oppressive to members of society who do not have white, heterosexual, religious, and male privilege (the list of groups that have privilege, and the groups that do not is much more comprehensive than this short list.) I did not fully understand why counselling (as well as teaching) had to be Decolonized until my graduate program. Traditional psychology, as well as a lot of research and media spin, suggests that “normal” people should be “tolerant” and “sensitive” to groups that do not have privilege. This implies that the Western European model of life – and Western theories of psychology and counselling- is normal, and that all other life
experiences are not normal. There is then an unequal power balance, even among psychologists who claim to be “culturally sensitive,” when treating clients who come from different cultures, or who identify as sexual minorities.

One of the ways to avoid creating an oppressive counselling relationship, and instead create a therapeutic alliance, is by connecting the counselling experience to the client’s culture. This means that the counsellor or psychologist will need to learn about the client’s culture, and perhaps find ways to connect that client to other people who can provide more specific guidance or mentorship. It is particularly important to avoid assuming that the client knows about her, his, or their culture simple because of sexual orientation or race. In treating one of Mr. James’ clients, the concepts I learned in Multicultural Healing and Deconstructing Counselling came to the forefront.

Mr. James and I were both struggling to connect with a client who has cognitive challenges. It was difficult to tell with this client whether he was answering our questions, or just responding back to us with what we said to him. This idea of reflecting answers emerged in my first session with him when I tried to find out about his interests. At one point, he claimed to like the Jackass movies. He told me that he cannot watch them in his group home. I asked him if it was because of the swearing in the show, and he said “no.” A moment later, Mr. James wondered aloud, “I wonder why you are not allowed to watch Jackass.” The client immediately said, “Because of the swearing.” When Mr. James and I debriefed, he felt that I had implanted that idea into the client’s brain, and that he was just saying what I said. So, we were not sure what his interests actually are; he might like video games and Jackass movies, but it was unclear. I asked Mr. James if we have any connections with Elders, or any way to
find out how connected or disconnected this client is from his culture. As stated earlier, it is dangerous to assume that a young man who grew up on a Saskatchewan reserve is connected to his Indigenous language and his culture, but I was curious if a more culturally-informed and, perhaps, land-based approach would bring greater success in treatment.

Mr. James connected me with Ms. Wanita Bird, the Cultural Support Worker for Mental Health and Addictions in Saskatoon, who works with students in the Day Program. I was hoping that this was the right approach to take. The good news is that the client’s grandmother supported this when we discussed it at a case conference the next week. His grandmother did state that she would like a male mentor or male Elder for her grandson since protocols are different for men and women at sweat lodges and sun dances. We talked to Ms. Bird about that after the meeting.

A couple weeks later, I attended a Pow Wow at the University of Saskatchewan with Ms. Bird and the client. While I did not see dramatic changes in the client’s presentation, I did see his willingness to participate in the Multitribal Dance (which I also participated in for the first time in my life.) Since the client came with his class, I also saw that his social skills with peers were better than I expected considering how weak his communication skills appeared to be in our sessions. I am not sure I would have been able to observe this purely from meeting with him in an office setting.

If giving this client opportunities to connect with his Indigenous culture turns out to be positive then I will feel that I have begun to put what I learned from Dr. Sasakamoose and Dr. Snowshoe into practice. Opportunities to create more connections with Indigenous people in Saskatoon, and educate myself further about Decolonized approaches to counselling will be
valuable for when I am a permanent guidance counsellor. My goal as a counsellor will be to find the best way to ensure success for the Indigenous students I work with – and to lessen the gaps in success for Indigenous youth.

8. NO SHOWS: THE BIGGEST BARRIER TO SUCCESS

One of my clients was a No Show for five appointments out of six appointments, despite several attempts to reschedule. If one is following the letter of the law with a youth’s court conditions, a missed counselling appointment can lead to a breach of the client’s sentence – which the client’s community youth worker would report to the judge. In reality, though, it would often take a lot more than a missed counselling appointment to get breached. Some judges may expect psychologists and youth workers to allow for some flexibility before requesting a breach; whereas, other judges may take a tougher stance. In many cases, youth are given several chances to improve – those who work with youth often recognize that developmentally they need more opportunities to correct their behaviours.

I learned, however, that there are various opinions about this. I spoke to one staff member who thinks clients need to be breached every time they do not show up – no exceptions. Then there are others who feel that a breach is only necessary when a pattern of missed appointments is established. It appears that opinions vary among Community Youth Workers too. With the recent provincial budget, changes have been made in the Justice system that have amalgamated the roles of Community Youth Workers and Probation Officers. These Probation Officers have mostly worked with adults, but now have youth clients. This has led to higher caseloads for Probation Officers. The grey areas of working with young people who have committed criminal offenses may be difficult for the Probation Officers who are used to the more
straightforward approach to working with adults – if an adult commits a minor breach then that person may receive more community-based sanctions like a stricter curfew or an extension of the length of a sentence.

I often thought with certain clients who miss numerous appointments, after accommodations for rescheduling have been made, that they could be playing the system. However, I also recognize that these clients may view the system as not meeting their needs. Missing appointments could be a logical response due to a history of discrimination or poverty where they only saw the system oppress them, and not help them. This distrust, in that context, is perfectly understandable and a possible reason why some clients missed appointments. On the positive side, though, many of the clients who have a history of poverty and discrimination, which would justify a distrust of the system, were regular attenders during my practicum.

The psychologist’s most extreme course of action in the forensic context – after numerous attempts to encourage the client to attend have been made- are to suspend services. In most situations, though, a case conference with the client, the Community Youth Worker, and the psychologist is arranged. That is a chance to review the possible consequences for not attending, and create a plan for the client to successfully attend sessions again. This plan may involve a contract between the client and the psychologist that will outline what the client needs to do to avoid having treatment services suspended. I like the approach of meeting a client outside of an office setting, as happened with the client who I attend the Pow Wow with, but this may still be an issue of boundaries for psychologists who are employees of publicly-funded organizations like Health Regions or Public School Divisions. That said, how many clients would be more successful in treatment if that option was allowed to happen? It is an
important part of Decolonizing counselling – finding the healthiest environment for the client to experience healing.

There were a lot of no shows during my practicum – more than Mr. James was used to – which helps me understand why it is so difficult for some clients to get to the Action stage of the Transtheoretical Model of change. Again, many clients may not be interested in making intrinsic changes to their worldview – they may stay in the Pre-Contemplative stage. It is important to accept that the client gets to make the choice. It is not ethical for me to impose my values on to a client. The reasons to stay involved in a life of crime are complicated, and may relate to issues of acceptance and survival – two motivations that are powerful.

No shows are complicated, and require great judgment by the forensic psychologist and the Community Youth Worker. No shows for clients who struggle with organizing their week, or clients who occasionally forget, are one thing. However, a pattern of not showing up for appointments can be the biggest barrier to success. I can do my best to create a therapeutic relationship and find the best way to help clients, but both parties have to work together so success in treatment can be achieved.

9. MICROSKILLS

The microskills hierarchy for counselling is fundamental to conducting interviews with clients (Ivey, Ivey, & Zalaquett, 2016). The microskills are: attending, questioning, observation, encouraging/paraphrasing/summarizing, reflection of feeling, five-stage interview, confrontation, focusing, reflection of meeting, and influencing skills. In my Deconstructing Counselling class, these skills were practiced through videotaped mini-sessions, and a
videotaped half-hour counselling session that integrated all of the skills together. It was particularly helpful to analyze my half-hour counselling session. I was easily able to spot bad habits, and moments when I was not listening properly to the other student who was playing a client. I wanted to continue focusing on my incorporation of these microskills in my practicum.

I did not videotape my sessions with clients during the practicum, so I relied quite heavily on self-reflection. By nature, I am quite critical of myself. I would think about whether a particular client who was a “no show” for the next appointment missed because of how I approached the previous week’s appointment. In reality, not showing up for appointments might have more to do with the chaos facing that client than how the last session went. It could also relate to the system not meeting the client’s unique needs. Early in the practicum, I had not been aware of how habitual this client’s absences from appointments had been. By the end, I knew that there could be a fifty-fifty chance for this client to attend the appointment – no matter who was running the session. I think a balance of concern on my part about how to make the time valuable for the client, but not blaming myself if a client does not show is required.

After about three weeks of observing Mr. James then participating in the sessions using a tag-team approach, I began to see some clients on my own. After my first session alone with a client, I was assessing whether I overwhelmed him by throwing too much into the session. With some clients, Mr. James does not see that as a bad thing since clients sometimes need to be pushed further in counselling – it can be safer for them to stay in one place. Having a different person demand a bit more from them does not hurt. However, I recognized that I
have the habit of asking a lot of questions, but need to give the client more time to process what is being discussed. I saw this habit in my videotaped session in class, but I attributed it to trying hard to incorporate all of the microskills into one session. I think moving too quickly is a bad habit that new counsellors can have. It is something to be aware of, and to avoid in the future. Mr. James did not observe me doing this a lot in the practicum, so this may just be me feeling like I am moving fast when the pace appears fine to an outside observer.

I worked on two microskills, in particular, for my practicum: reflection of feelings and focusing because I felt that they were two of my weakest microskills in the Deconstructing Counselling class. Mr. James explained that clients are either more comfortable talking about their feelings or talking about issues in an intellectual manner. For the intellectual clients, it is important to work on the feeling aspect of treatment like empathy training. For those who are connected closely to their emotions, they need to work on the cerebral aspects of treatment like psychoeducation. He said that counsellors and psychologists are the same. We naturally have comfort with one or the other, so it may be that I am naturally more cerebral. That means that I need to work on reflection of feelings, though (similar to the pace of my sessions) Mr. James did not see deficits in that microskill. Focusing was an area in Deconstructing Counselling that I improved upon, so I just wanted to keep that progress up during the practicum. When Mr. James and I discussed my final evaluation, he felt that I had done quite well with that goal.

Observing Mr. James was an important part of improving my microskills integration. With his experience, he appears to incorporate those skills effortlessly. I did see a session where he brilliantly used paraphrasing and summarizing – I asked him about that later, and he said he
did that because the client threw something at him that he was not fully prepared for that day. This client is in open custody and has been making great progress – the person I read about in the court and treatment file is not the same person who I met in the treatment sessions. However, people from the outside world (“the community”) make it very difficult for him to stay positive. So, observing then debriefing with Mr. James about that session taught me how paraphrasing and summarizing can be used when I do not know exactly how to proceed in the session with the client. Paraphrasing to reflect what the client is telling me is a better approach to take than my “go-to” habit of asking several questions. A continuing awareness of my abilities to use microskills in real life counselling situations has been quite valuable as I continue to develop my personal counselling style.

10. RECORD KEEPING

The Saskatoon Health Region has a very centralized record keeping system, which is still paper based. Files are kept in two locked cabinets in the office – one is for treatment clients and the other is for clients currently involved with the court system. For clients who are receiving treatment, a new file is opened (even if there was a previous file for a court-ordered assessment) after the initial meeting. After the first meeting, a primary assessment (or initial meeting) report is filed. After that, all case notes, notes from case conferences, as well as emailed communication and phone communication related to the client is printed out and put in the file by the office manager. When files are taken out by the psychologist, or a practicum student, the whole folder is put in a re-filing basket when we are done with it. If individual papers need to be added to the file then they are put in another basket where they are added to
the main file. These files are kept secure to maintain the client’s confidentiality.

Aspects of this organizational system are followed in schools. The cumulative folders are kept in locked cabinets – the main office stores them in elementary schools, and they are kept in the Student Services office during high school. However, a guidance counsellor’s notes are stored by the guidance counsellor alone. This could be in a file cabinet in the counsellor’s office, or it could be kept digitally. A major goal for me with this practicum is to find a recordkeeping approach that I can adapt to my role in schools. Throughout the practicum, I wrote case notes for Mr. James while observing sessions and also wrote my own case notes. Reading through the client’s files gave me an idea of how the notes should be written. Every note I wrote, I sent to Mr. James for feedback. I soon developed my own style. I enjoyed writing these notes, and the area I most needed to work on was writing in a more passive voice since a more affirmative stance cannot necessarily be made in a psychological context unless formalized assessments have been administered. This was a stretch for me since as an English student then teacher I learned to avoid the passive voice. Learning to write case notes was one of the best skills I took away from this practicum.

I want to find the best way to keep my notes confidential, but I wrestle with the pros and cons of both the paper and digital organizational approaches. I like how the office for the Young Offender team has a clear, centralized approach to keeping paper records. That way, paper rarely gets lost. Without that, though, I am not sure about storing my notes in my own file cabinet at the school – what if there is a break in where those files are stolen? I am sure thieves could find a way to break into a locked file cabinet. The digital world does not appear secure either. What if my computer gets hacked, and those items get released? If it can
happen to organizations like Yahoo, the FBI, and the CIA then how do I protect my digital files? That said, digital is more convenient. I can type out notes on my computer, and keep them stored in a folder for each client. Keeping digital notes is what I lean to, but I feel better about the recordkeeping methods the Saskatoon Health Region employs. I will continue to work with the school division to find the best way for guidance counsellors to keep their notes safe and secure.

11. CONFIDENTIALITY AND OTHER ETHICAL DILEMMAS

I have struggled with the “grey” areas of confidentiality. My role in the school system requires me to communicate with several people about students – administration, parents, teachers, social workers, outreach workers, among others. There are the basic areas where confidentiality does not apply – the client is harming self, the client is being harmed by someone else, the client is harming others, or a child is in danger – but there are many times when I am asked for information that does not apply to any of those situations. I want to know how much information I convey to my administrators, since they are my direct supervisors, without breaking confidentiality.

I sense a similar challenge in forensic psychology since the clients have been court ordered to see the psychologist. With youth clients there are community youth workers/probation officers, psychiatrists, certain family members, and social workers involved who may need to be kept in the loop. The informed consent process explains all this to the client, so s/he (or a legal guardian) can decide who the psychologist can and cannot share information with over the course of treatment. And, again, not all information that is requested is about suicide, threats, child abuse, or crime.
What I have observed Mr. James do in these situations is to simply check with the client. This occurred during a monthly Rounds Meeting at the Day Program where the session earlier in the day had relevance to the meeting. Mr. James just asked the client if it was okay for him to share what was talked about that day. This client did not mind. I suppose if a client said no then he could not provide that information. I feel in the school context that a lot of high school students will say no if I ask to share information with administration or parents. However, that is the simplest solution I can come up with for this dilemma.

Another example of a tricky situation is making a phone call to set up an appointment. When a psychologist with the young offender team is first assigned a file, s/he must call the client’s house to set up an appointment. If someone other than the client answers the phone then the psychologist cannot necessarily identify who s/he is because it will reveal that the client has a court order to attend treatment. I asked Mr. James how to handle that situation. He suggests either leaving his number for the client to call – or saying that the Youth Worker told him to call. A phone call is a simple thing, so it was good for me to see how easy it would be to break confidentiality just by trying to book an appointment.

Another experience I had was more of an overlap between the Education Act and my therapeutic role during this practicum. I had a psychoeducational session where inappropriate actions by a teacher – my client was not the victim of these actions – were brought up by the client. I had to make a judgment call. Since this is an educator who is not in my school division or my city, and because this conversation was leading to a therapeutic goal for the session, I allowed this topic to be discussed. I had to recognize in that moment that this teacher’s abuse of power made me uncomfortable, but I never let the client know that. He
needed to talk about this, so while this may be a “no brainer” in a treatment context it is still an example of how the dual role of educator and counsellor can sometimes overlap. It is important to note that the teacher’s actions were known by the community, and had been dealt with by local law enforcement.

It is important to recognize these difficult moments when counselling, and to deal with them after the session. I let Mr. James know that I had felt a bit uncomfortable which had rarely happened during this practicum. Having this experience was valuable because I can better prepare for, in the moment, handling a perceived ethical dilemma then later process my feelings about what happened in the session.

There are limits to confidentiality in the forensic context and in the educational context. The main idea is to “do no harm” to my client, and to prevent harm to the larger community (“American Psychological Association (APA)”, 2017). Therefore, in most situations, I need to ask my client’s permission first before revealing something that was not part of our informed consent agreement. Much like recordkeeping practices, I will continue to work with my administrators, colleagues, and the school division about the best practices around confidentiality and other ethical dilemmas.

12. MY STRENGTHS

I often rely on feedback from others to fully identify my areas of strength, so before my practicum I focused on the positive and constructive feedback I had received from the instructors for my courses. Apparently, my background in theatre is effective for role playing in the context of therapy. I also, as stated earlier, am effective at asking questions. I do an
effective job of using attending skills with clients. However, I wanted to see if I could continue developing those skills and finding new strengths during the practicum.

Mr. James gave me terrific feedback throughout the practicum. While it was not always possible for him to observe my one-on-one sessions, he was able to supervise me while working with clients that we saw together – and we arranged for him to observe some sessions with clients I had worked with for a few weeks. Mr. James saw that my background as an educator was useful when clients were struggling with school, or struggling to find a way to get back to school after being released to the community. One example was a client who was transitioning from the Day Program to half days at a high school, with the goal of attending high school full time in the fall. I suggested that he take an elective that he enjoys (which also counts towards graduation requirements) with a more academic class for his first full-time quarter. That way, if he has some struggles with going to school full time, he will hopefully have a class to go to that he sees as interesting and relevant to his life.

With another client who was struggling to stay in school after years of not attending, I tried to get information from some testing that was done by a previous psychologist to the client’s school. That way, he may receive more learning supports to help make school work a less daunting task for him. This is an area that I have learned a lot about during my career, especially during my two years as a guidance counsellor, but I did not necessarily identify it as a strength because I was not sure it would be useful in the forensic context. However, if psychologists are looking at treating the whole person rather than merely the “young offender,” using all areas of expertise and all available supports will likely benefit clients.

Mr. James did not have as much information about the school system, so he was happy for
me to take the lead when that topic came up in a few different sessions. Mr. James also noticed that I am effective at finding ways to connect a client’s culture to treatment. The example described in the section of the paper about finding alternative approaches to treatment relates well to the idea of treating the whole person. That client’s spiritual needs likely require as much attention as his substance abuse, educational, and antisocial challenges since a spiritual void can have a negative effect on those other areas of his life. I am pleased that Mr. James sees this as a strength because I want to be a much better educator and counsellor for my Indigenous students. I feel that living with privilege has kept me in the dark for too many years. I still have a lot to learn. I have a responsibility to support equality and equity. It is not right that others do not have the same advantages that I had growing up. I need to be an advocate for change.

Another area that emerged as a strength is writing case notes. I have enjoyed writing throughout my life – I have written and produced plays for the Saskatoon Fringe Festival, and writing was such an interest in high school English that it led me to teach English and Creative Writing. There is a lot of writing involved in the work that the Young Offender team does, whether it is writing court assessment reports, initial treatment reports, achievement and cognitive psychological assessments, email communication with other members of the client’s team, or writing case notes. As stated earlier, Mr. James writes thorough notes. I felt like I had the freedom then to write detailed notes, and to experience how that process can help a psychologist reflect on a session and make a plan for the next session. It felt good to write these notes – I know that it is considered a chore for some psychologists, but I enjoyed it. As stated earlier, it was a challenge to write more in the passive voice since conclusions cannot be
made without using specific diagnostic tools, but learning this has made me a more well-rounded writer. I found that writing case notes was as rewarding an experience as playwriting or other forms of creative writing. Allowing my brain to work through what happened in the session, make connections, and find the best way to approach treatment with a client was satisfying. I suspect that part of my enjoyment was being able to discuss these ideas with Mr. James, and to get his feedback. I know that I will still enjoy writing case notes when I am working without supervision because I love writing. I have loved it since I was young, and it is nice that I can apply that skill to the practice of counselling. My next step is to figure out how to write case notes at this level in a guidance counselling context where I potentially see several students throughout the day who have various academic needs, as well as personal counselling needs. Not every note will require the detail I have put into the case notes during my practicum.

13. MY AREAS FOR IMPROVEMENT

I find I learn best from failure. I have spent a great fraction of my life being afraid of failure – much like the students I counsel at my high school. But failing is the only way to learn. I am trying to redefine this word for myself, and for those around me. I want to keep learning through trying and making mistakes. So, identifying my weaknesses is central to my growth as a counsellor.

An area I want to keep working on is time management in sessions. One day, I was having a productive session with a client then looked at the clock and realized that I only had five minutes left. I had not started to wind the session down, which involves reviewing what was
discussed, making a plan for the next session, and confirming the next appointment time. It is like being a beginner teacher again – learning how to time each lesson. I need to make sure I finish the check in at the beginning of the session within the first five to ten minutes, so the main topic can be given enough time. I think I do well with the middle part of the session, but it is easy to let the main topic go on too long. I decided to focus on time management in the last two weeks of my practicum after having that experience. It may not have made a difference to the client, but I know that I can still improve in this area.

I had another habit, which Mr. James did not see as a bad thing, of focusing heavily on the client’s educational needs. This works well for my future work in schools, but I was not sure if it always served the client effectively or not – perhaps my Westernized world view puts more emphasis on traditional education than my clients will. It is important to pay attention to this when working with clients in the future. Another question I had was if I was avoiding messier topics by addressing educational needs instead? I identified this habit fairly early in the practicum, so I focused on allowing clients to process non-educational topics more in sessions I ran since this does not come as naturally to me.

This relates to another area that I want to continue to work on. There are times when I need to be more direct with clients. In a session where the topic of a dysfunctional relationship was brought up, it was important for me to learn to focus a session on this non-educational topic. However, I was hesitant to get to, potentially, the heart of what the client was telling me. I got caught in the trap of the client trying to convince me that the situation is hopeless. I was being solution-focused in the questions I asked, and we were going in circles. Mr. James was observing this session, and he asked a question that helped shift the topic into a
more constructive direction.

After the session, Mr. James gave me the feedback that there are times to ask a difficult question to find out what clients actually want. In this case, just asking the client about whether he is thinking about leaving the relationship was needed. So, perhaps the hesitancy to deal with the messy issues is connected to the hesitancy to be direct with clients. Fortunately, the next day I was able to observe a session where Mr. James demonstrated how to ask a client tough questions. I now know how to approach this situation the next time it happens. I can see how this could play out in a guidance counselling context. Students try to convince me that it is impossible for them to get work completed to pass a class. Using a more direct strategy can avoid game playing or fatalistic thinking with clients. With a lot of these areas for improvement, I wanted to aggressively address them in the last two weeks of my practicum. It feels like I was just identifying what I needed to work on when it was time for the practicum to end.

14. CLOSURE

Given the length of time I spent at Child and Youth Services, I was only able to meet with a few clients one-on-one, and having the one be a regular “no show” lessened the number of chances I had to work individually with that client. So, providing closure with each of these clients was not possible. I feel like I was just in the process of earning their trust when the practicum ended. However, aspects of closure are still challenging for psychologists in the young offender team. The psychologists typically know the last day that a client is ordered to see them, but they also leave the door open to return for further counselling. So, those who never come back may not find total closure with their treatment. Then again, they may find
treatment in another form, but the psychologist may not know what happens to that client after that last session. However, some clients may stay longer and bring the therapeutic relationship to a more natural end. I heard about two clients who were still making regular use of appointment times, and this appeared to be positive since their life challenges, at times, seem overwhelming. Apparently, though, it is rare that clients return after their last court-mandated session.

I may not have had closure with all of these incredibly interesting people, though I was able to thank most of them for letting me work with them. The experience they gave me will stay with me for years – and has already made me a better counsellor.

15. SUMMARY

I learned many practical skills, and gained further knowledge of the profession of psychology, during my practicum at the Saskatoon Health Region’s Child and Youth Services. Not only did I learn about forensic psychology by working with young people who had been sentenced for violent or sexual-based offenses, but I also gained confidence in my abilities as a counsellor. I will now be an even more effective guidance counsellor for the Saskatoon Public School Division.

There are many reasons why young people commit criminal offenses. The analogy of Pathways from the resource book of the same title is apropos for counselling young people. There is not one moment that leads to an offense. There are many factors that need to be addressed with forensic clients, and no two clients are ever the same because they take different pathways to commit their crimes.
I will continue to be interested in this area of psychology, and I plan to continue learning about it in the years to come. This practicum has enriched my graduate program immensely. My courses, instructors, practicum placement, and professional associate have all helped me to become a better counsellor, and a more aware human being when it comes to issues of inequality in today’s society. No learning experience could be more valuable than one that leads to this level of self-improvement. I have enjoyed my graduate program, and will look back on it fondly for years to come.

16. NEXT STEPS

This fall, I will be returning to teaching full time. I have learned through this practicum to better accept people for who they are, and to not judge their actions even if they contradict the values of my upbringing. The key to being an effective educator is similar to being an effective counsellor or psychologist – though the jobs can require different skill sets – the student or the client will work better if they trust their teacher or their counsellor. A teacher-student relationship is a learning alliance, and the counsellor-client relationship is a therapeutic alliance. Both people need to work together to create success. I want to keep finding ways to be an advocate for people who do not feel that their life experience is reflected in the educational system or the mental health system. To truly commit to this work, I have to be an active, encouraging member of that alliance.

Learning is a lifelong process, and I feel that I need to learn a lot more about Decolonization. To honestly find the best way to teach and counsel all people, I need to keep learning from the life perspective of people who do not come from a Eurocentric, Westernized
approach to life. To truly create effective alliances with clients, students, and their families I will continue to learn, and continue to improve.

I will also continue to develop a more direct counselling style to go with my natural love for person-centred counselling. This will make me a well-rounded counsellor, if I can borrow for different theories and experiences to find the best treatment approach for each individual client. Forensic psychology is quite unique, and I found that I had to learn to be more direct when leading a session. I will continue to use these skills when I am back in Student Services.

I will have some time to reflect on this experience before I am back in the guidance counselling role, which will help me gain greater perspective on how to keep growing as a counsellor. My hope is to work with people to make positive changes in the education system, so that all students can succeed – no matter what role I have in schools I can work towards that goal now and continue to work towards that goal for years to come.
REFERENCES


Center for Substance Abuse Treatment. (1999). *Enhancing Motivation for Change in Substance Abuse Treatment*. Maryland: Center for Substance Abuse Treatment.

*Diagnostic and statistical manual of mental disorders (5th Ed).*


APPENDICES

APPENDIX A
MENTAL HEALTH AND ADDICTIONS SERVICES
PAPERWORK

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan
MENTAL HEALTH AND ADDICTION SERVICES

INFORMED CONSENT
Page 1 of 1

The Young Offender Program is mandated to provide services to youth identified as young offenders. As part of our mandate, we sometimes must provide information to other agencies, services or programs. Information will be provided only on a "need to know" basis. This form outlines the limits of confidentiality for the duration of the service provision.

Confidentiality is limited by requirements of the Criminal Code of Canada, the Child and Family Services Act, and the Mental Health Services Act.

I, ___________________________ understand that information shared with the Young Offender Program may be shared with the following agencies:

- Queen’s Bench Court
- Provincial Court
- Crown Prosecutor
- Defense Council
- Ministry of Justice: Youth Worker
- Ministry of Justice: Kiburn Hall
- Ministry of Justice: Yarrow Youth Farm
- HRVYO Admission Committee
- Ministry of Social Services
- Addiction Services:
- Family/Caregivers:
- School:
- Other (e.g. Police, hospital staff):

______________________________       __________________________
Signature of Client              Date

______________________________       __________________________
Signature of Guardian/Parent     Date

______________________________       __________________________
Signature of Staff               Date

Word Form #103766 01/15 Category: Consents/Release/Transport
MENTAL HEALTH AND ADDICTION SERVICES

SERVICE AGREEMENT

Page 1 of 1

The purpose of this form is to explain the terms of service provided by the Young Offender Team.

1. The information obtained from you will be used by the Young Offender Team to provide services to you for administrative purposes, and research and training. Information is only shared on a "need to know" basis.

2. Services that will be offered to you are:
   □ Court Ordered Assessment
   □ Suicide Risk Assessment
   □IERG Services
   □ Forensic Treatment
   □ Trauma Related Services
   □ Psychological Assessment
   □ Forensic Risk Assessment
   □ SO Services
   □ Aggression/Anger Management Services
   □ Behavioural Services
   □ Substance Management Services

3. Confidentiality is limited by requirements of the Criminal Code of Canada, the Child and Family Service Act, and the Mental Health Services Act. Thus, information provided by you to the Young Offender Team will have limits on confidentiality as outlined to you.
   - Legal Mandates
   - Testify in Court
   - Sharing at Conferences
   - Risk to Others
   - Self Harm
   - Other:

4. Terms specific to this situation (if any):

5. I understand and agree to the above terms of service as explained to me. I understand that I may withdraw my agreement for services or ask for a review of the agreement at any time.

I understand but do not agree to the above terms of services as explained to me. I do not wish to receive services at this time. Furthermore, I understand that the following will be notified:

   a) ___________________________ initials
   b) ___________________________ initials
   c) ___________________________ initials
   d) ___________________________ initials
   e) ___________________________ initials
   f) ___________________________ initials

Signature of Client ___________________________ Date ___________________________

Signature of Guardian/Parent ___________________________ Date ___________________________

Signature of Staff ___________________________ Date ___________________________

Word Form #103766 01/15 Category: Consents/Release/Transport
MENTAL HEALTH AND ADDICTION SERVICES

VERIFY THE FOLLOWING INFORMATION:

Client Name: ________________________ □
HSN: ________________________ □
Date of birth: ________________________ □

PRIVACY NOTICE

Saskatoon Health Region and Mental Health and Addiction Services (MHAS) is committed to respecting and ensuring the privacy, security and confidentiality of personal health information, consistent with Criminal Code of Canada, The Child and Family Services Act, The Mental Health Services Act, and The Health Information Protection Act legislations and guidance from professional associations.

Collection and Storage of Personal Health Information

Personal health information is collected about you directly from you or from the person acting on your behalf. Personal health information may include your name, date of birth, address, health history, record of your visits to Mental Health and Addiction Services (MHAS), clinical assessment tools (e.g. CAFAS, CDDI) and the support you received during those visits. Your information may be collected from other sources if you provide consent to do so.

Your personal health information, whether collected in writing, on a computer, or by other means is stored safely and securely to protect your privacy.

Disclosure of Personal Health Information

Your personal health information may be:

- communicated with your health care providers including your family physician and/or other health care institutions, but only the information required for treatment support and continuity of care (unless you advise Saskatoon Health Region otherwise);
- used to comply with legal and regulatory requirements; in some situations, information must be disclosed by law (for example, when a child requires protection).

To Access or Correct Your Information

If you require access to your personal health information or believe a record held by MHAS is inaccurate or incomplete, you may make a written request to access and/or correct your personal information. Please contact your care provider or the Saskatoon Health Region Privacy Office.

Saskatoon Health Region
Privacy Officer
Phone: (306) 655.7679

You have the right to contact the Ombudsman Office to discuss any concerns you have about services you have received:

Phone: 306-787-6211 or 1-800-667-7180

Signature of Service Provider ________________________ Date ________________________

This verifies that this privacy information was discussed with the client and an understanding was met; and the client identification was confirmed

Word Form #103068 03/14 Category: Consents/Release/Transport
MENTAL HEALTH AND ADDICTION SERVICES

CLIENT REQUEST FOR EMAIL/TEXT MESSAGE COMMUNICATION

Please be advised that this request applies only to clients of Saskatoon Health Region (SHR) Mental Health & Addiction Services (MHAS).

☐ Email communication Email Address: __________________________

I request and authorize __________________________ to communicate information with me regarding aspects of my healthcare through the above email address. My signature below denotes that I have read the document, Patient Email/Text Message Communications – Questions and Answer Fact Sheet, and accept the risk of loss of privacy of confidential health information associated with email communication. This authorization for communication by means of email is valid until I notify the department listed above, in writing, that I no longer authorize the use of email to communicate information concerning my healthcare. I understand that information communicated by email may be retained within my health record. MHAS also retains the right to terminate email as a communication option if it becomes burdensome or is used inappropriately.

☐ Text Message communication Telephone Number: __________________________

In an effort to keep information confidential, SHR MHAS staff will de-identify your information by not using last or first names.

1. You will receive an initial text message from SHR MHAS staff requesting your chosen password in order to initiate communication via text message. Your request will not be effective until you receive and respond appropriately to this text message.

2. Communication via text message is not to be used for counselling and/or therapeutic purposes. Information such as treatment options, test results, etc. will not be communicated in this manner.

3. There may be some delay in SHR MHAS staff responding to your text message. If you are in an emergency situation please dial 911

Please choose one of the following security questions. The answer you provide to this question will become your PASSWORD.

What is your grandmother’s first name?
What is the first elementary school you attended?
What is your oldest sibling’s birthday month?
What is your mother’s middle name?

I understand and agree to the following:

• I certify the email address/phone number on this request is accurate, and I accept full responsibility for all messages sent to or from the email address and/or phone number.

• I understand and acknowledge that these forms of communication may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated in this way.

• I understand that all communications in which I engage may be forwarded to other providers on a need to know basis for purposes of providing treatment to me.

• I agree to relieve SHR MHAS staff from any and all claims and liabilities arising from or related to this request to communicate via email or text messages.

_________________________________________  __________________________
Signature/Guardian  Date of Consent

_________________________________________
Witness

Word  Form # 103734  01/14  Category: Consents
PATIENT EMAIL/TEXT MESSAGE COMMUNICATIONS
Questions and Answer Fact Sheet

The following questions and answers are guidelines for utilizing email or text messages as a method of communication with your healthcare provider.

What are my risks when using email or text messages?

- It is not guaranteed to be secure or confidential; unauthorized individuals may be able to intercept, read and possibly modify the messages you send or are sent by SHR Mental Health and Addiction Services (MHAS)
- They may inadvertently be sent to a wrong destination or to the wrong individual
- Emails can be used to spread viruses, some of which may cause unauthorized email distribution
- Employers may monitor email/text messages sent or received by employer-owned systems
- Shared family accounts can jeopardize confidentiality

When is it okay for me to use email/text messaging?

Email and text messages should only be used for non-urgent issues such as routine enquiries or appointment information. **Never** use email or text messages for communication of serious, urgent or time critical issues. **Never** use text messages for counseling type information or medication information. We do not advise using text messages for discussing sensitive information.

How soon will I hear back from my provider?

MHAS health care providers will do their best to respond to email and/or text message communications in a timely manner. Weekend and evening communications may not be responded to until the next business day.

How will the information in my email/text message be used?

The information within your email or text message may be shared with other SHR MHAS health care providers as part of your care team. MHAS will not, however, share emails or text messages with third parties not involved with your care without your prior consent, except as authorized or required by the Health Information Protection Act (HIPA). Please keep in mind that all email messages, sent or received, may become part of your health record.

What should I do if I change my email address or cell phone number?

You must notify your MHAS health care providers as soon as possible to maintain confidentiality.

Also...

Instead of creating new email/text message, be sure to reply to the last email/text message. This establishes an email/text message trail that allows you and your MHAS health care provider to track messages, as well as eliminates the need for entering the email address and/or cell phone number, therefore reducing chances of entering an email or cell phone number incorrectly. For your own records, you may want to save your messages.

***If you have any questions or concerns, please contact your MHAS health care provider***
Suicide Screening Questions (Ideation/Planning/Behaviour/History)

All clients must be screened for suicidal thoughts and behaviors. A hierarchy of screening questions below, which gently leads to asking about suicidal ideas, is a generally accepted procedure for all health care professionals. These questions may have to be asked in a different manner with younger or cognitively challenged populations.

1. Are you having any feelings of hopelessness, helplessness or depression?

2. Have you had any thoughts, urges or behaviors related to harming yourself?

3. Have you recently engaged in any reckless behavior related to harming yourself?

4. Have things been so bad lately that you have thought you would rather not be here?

5. Are you thinking of suicide?

6. Have you made any current plans?

7. Do you have the means to act on your plan?

It is important to clarify the answer and watch for answers that avoid directly answering the question. If any of the above questions are answered “YES” an assessment of risk level must be done and a safety plan developed.

Re-assessment Timelines

NO: Re-assess as required

LOW: Follow-up appointment and suicide risk assessment within 30 calendar days

MODERATE: Follow-up appointment and suicide risk assessment within 7 days

HIGH: Refer for hospital based evaluation. Re-assess within one calendar day if in the community.

(note: Mobile Crisis can be contacted to continue reassessment over weekends or stat holidays)
| SUICIDE RISK ASSESSMENT GUIDE - COMMUNITY |

**DOCUMENT EACH RISK FACTOR AND INTERVENTION PLAN IN PROGRESS / ASSESSMENT NOTES**

<table>
<thead>
<tr>
<th>TRAJECTORY</th>
<th>AT RISK MENTAL STATES</th>
<th>SUICIDE ATTEMPT/ SUICIDAL THOUGHTS</th>
<th>SUBSTANCE USE</th>
<th>CORROBORATIVE HISTORY</th>
<th>STRENGTHS/SUPPORTS (coping &amp; connectedness)</th>
<th>REFLECTIVE PRACTICE</th>
<th>RISK REDUCTION FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>depressed</td>
<td>Intentionality</td>
<td>Current misuse of alcohol/drugs</td>
<td>family, parent or guardian; medical records; other service providers/ sources; availability of supports; willingness/ capacity of supports; safety of person &amp; others</td>
<td>level &amp; quality of engagement; changeability of risk level; engagement; confidence in risk factors</td>
<td>Treat as a medical emergency that is best facilitated by hospital based evaluation; Provide clear and concise information about available services and treatment options; Refer to Emergency Services for crisis assessment; Present appropriate services with information regarding need for suicide assessment and possible admission to an inpatient facility</td>
<td></td>
</tr>
<tr>
<td>媒體</td>
<td>Command hallucinations or delusions about dying; Preoccupied with death; hopelessness; worthlessness; intense anger, hostility.</td>
<td>An attempt with high lethality (ever); Recent suicide attempt; Expresses wish to die; Evidence of a plan; Suicide note</td>
<td>Current substance intoxication or abuse</td>
<td>Unable to access or verify information; Conflicting account of event to those of the person at risk; Information supports suicidal intent</td>
<td>Patient is refusing help; Lack of supportive relationships; Hostile relationships; Supports not available or unwilling/unable to help</td>
<td>Low assessment; confidence; High changeability; No rapport, poor engagement</td>
<td></td>
</tr>
<tr>
<td>MEDIUM</td>
<td>Moderate depression;</td>
<td>Frequent thoughts</td>
<td>Access to same information; Some doubts to plausibility of the person's account of events.</td>
<td>Patient is ambivalent; Moderate connectedness; Few relationships; Relationships available but unwilling/unable to help constantly,</td>
<td>Patient is accepting help; Therapeutic alliance forming; High level of connectedness and supports; Willing and able to help constantly; Identifies reasons for living/hope</td>
<td>Follow-up appointment and suicide risk assessment within 7 days</td>
<td></td>
</tr>
<tr>
<td>LOW</td>
<td>Mild depression, anxiety; Some symptoms of psychosis; Some feelings of hopelessness; Moderate anger, hostility.</td>
<td>Risk of substance intoxication, abuse or dependence</td>
<td>N/A or vague thoughts</td>
<td>N/A or vague thoughts; No recent attempt or 1 recent attempt of low lethality and low intentionality; No plan identified</td>
<td>Patient is accepting help; Therapeutic alliance forming; High level of connectedness and supports; Willing and able to help constantly; Identifies reasons for living/hope</td>
<td>Follow-up appointment and suicide risk assessment within 90 calendar days; Develop safety plan</td>
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**RESPONSE PLANS**

- Triage as per standard triage process
- Re-assess as required
MENTAL HEALTH AND ADDICTION SERVICES

SUICIDE RISK FLAG FORM

Initial Risk Assessment:  □ High  □ Medium  □ Low

Date of Initial Risk Assessment: _______________________

List all Suicide Risk Reassessments below including the date and time and reason for reassessment.

If you assess an individual at **NO FORESEEABLE** risk you must reassess until they have been assessed 2 times as No Foreseeable risk.

<table>
<thead>
<tr>
<th>Date</th>
<th>Reassessment (circle)</th>
<th>Next Assessment Date</th>
<th>Clinician</th>
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<tbody>
<tr>
<td></td>
<td>High</td>
<td>No Foreseeable</td>
<td></td>
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<td></td>
<td>High</td>
<td>No Foreseeable</td>
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APPENDIX B
HOURS, CLIENT DEMOGRAPHICS, AND ASSESSMENTS

HOURS BY TYPE

Direct

Court- Ordered Client Assessment Sessions 6
Client Treatment Sessions 40
Treatment Planning and Community Consultations 20

Indirect

Case Conferences/Rounds Meetings 8
Reading Case Files/Court Reports 20
Psychological Assessment: Scoring/Interpretation 2
Reading/Research/Preparation 20
Team Meetings/Staff Meetings 4
Professional Development 3
Case Note Writing/Initial Note Writing/Assessment Report Writing 40
Journal/Report Writing 27
Paperwork for New Treatment Clients/Courts Assessment Clients 5

Supervision

Teacher Consultation – Individual Supervision 35
Practicum Goals Assessment 5
Debriefing 37

Summary

Direct 66
Indirect 12
Supervision 77
Total 272
## DEMOGRAPHICS

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<th>Age</th>
<th>13-17</th>
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<td>Female</td>
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<td>Sexual Orientation</td>
<td>Heterosexual</td>
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<td>Race</td>
<td>Asian Origin</td>
<td>Indigenous</td>
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<td>Disabilities</td>
<td>Serious Mental Illness</td>
<td>Learning/Cognitive Disability</td>
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<tr>
<td>Total Clients Seen</td>
<td>Individuals</td>
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## INTEGRATED REPORTS

First Experience: I observed professional associate administer Wechsler Intelligence Scale for Children – Fifth Edition (WISC-V) to an adolescent male. I also assisted by writing background section of the report, and learned how the test is scored.

Second Experience: I observed professional associate administer Wide Range Achievement Test 4 (WRAT-4) to an adolescent male. I was also shown how the test is scored.