

A CLINICAL FIELD PRACTICUM EXPERIENCE AT THE NORTHWEST
COMMUNITY ADDICTIONS AND MENTAL HEALTH CLINIC UTILIZING COGNITIVE
BEHAVIORAL THERAPY, DIALECTICAL BEHAVIORAL THERAPY AND
MOTIVATIONAL INTERVIEWING

A Field Practicum Report

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Abstract

This report is a reflection on my clinical practicum experience at the NW Community Addiction and Mental Health Clinic in Calgary, AB, with Alberta Health Services. The goals of this practicum were to: 1) gain clinical social work experience and knowledge in the area of outpatient mental health and addiction care; 2) to become familiar with clinical assessment and interventions used within the outpatient mental health and addictions clinic; and 3) to gain knowledge and skills in the clinical theories of Cognitive Behavioural Therapy (CBT) and Dialectical Behavioral Therapy (DBT) used in individual and group settings within the clinic. This report opens with an introduction to my learning objectives, the NW Community Addiction and Mental Health Clinic and individual and clinic ideologies and is followed by a literature review and discussion surrounding how I achieved my practicum goals. Lastly, the report discusses professional challenges and ethical considerations followed by a final summary and conclusion.

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Chapter 1: Introduction

Awareness surrounding the need for mental health and addiction care has grown over recent years. It has become evident that mental health and addictions supports are essential to the wellbeing and quality of life of many, as one in three Canadians meet the criteria for mental health or substance use disorder within their lifetime (Statistics Canada, 2012). I am one of those Canadians that have been touched by the effects of mental health and addictions, in both a professional and personal capacity. Due to the impact that these experiences and stories have had on me, this area of work has become my passion.

As I began my Masters of Social Work journey, I knew that I wanted to enter into the realm of clinical social work so I could continue to deepen my knowledge and skills in this area and become one of the professional supports that is highly needed within this country. Throughout my experience, I could see that counselling was one of the key aspects of mental health and addictions care, and I wanted to use this educational opportunity to deepen my practice in this area. Research conducted over many years illustrates that psychological treatment provides significant benefits for around 75% to 80% of people treated (Mental Health Commission of Canada, 2017). It is evident that clinical counselling services have the potential to provide individuals with appropriate skills and insight to better support their recovery and address both their mental health, addictions and other psychosocial needs.

When the placement arose, at the Alberta Health Services NW Community Addictions and Mental Health Clinic, I knew this placement had the potential to deepen my clinical competencies and, in turn, strengthen my ability to provide appropriate clinical care to the many people that continue to touch my life. I believe that this field practicum experience has not only expanded my clinical skills, it has also extended my understanding of the many biopsychosocial

factors that individuals face and has deepened my awareness, as a social worker, which I believe has numerous benefits to my ongoing practice. The purpose of this report is to present my practicum experience and provide details around my learning outcomes, skills development and overall growth as a graduate level social worker.

1.1 Personal and Professional History

I have years of social work experience within the community of Calgary, providing services to individuals faced with mental health and addiction. In many instances, I utilized healthcare services, both inpatient and outpatient, to support those clients struggling in community. The extensive mental health and addictions resources provided by Alberta Health Services became an essential resource for many I supported throughout the years. As I continued to see the benefits of these many programs, practising as a social worker within a healthcare-based team became a career goal. This practicum opportunity allowed for me to begin that journey within the mental healthcare system.

Unlike many practitioners, I was not always aware that social work was suited for me. Even though I always knew I wanted to enter a helping profession, it took years of experience working with vulnerable populations before I acknowledged that this was the career path that I wanted to embark on. Most of my initial career was spent working with individuals with developmental disabilities and mental health concerns. As time went on, I developed more and more interest in the lives of people and began to have a deeper understanding of systematic struggles that are faced by the most vulnerable populations.

When I began to work with women facing homelessness within Calgary, I then was exposed to more intense mental health and addictions concerns faced by some of Calgary's most marginalized. I knew this was the area that I wanted to continue in, as I developed a deep love

and connection to the stories that these women held and established an interest in the psychosocial factors that surround individuals faced with mental health and addictions. Not only did I feel a professional connection to these women's stories, but I always felt a personal draw to this work and each individual. With a history of exposure to mental health concerns within my family, the stories that I encountered often fostered a deep empathetic understanding of the complexities of losing mental acuity that I knew benefitted my practice.

As my career continued to develop, I could see that there was a high need for more mental health support within the city of Calgary, and I knew that clinical social work was the direction I wanted to move my career. I held extensive experience providing case management and supportive counselling, and I quickly realized that I wanted to provide more intense clinical support. Through some self-reflection, I realized that supporting individuals suffering from the hardships of mental health and addictions was a strength that I had, and I wanted to continue to pursue this passion. The passion and the many client stories that I held in my heart led to a flourishing interest in clinical practice and in turn, led me to want to complete my Master of Social Work degree.

1.2 Alberta Health Services (AHS): NW Community Mental Health and Addictions Clinic

When I embarked on my MSW journey, I knew that I wanted to complete a field practicum where my passion fell. I wanted to use this opportunity to become more specialized in clinical social work and develop my counselling skills and competencies. When the opportunity to complete my practicum at the NW Community Addictions and Mental Health Clinic arose, I was extremely thrilled. I was assured that this placement would provide me with an opportunity to work within a clinical setting, allowing me to strengthen my clinical skills in the practice area of concurrent disorders, which is where I wanted my career to continue, post MSW completion.

The NW Community Addictions and Mental Health Clinic is an Alberta Health Services (AHS) community-based outpatient mental health program that provides psychiatric, therapeutic and case management services to adults eighteen years or older in Calgary, AB (Alberta Health Services, 2019). Patients attending this clinic, face moderate to severe mental health diagnosis in addition to numerous other psychosocial factors (Alberta Health Services, 2019). Referrals received at the NW clinic are triaged through the AHS centralized intake service, Access Mental Health (Alberta Health Services, 2019). Both adult and youth referrals to Access Mental Health are received through a variety of avenues including primary care physicians, AHS and community programs, community members, and patients in the Calgary region. Access Mental Health completes an intake screening and consultation to determine which AHS program would best support the patients' care needs and then appropriately refer to the program (Alberta Health Services, 2019).

The NW Community Addictions and Mental Health Clinic provides services that are covered by Alberta health care (Alberta Health Services, 2019). The clinic is established in two locations within Calgary – the larger main clinic and the satellite clinic that is housed within another AHS program. Throughout my placement, I was located at the satellite clinic. The multidisciplinary team of the clinic consists of; psychiatrists, psychologists, registered nurses, social workers, a peer support worker and independent living workers who were contracted through the Canadian Mental Health Association (Alberta Health Services, 2019). There are a variety of services provided to adults that attend this clinic including mental health assessment and diagnosis, psychiatric consultations, medication management, individual and group therapy, case management and outreach, and peer support (Alberta Health Services, 2019).

The therapists within this clinic specialize in treating a variety of mental health diagnoses in addition to concurrent disorders. These include, but are not limited to anxiety, depression, PTSD, personality disorders and addictions. In addition, the therapists provide accessible services to individuals with a variety of psychosocial concerns which include poverty, abuse, grief, physical health, marital breakdown, and numerous other concerns. As stated by the clinic's philosophy statement, "The NW Community Mental Health Centre (Adult Team) is committed to providing community-based, accessible addiction and mental health service to adult Albertans" (Alberta Health Services, 2016, p. 2). Additionally, the mission statement adhered to by the clinical staff states,

Our mission at the NW Community Mental Health Centre (Adult Team) is to enhance the quality of life of individuals with addiction and mental health concerns. To this end, we offer services that are: Client centered, mutually respectful, sensitive to diverse populations, evidence-based, offered in an environment of confidentiality and safety, individualized, goal oriented and time limited, collaborative and integrated with other community resources. (Alberta Health Services, 2016, p. 2)

1.3 Practicum Goals and Learning Activities

My practicum consisted of 450 hours, which were completed fulltime between May 1st – August 21st, 2019, under the direct supervision of one of the clinic's therapists who held an MSW. In my practicum proposal, I outlined three main goals, each comprising of multiple learning activities, which illustrated the required steps that were needed to successfully reach each of the goals during my placement. The first goal stated that I would gain clinical social work experience and knowledge in the area of outpatient mental health and addiction care. This was measured through the completion of the following learning activities:

- Participate in team meetings, case consults and training to enhance clinical social work knowledge and skills.
- Participate in opportunities to gain knowledge and skills from the multidisciplinary team within the clinic.
- Gain a deeper knowledge of community programs, services and resources that offer adult mental health and addictions supports in Calgary.
- Review and incorporate the Alberta College of Social Workers practice standards and code of ethics into practice.

The second goal, outlined within my practicum proposal, required that I become familiar with clinical assessments and interventions used within the outpatient mental health and addictions clinic. In order to reach this goal, the following learning activities were completed.

- Gain knowledge around specific social work clinical theories used within the clinic.
- Gain further understanding around the use of intake assessments, biopsychosocial assessments, and treatment plans used within the clinic along with discharge planning and appropriate resources and referrals in the community as they relate to the mental health and addiction recovery.
- Conduct 5-10 biopsychosocial mental health assessments.

Lastly, I identified the goal of gaining knowledge and skills in the clinical theories of Cognitive Behavioural Therapy and Dialectical Behavioural Therapy used in individual and groups setting within the community clinic. Learning activities included:

- Complete a comprehensive literature review on the use of Cognitive Behavioural Therapy and Dialectical Behavioural Therapy within mental health and addictions care.
- Conduct individual therapy sessions utilizing Cognitive Behavioural Therapy and Dialectical Behavioural Therapy with my assigned caseload of 8 -12 individuals
- Assist with conducting 10 group psychotherapy sessions utilizing Cognitive Behavioral Therapy.
- Gain further understanding about when it is clinically appropriate to use each theory.

This report will explore the experience I had throughout my field practicum at the NW Community Addiction and Mental Health Clinic to achieve my practicum goals and learning objectives. I will begin by examining the values and ideologies of both myself along with the NW Community Addiction and Mental Health Clinic and the connection to human rights. I will then discuss the theories of Cognitive Behavioural Therapy, Dialectical Behavioural Therapy and Motivational Interviewing and the literature conducted in the area of Mental Health and Addictions care. This will then lead to a discussion around my practicum goals and learning activities and will examine how I met each of these requirements throughout my four months at the clinic. The following chapter will be a dialogue surrounding both professional and ethical challenges that arose. Lastly, I will complete this paper with a conclusion providing my overall learning and final thoughts moving forward into my career as a graduate-level Social Worker.

Chapter 2: Ideologies, Values and Human Rights

This chapter will examine the values and ideologies of both the NW Addictions and Mental Health Clinic as well as my own. Many of the values and beliefs that this program is based upon stem from the larger value perspective of Alberta Health Services as a whole. Additionally, it became evident throughout my experience that each clinician's individual values and beliefs are also integral in the care of the clients in this program. Throughout my time in the program, I continued to strengthen and build insight into my own individual ideology and value in my clinical practice.

2.1 My Individual Values, Ideologies and Human Rights

For years, I have been practicing from a strength-based perspective, always recognizing the value that each person holds within society as well as the strengths that they bring forward. I always believe that these individual strengths can continue to be built upon (Tondora, Miller, Slade, & Davidson, 2014). When we acknowledge the strengths that people hold, we move away from the "problems" that they struggle with and move towards building self determination and acceptance in many different capacities. However, this shift from a deficit to strength-based approach does not mean that we ignore people's hurt, pain and trauma (Saleeby, 1997). As described by Tondora et al., (2014), "Providers attempt to reframe perceived deficits within a strength-based framework, as this will allow the individual to identify less with the limitations of his/her disorder" (p. 73).

I believe that my strength-based practice has grown and continued to develop throughout my placement. The avenues in which this continued to develop was through both my clinical assessment and therapy practice. The completion of a mental health assessment is a requirement for all new patients that received therapy through the clinic, and this work was a large portion of

my practicum placement as I conducted a total of 10 biopsychosocial assessments. These assessments are looking to examine the mental health symptoms and other biological and social struggles that are faced by these new clients to ensure that the best clinical approach and interventions are used to meet their needs within the clinic. As accounted by many, it can be an extremely challenging process, as it delves into many experiences, memories and difficulties that can be largely negative. Traditionally, mental health assessments in healthcare are largely focused on the deficits, problems and diagnoses that each individual faces and I quickly learned that weaving a strengths-based perspective into this assessment can have a multitude of benefits (Hirst, Lane & Stares, 2013). Healy (2014) suggests that such a focus on deficit in social work stems from the profession's historical foundation in religious charities and the assumption that service users' problems are attributed to their moral failings (p. 165).

I found that incorporating a strengths-based aspect into my assessments allowed for an opportunity to discuss what strengths each individual held and also helped to build a strong therapeutic relationship. I ended each of the assessments, by reflecting multiple strengths that I recognized through the assessment and illustrated the importance and value of each. I saw how this created an instant connection for many people, as they could see that the therapist validated the strengths they brought forward and understood the barriers that got in the way of their full success. In addition, this intervention also helped to reframe the negatives presented throughout the assessment, into transferable skills that the client can begin to recognize and build upon throughout their recovery (Tondora et al., 2014). As described by Francis (2014), "...what matters in a strengths based assessment is that it seems to ask questions towards strengths that help the client to reframe their issues/thinking, and explores exception finding aspects in their

life which is a quite unique way of listening to the lived experience of clients as they are experts by their experience” (p. 264).

In addition, utilizing this approach also allowed for clinicians to step back from the labelling and diagnosing, which traditionally surrounds mental health assessments. I recognized that when assessments are focused on diagnosis, it has the potential to take away from the client narrative and their voice within their experience of sharing (Francis, 2014). In many instances, there were clients that wanted to focus on their diagnosis, to better understand and normalize their experiences and for many others, they did not want to see another label become attached to them.

In general, strength-based social work practice is aligned heavily with a human rights-based framework as it is established on the ideology that promotes resilience and the furthering of human rights (Berthhold, 2014). It steps away from focusing on deficits and moves towards empowering clients by utilizing the strengths, characteristics and power that they already hold rather than looking to decrease that through a focus on inabilities. In addition, it decreases the power differential between social worker and client as it allows for the opportunity to reflect on the client’s control and expertise in their own life (Hirst et al., 2013).

2.2 Clinic’s Values, Ideologies and Human Rights

The philosophy of care within Mental Health and Addictions programming in Alberta Health Services is based on the recovery model of care (Alberta Health Services, 2019). This model focuses on the principles of respect, empowerment, hope, holistic recovery, and strengths-based recovery (Alberta Health Services, 2016). Furthermore, this model believes that recovery looks different for each patient and is not limited to the absence of symptoms, but rather it supports each individual’s therapeutic goals to work towards meaningful lives and the

maintenance of daily functioning (Alberta Health Services, 2016). This model illustrates the importance of placing value on everyone that is served and recognizing the importance that they each hold within society (Berthold, 2014). Essentially, this approach embraces a holistic view of people and a biopsychosocial understanding of mental health and enables individuals to live a meaningful life with their mental illness (Mental Health Commission of Canada, 2017).

The recovery care model aligns with a human rights perspective of clinical social work practice (Berthold, 2014). This model illustrates the importance of self determination and exemplifies that clinicians should be focusing on what the patient believes a meaningful life would look like. It is key that clinicians support the wishes that their clients hold and do not intervene in their decision making, even though recovery goals may look different between the clinician and the patient (Berthold, 2014). For example, we had many patients that refused the idea of psychiatric medication even though it was highly recommended, and when practicing from both a recovery care model and human rights perspective, it is extremely important that we respect the decision making capacities of these patients.

One of the ways that the recovery care model is implemented in the program's therapeutic practices is through SMART goal formulation. SMART goals are intended to be Specific, Measurable, Achievable, Relevant and Time Bound, which is essential to provide goal directed therapy (Alberta Health Services, 2016). When implementing SMART goals, it was imperative that the process was self directed and that goals were created by the patient. It was evident that this patient-centered process was essential to ensure that patients met the recovery success that they were striving for (Alberta Health Services, 2016). Recovery goals are essential to assist patients and their families to move towards their strengths and success and away from the label of chronic relapse (Alberta Health Services, 2016).

Patient and family-centered care is the second philosophy that is utilized within Alberta Health Services programming. Furthermore, this initiative understands that patients and their families are integral players on their healthcare team and should have active participation in their care (Alberta Health Services, 2015). As described by Alberta Health Services (2015), “Patient- and family-centred care respects and responds to patient and family expressed values, needs, and preferences ensuring clinical decision-making incorporates these values” (p. 16).

Patient and family-centered care was practiced within the clinic’s programming as well as individually through each clinician's practice. In many ways, I felt that this practice had many correlations to the client centered practice that I have implemented throughout my career. Even though this was an adult program, patients could have family involvement within their treatment. For example, patients were encouraged to bring any family or support to the group orientation session before their therapy began, and they were also permitted to bring in family members into their individual sessions if they chose. Throughout my time in the clinic, I observed multiple sessions with couples and other family members participating. It became imperative that there was ongoing open conversation with patients surrounding their values, wishes and needs, to ensure that the services being provided were truly aligned with the patient and family-centered care that the clinic practice. In turn, these ongoing conversations along with the support of the patient’s self determination ensured that the mental health treatment being provided was aligned with the patient and their families’ best wishes.

There were examples of practice, which took place within the clinic, that did not align with the above-mentioned values and ideologies. For instance, one of the clinic’s practices did not allow patients to book their own psychiatry appointment. In turn, they must book these appointments through their therapist rather than allowing them to call and book on their own. In

multiple ways, this approach challenges self determination which is a key principle within both the recovery and patient and family centered care models, in addition to the human rights perspective (Alberta Health Services, 2016; Berthold, 2014). This practice created a lot of frustration for patients as the control of their treatment was taken out of their hands. This practice was developed using an operational viewpoint as the clinic considers psychiatrists ‘contractors’ working for the clinic, thus not servicing the patients directly. In numerous ways, this goes against the inherent rights of patients as they are forced to jump through multiple hoops to get the mental health and addiction care they need to work towards their recovery.

The following section of this paper will examine the theoretical perspectives that I utilized throughout my placement at NW Community Addictions and Mental Health Clinic. This section will review literature focusing on the theories of Cognitive Behavioural Therapy, Dialectical Behavioural Therapy and Motivational Interviewing and discuss the implementation of these theories in my clinical practice.

Chapter 3: Therapeutic Approaches

Throughout my practicum, the four main therapies that I most regularly observed and utilized included Cognitive Behavioural Therapy (CBT), Mindfulness Based Group Cognitive Behavioural Therapy (MBCT), Dialectical Behavioural Therapy (DBT) and Motivational Interviewing (MI). This section discusses each of these modalities by introducing research and literature that examines the use of these models in mental health care. In addition, this section will examine how CBT and DBT are utilized in the treatment of concurrent disorders, and lastly, it will discuss the use of Motivational Interviewing with psychotherapy, specifically CBT and DBT.

3.1 Cognitive Behavioural Therapy

3.1.1 What is Cognitive Behavioural Therapy?

Cognitive Behavioural Therapy has been extensively implemented in a variety of areas within the field of Social Work. It has been formulated in response to the rising requirement for evidence-based approaches, as it is an empirical form of talk therapy that responds efficiently to numerous clinical diagnosis in addition to several psychosocial factors (Nathan & Webber, 2010). CBT is a form of therapy that examines the connection between thoughts, behaviours and emotions (Albin & Bailey, 2014). According to Rector (2010), “In CBT, you learn to identify, question and change the thoughts, attitudes, beliefs and assumptions related to your problematic emotional and behavioural reactions to certain kinds of situations” (p. 3). It recognizes and examines dysfunctional thinking and behavioural patterns and replaces them, which allows clients to better manage their current problems and improve mental health (Chawathey & Ford, 2016). More specifically, it aims to address these unhelpful thinking patterns and behaviours to help to reduce their overall stress (Chawathey & Ford, 2016).

CBT is a structured and targeted type of therapy in comparison to many other forms of talk therapy and has been created to be time limited with an average of 10-20 sessions (Somers, 2007). It is a symptom and problem focused type of therapy that allows for clients to take a more active role in their health and wellbeing (Sochting, 2014). CBT largely relies on the therapeutic relationship and requires a collaborative effort of the therapist and the patient (Somers, 2007). The therapy aims to help individuals become their own therapists by learning how to monitor their own thoughts and behaviours and successfully apply coping skills that can be adapted within different areas of their life (Fenn & Byrne, 2013).

CBT was first developed in the 1960's and 1970's by Aaron Beck and Albert Ellis (Nathan & Webber, 2010). It derived from the Cognitive Model which proposed that emotions and behaviours are largely resulting from the client's interpretation of the events (Grant, 2010). With this development, psychotherapy began to shift as researchers observed the effects that cognitive errors had and began to better understand what cognitive distortions were and how they can be altered to improve an individual's mental health (Chan, Berven, Thomas, Sussman & Akande, 2015). Essentially, this theory argues that change is created by influencing a person's cognitive system, which in turn works to alter how an individual perceives and assigns meaning to their everyday life (Chan et al., 2015, p. 92).

Beck (1976) found that there were three levels of cognition which include core beliefs, dysfunctional assumptions, and negative automatic thoughts. Core beliefs, also known as schemas, are deeply held beliefs that are often learned early in life and are influenced by experiences that take place within childhood (Fenn & Byrne, 2013). These core beliefs influence the way in which individuals perceive and think about situations throughout their lifetime (Chawathey & Ford, 2016). Dysfunctional assumptions are rigid rules of living that people adopt

and live by daily (Fenn & Byrne, 2013). Lastly, negative automatic thoughts are the mental processes that are involuntarily activated in certain situations and will often lead to certain emotions or behaviours (Fenn & Byrne, 2013). These three levels of cognition view these cognitive errors through a multitude of cognitive distortions that will arise when individuals are having these mental health disruptions (Chan et al., 2015). These cognitive distortions include arbitrary inference, overgeneralization, selective abstraction, magnification and minimization, personalization and dichotomous thinking (Chan et al., 2015).

According to Beck, Liese and Najavits (2005), there are key principles that CBT practitioners should apply in their practice. Firstly, they argue that therapy should be founded on an individual's unique case conceptualization and it requires a strong therapeutic alliance. Moreover, it is goal oriented and largely focuses on the present by utilizing a time sensitive, structured and participatory framework applying such things as psychoeducation and relapse prevention (Chan et al., 2015). There are a variety of interventions that can be applied in therapy to address both cognition and behaviour. It is evident that some individuals will require more behavioural interventions while others more cognitive interventions depending if the practitioner is focusing on environmental or cognitive determinants of behaviour and the mental health symptoms they are experiencing (Sochting, 2014).

Research has shown that there are some predictors that illustrate a better response to CBT (Somers, 2007). The severity of the mental health diagnosis and the client's length and history of this experience have been found to have an influence on the outcome of treatment (Somers, 2007). Moreover, it has been discovered that individuals with less severe mental illness, shorter length of illness and later life onset respond better to CBT (Somers, 2007). Another important predictor of the outcome of treatment was the strength of the therapeutic relationship as it has

been found that this alliance also illustrated how patients' interpersonal relationships are functioning outside of therapy (Somers, 2007).

3.1.2 Group Mindfulness Based Cognitive Behavioural Therapy (MB-CBT)

Mindfulness based CBT has been found to be a leading treatment for improving mental health such as anxiety, depression and stress (Fjorback, Arendt, Ørnbøl, Fink, & Walach, 2011). MB-CBT is comprised of both the core aspects of basic CBT material and a variety of mindfulness-based stress reduction interventions (Crane, 2009). Mindfulness is defined as awareness that is created when a particular experience is focused on in the present moment in a non-judgemental way (Kabat-Zinn, 1994). MB-CBT aims to help clients become more aware of body sensations in addition to thoughts and emotions (Crane, 2009). According to Boettcher, Astrom, Pahlsson, Schenstrom, Andersson and Carlbring (2014), "In contrast to traditional CBT, mindfulness-based interventions do not target the reduction of anxiety symptoms directly. Instead, participants achieve a general way to relate to their inner and outer experiences by engaging in repeated meditation exercises" (p. 242). In the group facilitated in the clinic, each of Jon Kabat Zinn's (1994) nine attitudes of mindfulness were individually introduced each week as themes to focus on. In addition, there were weekly mindfulness activities that allowed group engagement and required that clients incorporate these activities into their daily lives (Alberta Health Services, 2019).

According to the research, time and cost efficiency of group therapy has created an increasing prevalence of this practice. In comparison to individual therapy, it is found that a single therapist or co-therapists can treat four times as many as they can in an individual setting (Sochting, 2014). There are many benefits of group therapy, which include an increase in belonging and a decrease in the experiences of social isolation, stigmatizing and marginalization

for the group members which often leads to a sense of being for many (Sochting, 2014).

Moreover, this provides an opportunity for individuals to participate in a safe space that allows them to work through their mental health alongside peers.

3.1.3 Cognitive Behavioural Therapy in Outpatient Mental Health Treating Concurrent Disorders

CBT has become a leading treatment in the field of mental health and addiction across Canada and in numerous other countries (Rathgeb-Fuetsch, Kempter, Feil, Pollmächer, & Schuld, 2011). CBT has been found to effectively treat a variety of mental health concerns including generalized anxiety disorder, obsessive compulsive disorder, social anxiety, depression, eating disorders, chronic pain syndromes, post traumatic stress disorder, addiction and personality disorders in addition to numerous other non diagnosable living problems (Chewathey & Ford, 2016; Sochting, 2014). Specifically, Canadian clinical guidelines have outlined CBT as a first line treatment for those struggling with depression and anxiety (Sochting, 2014, p. 9).

In many cases, CBT has also been found to be successful in the treatment of concurrent disorders within mental health, which is an extremely common presentation of many people who require psychiatric support. As described by Rathgeb-Fuetsch et al. (2011), comorbidity is extremely high in mental illnesses such as anxiety, with 50 % of individuals having another psychiatric disorder which most frequently is depression and substance use. Often, by the time patients get treatment of symptoms, they have already begun to develop symptoms of comorbid disorder. (Rathgeb-Fuetsch et al., 2011).

3.2 Dialectical Behavioural Therapy

3.2.1 What is Dialectical Behavioural Therapy?

DBT has many similarities to Cognitive Behavioural Therapy as it was formulated as an extension of this model. It was specifically created by Marsha Linehan as a treatment for self harm and suicidal behaviour, which later led to use as the first line treatment for Borderline Personality Disorders (Van Dijk, 2012). It was found that traditional CBT treatment did not create effective results for all clients, as some reported that it had too much problem and solution focus and left individuals feeling misunderstood and invalidated (Pederson, 2015). Moreover, Linehan found that individuals responded well to her fluid movement between acceptance and change rather than the focus on one over the other, which led to the dialectic that takes place within DBT (Pederson, 2015). In DBT, therapy is much more flexible as it is guided by principles rather than protocols like CBT, which is essential when working with individuals who are managing their emotions, such as those diagnosed with Borderline Personality Disorder, as there are often a variety of problems that must be addressed (Van Dijk, 2012).

The orientation of DBT is comprised of three theoretical positions which include behavioural science, dialectical philosophy and Zen practice (Miller, Rathus & Linehan, 2007). As described by Miller et al., (2007), “Behavioural Science, the technology of behavioural change, is countered by acceptance and tolerance of the client (with practices drawn from both Zen and from Western contemplative practice); these poles are balanced within the framework of the dialectical position” (p. 40). This dialectical position has three main principles that include; the idea that everything is interconnected, reality is not static, but rather is a process of nonstop change, and lastly, the truth can be found by assimilating or synthesizing varying views (Van Dijk, 2012, p. 14). These theories of practice create a treatment focus that moves through both

acceptance and change which is essential in treating this population. As described by the DBT Center of Vancouver (2019), “ DBT is based on the idea that, for people to build a better life and reach important goals, they need to make some important changes (such as reducing suicide attempts, self-injury, relationship problems, impulsive behaviour), and also need to learn to accept themselves”.

According to Linehan (1993), there are five essential functions for the use of DBT: 1) to teach skills for healthier emotional and behavioural regulation, 2) to improve client motivation to practice these skills, 3) to ensure the skills are adaptable to use in a variety of settings, 4) to help create an atmosphere that reinforces skill use and 5) to increase the therapist's own motivation to keep working successfully with clients (Linehan, 1993a, 1993b). The fulfillment of these functions is done through the four main DBT components which include; skills training group, individual therapy, telephone consultation and consultation groups, however, DBT is not always practiced with all of these aspects and is often implemented in a flexible manner (Van Dijk, 2012).

The fundamental philosophies of DBT combine CBT and meditative practice with techniques focusing on the skills of; emotion regulation, mindfulness, interpersonal effectiveness and distress tolerance (Bass, van Nevel, & Swart, 2014). The skills training group is a psychoeducational group that looks at strengthening the skills and capabilities of participants in each of those four areas listed previously (Van Dijk, 2012). Individual therapy is used to help clients apply the skills that they learn in a group and focus on their individual needs by examining triggers for target behaviors and the contingencies that are maintaining these behaviors (Van Dijk, 2012). Thirdly, telephone consultation is used as a brief interaction to help coach clients to use their skills and overcome obstacles that they come across (Van Dijk, 2012).

Lastly, the therapy consultation team is utilized to support the therapist and help to develop their skills and examine specific cases if needed (Van Dijk, 2012).

The therapeutic alliance is extremely important in all types of therapy however, in DBT specifically, it is one of the key factors. Furthermore, the therapeutic relationship should be from an acceptance-based approach and ensure that it is nonjudgemental (Pederson, 2015). The therapeutic relationship in DBT is based on learning theory as it is often viewed that Borderline Personality Disorder is a pattern of learned behaviors (Van Dijk, 2012). A deep, genuine and real therapeutic alliance with the client can often be used in a variety of ways to help clients make necessary changes (Van Dijk, 2012). Validation is a key aspect of the development and maintenance of a good therapeutic alliance as this acceptance strategy helps an individual feel understood and open up to learn skills and change behaviours (Pederson, 2015). Validation creates the safety needed to allow for client expression, as it helps to downregulate affect and assists in the development of self efficacy of emotions and, in turn, leads clients to feel emotion in a more balanced way (Pederson, 2015).

3.2.2 Dialectical Behavioural Therapy in Outpatient Mental Health with Concurrent Disorders

Even though DBT is known to be effective specifically with individuals diagnosed with Borderline Personality Disorder, it also has effectiveness with a variety of other mental health diagnoses, which include other types of personality disorders, bipolar disorder, depression, anxiety, bulimia, binge eating, low self-esteem, anger, chronic pain and relationship issues (Van Dijk, 2012). DBT is effective in an outpatient mental health setting because it is thought to be a successful long-term treatment as it is recommended for individuals to participate for at least a

year (Van Dijk, 2012). In addition, outpatient clinics frequently have both group and individual therapy availability, which has the potential to create more success (Van Dijk, 2012).

DBT is a common treatment approach for individuals with concurrent disorders. Furthermore, it has been found that individuals with Borderline Personality Disorders are more likely to meet criteria for concurrent substance use, in comparison to individuals with other psychiatric disorders (Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999). For many, struggles with emotion regulation and distress tolerance correlate with substance use as it is often used to help manage, escape or avoid the erratic emotions that they are regularly faced with. There is a wide range of evidence that shows DBT as an effective treatment for drug and alcohol abuse as it can help to decrease urges, cravings, and physical discomfort from abstaining (Edgewood Health Network of Canada, 2019).

3.2.3 Limitations within the Evidence-Based Approaches of CBT and DBT

As the above research illustrates, both CBT and DBT have been found to be effective approaches for those faced with mental health challenges; however, research has also outlined many critiques of these standardized theories within social work practice. One of the limitations is their emphasis on the present moment and the lack of focus on the client's history and the role these histories play on the current presenting problem (Capuzzi & Gross, 2011). This can dismiss very important experiences in the client's life and it does not create an opportunity to recognize any family of origin connections to the current problem, and for some people, it does not find the 'root' of the issue (Edelstein, Kujoth, & Steele, 2013).

The prescriptive approach that is often created in evidence-based approaches, such as CBT and DBT, can often lead clinicians to have a standardized and stepped model and a more time efficient assessment and treatment. Nevertheless, research shows that in many instances

these models and time efficient approaches can narrow down social work practice by reducing opportunities for holistic care or for the pursuit of social justice (Baines, 2011). Lastly, standardized evidence-based approaches, such as CBT and DBT, also create individualistic explanations and interpretations of the client's presenting problem (Baines, 2011). For instance, within CBT, this is demonstrated through the examination of individual thought and behavioural patterns. This individualistic approach creates pressure on the client as CBT views mental health as an individualistic error in thinking and behaving. Moreover, it also leads treatment to become focused on the individual rather than a holistic picture that recognizes the multiple layers of oppression and structural factors that impact their lives, health and recovery (Baines, 2011).

3.3 Motivational Interviewing

3.3.1 What is Motivational Interviewing?

Motivational Interviewing [MI] is a guided conversational style that is used to strengthen an individual's own intrinsic motivation and commitment to make a change (Naar & Safren, 2017). It is a natural way that social workers, and other helping professionals, can facilitate a constructive method to push through the challenges that often emerge when looking at another's motivation to change (Miller & Rollnick, 2013). Furthermore, MI is done in a way that activates an individual's own motivation and resources for change through the partnership created (Miller & Rollnick, 2013). This is done by positioning conversations so that people will talk themselves into change, based on their own values and beliefs rather than those apposed on them (Miller & Rollnick, 2013).

MI is conducted in a guiding style and requires not only asking questions but involves very superior listening to help individuals move through ambivalence and resistance (Miller & Rollnick, 2013). It is extremely important that clinicians are utilizing OARS: open questions,

affirmation, reflection and summary throughout the use of this counselling technique. Not only does this communication style continue to strengthen the therapeutic relationship but it also is essential in facilitating motivation and change talk throughout the process (Miller & Rollnick, 2013). MI takes place in four ordered processes which include engaging, focusing, evoking and planning (Miller & Rollnick, 2013). Each of these stages flow into each other, as engaging is key in creating a relationship and creating a focus for change. Evoking becomes possible when a goal for change has been confirmed and the clinician can begin to elicit the client's motivation (Miller & Rollnick, 2013). When individuals reach readiness through the evoking stage, they will enter into planning where they begin to determine what and how the change will take place (Miller & Rollnick, 2013).

3.3.2 Integrating Motivational Interviewing into Cognitive Behavioural Therapy and Dialectical Behavioural Therapy

MI can be a brief interaction or something that is longer term, which allows it to be utilized in a variety of settings with both individuals and groups (Miller & Rollnick, 2013). For many clinicians, MI is integrated into their clinical practice and is not a way of doing but rather a way of practicing (Miller & Rollnick, 2013). Furthermore, it is not just something that is applied separately but rather it can be utilized alongside many different types of treatment. For instance, it has been found that Motivational Interviewing is a well-suited addition to the clinical use of CBT and DBT in Mental Health and Addictions settings (Bein, 2013).

Motivation is a key component for effective therapy, and for many, their motivation often fluctuates throughout their treatment. For some clients, it may be difficult to begin counselling and for others, motivation may decrease or change halfway through treatment. Therefore, MI can be an effective tool to address the ambivalence and resistance that can come up throughout any

stage of treatment (Marker & Norton, 2019). In many cases, it has been implemented as a prelude to action-oriented therapies, as it increases the likelihood that clients have stability in their motivation and confirms more readiness to implement change (Marker & Norton, 2019).

It has been found that when MI is combined with another form of treatment, the efficacy of both can be enhanced (Miller & Rollnick, 2013). For example, research shows that integrating motivational interviewing into therapy practices such as CBT, has the potential to create more potent behavioural treatment than the modalities do independently (Naar & Safren, 2017). A study done by Naar & Safren (2017) found that MI integration into CBT has increased outcomes for alcohol consumption, cocaine use, generalized anxiety and child behavioural problems (p. 4).

A study conducted by Westra, Constantino and Antony (2016) found that clients who participated in integrated CBT-MI treatment for anxiety reported; less attrition, enhanced long term outcomes, improvements after treatment ended and clinically significant change which included worry and stress. Furthermore, the research found that combining these two approaches helped individuals to openly explore their ambivalence to change and created more commitment, which in turn prevented individuals from responding with worry and anxiety in the future (Westra et al., 2016). They also found that the MI spirit created a more person-centered type of therapy that shaped a more client driven approach, which has the potential to create more long lasting internalized positive belief in self (Westra et al., 2016). All in all, it was found that MI created more self trust and client agency, which formed a stronger therapeutic relationship and shaped longer lasting outcomes (Westra et al., 2016).

These theoretical approaches of Cognitive Behavioural Therapy, Group based Mindfulness Based Cognitive Behavioural Therapy, Dialectical Behavioural Therapy and Motivational Interviewing were the four theories outlined in this chapter and were integral

throughout my placement. I deepened both my knowledge and skills in these areas, which allowed me to implement them in both individual and group settings. The following chapter will examine how these theories were implemented and, in turn, how my overall practicum goals and learning activities were achieved during my time at the NW Addictions and Mental Health Clinic.

Chapter 4: Achieving Practicum Goals and Learning Activities

This chapter will summarize the goals and objectives outlined within my practicum proposal, which were utilized to measure the outcome of my practicum experience. Furthermore, it will also provide a critical reflection focusing on how these goals were achieved within my practice during my practicum placement.

4.1 Clinical Social Work in Outpatient Mental Health and Addictions

The first goal outlined was to gain both clinical social work experience and knowledge in the area of outpatient mental health and addiction care. This practicum was the first opportunity that I ever had to practice within a clinical mental health and addiction environment. Since this was my first clinical experience, the learnings were vast and there was not a single moment throughout those months that I was not learning and developing.

The community clinic provided an opportunity that allowed me to gain a range of knowledge and skills from a multidisciplinary team consisting of clinical social workers, psychologists, psychiatrists, nurses, peer support staff in addition to administrative and managerial staff. I was able to participate in multiple operational team meetings, as well as numerous case consults. Each of these opportunities created a possibility for me to gain knowledge from practitioners from a variety of disciplines, which deepened my understanding of mental health treatment in an outpatient setting. Participation in the case consults allowed me to hear clinical discussions around difficult and complex cases faced within the clinic and permitted me to participate in this clinical discussion. Furthermore, the knowledge gathered also helped to deepen my clinical assessment and intervention skills as it pertains to more complex clients.

The team meetings taught me the operational and clinical policies of the NW Community Mental Health and Addictions Clinic. In addition, it also helped to deepen my awareness around

the mental health and addictions initiatives that were taking place within Alberta Health Services and expanded my understanding around the direction that the clinic was taking moving forward. These experiences also deepened my critical thinking and reflective practice as my professional associate and I would have ongoing conversations around the direction of care that the clinic was taking and discuss, compare and reflect through the use of the standards of practice and ethics of social work.

I had multiple opportunities to shadow different staff and clinicians in both individual as well as group environments. For instance, I shadowed the orientation group facilitated by the peer support worker, administration and the clinical supervisor, which taught me how the clinic's intake process was operationalized and how clients were introduced to the community clinic. In addition, I also had multiple opportunities to be part of debriefing after each of the weekly CBT groups, which allowed for active learning with multiple clinicians and the clinical supervisor. The feedback that the clinicians all provided each other was extremely helpful for my own learning as it allowed me to learn from the practice and development of others, not only from my own.

Early on in my practicum, I attended a few trainings that helped to strengthen my skills and knowledge. For instance, I became fully trained in all the clinic's computer programs which consisted of the clinical documentation system as well as the data collection systems including Sunrise Clinical Manager, Health of the National Outcome Scale, and CARA data collections. This education allowed me to deepen my clinical documentation skills and ensured that I understood the processes used for patient care. In addition, I also had the opportunity to attend the Alberta Health Services wide Mental Health and Addictions orientation. I was able to learn the objectives, policies and protocols that the Mental Health and Addictions programming were

taking. This was a great networking opportunity as it increased my awareness around the multiple different inpatient and outpatient programs within Calgary. It also taught me the referral requirements for each of the programs which allowed me to utilize these programs later in practicum. The last training opportunity I had took place within one of the clinical group supervisions. This was conducted by a consulting psychologist that focused on DSM 5 and diagnosing of clients. This was a great opportunity, as this was the first training I had ever had in this specialty area, and it deepened my confidence and understanding around the DSM 5 and how to provide a provisional diagnosis to the clients I was supporting.

I also had the opportunity to shadow multiple psychoeducational groups at the Adult Addictions program at AHS, as they were housed within the same building as the community clinic. This opportunity helped to deepen my understanding of the services that they provide and expanded my knowledge around types of psychoeducation specifically used with adults facing addiction. In addition, I also extended my understanding of how clients can access their services within Calgary which became essential knowledge when supporting my own caseload.

To conclude, I had ongoing supervision with my professional associate which led to a deepening of my clinical social work skills. These scheduled and unscheduled supervision sessions allowed me to continue to expand my reflexivity in my practice in that I was able to continuously discuss both the successes and challenges within my practice and overall caseload. These discussions focused on such things as transference and countertransference, ethics and practice, therapeutic relationships and overall confidence. I believe that reflexivity is imperative to continue to be a competent Social Worker, as it is key that we continue to critically assess ourselves and deepened both our knowledge and overall awareness within our practice (Leung, Lam, Chow, Wong, Chung, & Chan, 2012). This practicum opportunity led me to become more

aware of overall social challenges faced by many, and my location within it, and how to best manage those differences that my location may create (Leung et al., 2012). I believe that the ongoing observation and supervision done throughout this placement helped me to do this and emphasized the importance of ongoing self examination, for the rest of my career. I believe that I have strengthened my introspection which I will continue to deepen as my social work practice evolves.

4.2 Mental Health Assessments and Treatment Planning Using a Bio Psychosocial

Approach

The second goal outlined within my practicum proposal was to become familiar with the clinical assessments and interventions used within the outpatient mental health and addictions clinic. The clinical mental health and addiction assessment, which is conducted when clients initially begin treatment, became a big piece of my practicum experience. Essentially, an assessment is a clinical process utilized to clinically understand the nature of the client's situation and recognize the direction of therapeutic treatment (Meyer & Melchert, 2011). Throughout my placement, I conducted 10 assessments independently and shadowed 3, completed by my professional associate. Furthermore, these intake assessments were 90 minutes in length and were integral in the development and direction of mental health treatment.

The comprehensive assessment was guided by the DSM 5 and utilized a multitude of questions to examine the mental health and addictions symptoms brought forward. Each clinician utilized a different formulated assessment; however, each of them based their assessment and screening from the DSM 5. In many situations, clients who attended the clinic for therapy already had a clinical diagnosis from the team's psychiatrist or from previous care. Nevertheless, it was expected that each clinician provided an adequate provisional diagnosis using their

biopsychosocial assessment guided by the DSM 5. As a very novice clinician, this was very difficult and required a lot of guidance from my professional associate. I found it to be very challenging to formulate and provide a DSM 5 diagnosis after just one assessment with a limited amount of time. This challenge emphasized the importance of utilizing strong listening skills, reflective processing and critical thinking.

Even though many clients either did not require diagnosis due to history or refused the use of such labels, it was still required to formulate the diagnosis to ensure that the treatment plan was clinically relevant and guarantee that the client diagnostic data was captured within my caseload. The use of diagnosis demonstrates that the mental health system is still largely medical and disease-based. According to Moncrieff (2010), a diagnosis is a formalized label on an already identified problem behaviour. If this is the case, why do we need to create a label for experiences and behaviours that clients are already identifying? Essentially, within this medical framework, a diagnosis identifies an unaccepted behaviour which then allows interventions to control and curb these unwanted behaviours (Moncrieff, 2010). In many instances, these diagnoses are used as a form of social control as it creates rules of conduct which ultimately outlines what normal behaviour is and how people should be treated and cared for if their behaviour meets these clinical requirements (Moncrieff, 2010).

The biopsychosocial model of assessment examines the client in a more holistic manner and looks beyond the simple cause and effect, a disease-based model that originates within the medical world (Heru & Drury, 2007). The biopsychosocial model is based on general systems theory, which examines how multiple systems effect and impact one another within an individual's life (Heru & Drury, 2007). Furthermore, this framework examines family, biological, sociocultural and psychological difficulties in addition to the biomedical model and

examine how they all interact and impact an individual's mental health (Heru & Drury, 2007). This model was not only used for assessment, but it was also utilized for treatment planning, integration of treatment interventions and evaluation of treatment (Meyer & Melchert, 2011). Applying this holistic lens allowed myself to gather a well-rounded assessment and case conceptualize and begin to create an individualized treatment plan that was specific to both the needs and difficulties of the client.

It became apparent to me that so many diagnoses overlap, and mental health and addiction can be very complex due to numerous competing systems. For example, one diagnostic overlap that arose in an assessment I conducted was grief and depression. Many symptoms of grief and depression overlap, and it was difficult to determine if this individual was suffering from one over the other, or both. Utilizing the biopsychosocial model of assessment helped to recognize the complexities of this individual's mental health symptoms and illustrated the need for holistic treatment that should not dismiss any of the biological, psychological or social factors that this individual was facing. Utilizing this lens led to the development of a treatment plan that looked at treating both grief and depression and the specific challenges that each created in the client's everyday life.

It was clear that it was extremely important to assess all aspects of the client's life through a holistic and social justice lens, as it helped to recognize the connection that environmental, situational or social aspects had on the overall health and wellbeing of the client. For example, it became evident that social factors, such as poverty, play a huge part in the mental and physical health of the clients we were seeing. As described by Kennedy and Arthur (2014), "Issues of social justice are integral to counselling...because people's health and well-being, including their mental health, are strongly influenced by social systems and societal beliefs" (p.

191). There were numerous stories that arose within sessions, that discussed the inequalities and oppressions that individuals were facing within their life.

As counsellors, it was important that we were able to support clients through these concerns and recognize the connection that this has on their mental health and, in turn, their recovery (Kennedy & Arthur, 2014). In many instances, it was imperative that counselling focused on basic needs such as food or housing, as these environmental inequalities were contributing to the deterioration of the individual's mental health and wellbeing. For many, they could not focus on any of their mental health struggles until we were able to work on establishing some stability in their home or work environment. As counsellors, it is important that these external structural and environmental factors are addressed as they can act as barriers that prevent individuals from receiving mental health treatment.

One example of how the biopsychosocial model was incorporated within the assessment, was through the completion of a family genogram at the beginning of each assessment. As described by Butler (2008), "Family diagrams visually record the facts of functioning across at least three generations of the multigenerational family" (p. 171). Through the use of these genograms, I was able to examine this functioning as well as the biological aspect of each client's mental health and addiction through the review of family history and predisposition and was also able to assess their social location. In addition, I found that utilizing the genogram helped to create a connection between the family history, multigenerational patterns and any current challenges they were facing when managing symptoms or their overall wellness (Butler, 2008). In doing this, we not only examined the biological and social aspects of the patient's health, but I found that utilizing the genogram created a sense of normalization and deeper understanding for the client and their current health and life challenges. It was an effective tool

to help create awareness surrounding the client's healthy and unhealthy lifestyle patterns learned through families and discuss how it may be contributing to their current overall health and lifestyle (Kehoe & Kehoe, 2008). It truly helped to gather a good narrative focusing on where the client was coming from and the biological, social and psychological factors that are within their family (Kehoe & Kehoe, 2008).

The assessments I conducted were not only biopsychosocial but were also strength-based. Furthermore, the assessment did not solely focus on diagnosis, labels and problems, but rather I was able to incorporate the strengths and solutions that each client presented with and weave them into their assessment and later treatment plan. One of the ways that I did this was through specific questions, which focused on what was going well, current resources, and identified strengths.

Sasha was one of my first independently conducted assessments I completed on my caseload. Sasha is a pseudo name given to a client on my caseload. Sasha provided both verbal and written consent to the use of her case to help me demonstrate my learning throughout this report and has allowed me to share the experiences we had in the session. Sasha was in her late 30's and had struggled with depression for much of her life. During Sasha's assessment, she reported having difficulties finding and maintaining employment and social relationships; she also experienced social isolation, and motivation and sleep related issues. Sasha was one of the first to be asked these strength-based questions. What I noted was that she could not recognize any strengths or resources she held. I remember feeling a bit shocked and panicked that she could not recognize a single strength or resource in herself; however, the approach I used really provided a chance for relationship building in that initial session. Moreover, it allowed me an opportunity to reflect back to her, the strengths I seen throughout the assessment, which I believe

created a sense of meaning-making during the session and also allowed us to begin to look at some of the skills we could build on in therapy.

When incorporating the strength-based perspective, I noticed that it fostered a lot of normalization for clients such as Sasha and would often exhibit validation, which I could see as an essential aspect of building the therapeutic relationship. The quick formation of the therapeutic relationship was key within the assessment session as it was essential to build a strong foundation to better ensure that clients return to their next session. Due to my professional history, building a therapeutic relationship in a quick time frame was one of the strengths I brought to this practicum. I was able to build on my previous experience and utilize my reflective listening and empathetic approach to create a connection with clients very quickly.

The assessments conducted were also formulated to assess concurrent disorders by examining both mental health and addictions. Moreover, the assessment not only examined the mental health diagnosis and symptoms but also assessed for any substance or behavioural addictions. In the assessment, we examined the quantity, frequency and duration of the substance use or behaviour. In addition, we assessed the impact and determined if this created any difficulties in functioning in the areas of physical health, work, relationships, recreation and social life (Skinner, 2005).

Essentially, the knowledge collected through the assessment is based on narrative reports provided by the client which means that a client must self report the use of substances or excessive behaviours. It was found that many patients were ambivalent about reporting any addictive behaviours, and I found that self reports would come out after our therapeutic relationship grew, and I implemented motivational interviewing approaches. As described by Washton and Zweben (2006), "Using motivational strategies throughout the assessment is

crucial, because patients' ambivalence and mistrust are often highest when they first appear for treatment" (p. 125). It became evident that ongoing assessment and evaluation is key in clinical social work. It is imperative that we are continuously assessing, examining and learning from clients, especially when we are considering the complexity of problems stemming from concurrent disorders. When we practice ongoing assessment throughout all the treatment stages, we are guiding the treatment in a more client-centered way (Skinner, 2005).

Treatment planning was another clinical intervention I utilized with each of the individuals on my caseload and was a large piece of my learning. I facilitated the completion of treatment plans with the eight clients on my caseload and was able to observe and co-facilitate, other client treatment plans, alongside my professional associate. The biopsychosocial and strengths-based information, gathered within the 90-minute assessment, assisted in the development of each of these treatment plans. Each of these individualized treatment plans were developed collaboratively with the client to ensure that the treatment plan was client driven and formulated using their strengths and motivation. As described by Washton and Zweben (2006),

...patients' presenting needs and problems vary substantially from one person to the next, as do their strengths, available resources, personal goals, and motivation/readiness for change. The more precisely the treatment plan takes into account these individual differences, the greater the patient's personal investment in making the desired changes and the greater the likelihood that treatment goals will actually be achieved. (p. 159)

Throughout the treatment planning process, I worked collaboratively with the client to determine the treatment goals, specific strategies, therapy modality and the time frame needed. More specifically, SMART goals were utilized as the guiding framework in this formulation. I had previous experience and knowledge around the use of SMART goals, so I was very

comfortable with facilitating conversations around the formulation of goals, which I believed was a strength in my practice.

I had a preconceived notion that the goals that would be formulated in therapy would look significantly different than the goals that clients devised when I was doing case management; however, I realized that they were not. There were some clients that focused specifically on decreasing mental health symptoms; however, there were many that focused on a variety of different social factors such as relationships, housing and work. Numerous treatment plans worked to treat the connection between both. For instance, Sasha's goals were focused on developing social relationships as she recognized that she had been struggling with social isolation which had an impact on her mental and physical health and saw that it was imperative to treat for her to return to work.

Lastly, discharge planning was a piece of my learning throughout my placement as it was an integral clinical intervention utilized throughout the months. In my own caseload, I only had two individuals that were discharged from the program. Each of these individuals had decided on their own that they no longer wanted to attend therapy due to their own personal reasons. Through the discharge planning process, I provided them with other possible community mental health and addictions resources and information about how to access services if they decided to return. I facilitated this conversation through a follow-up phone call with each discharged patient and was also able to gather feedback surrounding their experience at the NW clinic. In addition, a discharge summary was sent to the referring physician or program, psychiatry as well as the client's family physician. This summary was utilized as a means of continuity of care to ensure that these healthcare providers were aware of the treatment that was delivered to the client and

confirm that the patient was discharged from the program at the NW Community Addictions and Mental Health Clinic.

There were multiple clients that my professional associate had discharged from the program, who had either reached their treatment goals or maximum amount of sessions. I noted that often discharge planning was very difficult for clients, especially those that struggle with attachment concerns. I observed that it was very effective if we were transparent with the client about the program requirements early in their treatment as it seemed to help prepare them for future discharge. It was also effective to review the treatment goals with the client to help illustrate how far they had come and how they had reached their treatment goals. In many cases, this validated the individual's progress and helped to illuminate the client's strengths which in turn helped to foster the confidence in leaving therapy. A few clients who reached their maximum sessions, on my professional associate's caseload, did require additional counselling due to unresolved concerns which included such things as family and relationship challenges. For these cases, we ensured that the client was connected to an appropriate community-based counsellor or service, so they were able to continue the therapeutic work that they required.

4.3 Cognitive Behavioural Therapy, Dialectical Behavioural Therapy and Motivational Interviewing in Practice

The third goal outlined within my practicum proposal was to gain knowledge and skills in the clinical theories of Cognitive Behavioural Therapy and Dialectical Behavioural Therapy used in individual and group settings within the clinic. An essential clinical competency within this area was learning how to make the clinical determination between the use of CBT and DBT in treatment of clients. After conducting research on both clinical theories, in addition to observations and clinical consultations, I was able to apply strong clinical judgement to this

decision, which was based on the diagnosis, symptoms, main concerns, goals and treatment history presented by each client. By utilizing this approach, alongside the evidence-based research on both theories, I chose when to utilize each of these theories accordingly. For Sasha, it was determined to utilize CBT treatment based on her primary diagnosis and her goals of treatment that largely focused on behavioural changes and thought patterns.

As my practicum began, it became evident that Motivational Interviewing was going to be another key theory that would be utilized throughout my practicum experience. Moreover, I found that motivational interviewing was being utilized throughout the therapeutic process from assessment all the way to discharge. In addition, I found that I was able to implement motivational interviewing strategies alongside both CBT and DBT and essentially, I was utilizing it with almost all my clients no matter what their diagnosis was.

I utilized and practiced CBT in both group and individual therapy settings. More specifically, I participated in the clinic's Mindfulness based CBT group which was offered to 6-10 clients each Friday morning for eleven weeks. This group was open to any client attending individual therapy at the NW Community Addiction and Mental Health clinic, who would benefit from the support of a CBT psychoeducational group, which was determined between the individual therapist and their client. I had the opportunity to co-facilitate, lead and observe throughout the semester of group classes. This opportunity strengthened my group facilitation skills and increased my clinical knowledge of CBT and mindfulness.

This psychoeducational group was developed by Alberta Health Services and rolled out within all the outpatient clinics within Calgary. In a psychoeducation group, therapists take on the instructor role and focus on sharing knowledge on CBT and mindfulness and utilize the environment to teach clients skills (Center of Addictions and Mental Health, 2019). Unlike

process groups, the interpersonal relations of group members are not normally key to the success of this group; however, the relationships that were built did create a lot of support and normalization for group members (Center of Addictions and Mental Health, 2019). As further described by the Center of Addictions and Mental Health (2019), “The group dynamic allows members to feel supported and accepted, and it can reduce stigma and isolation”. It was evident that this group became key support for many of the clients who attended each Friday as it was a safe space where others shared similar stories and struggles, and many revealed that the group provided them with a sense of normalization.

The format of the psychoeducational group was standardized, and each group facilitator utilized a clinical manual. Each week we taught a new CBT skill and one of Jon Kabat-Zinn’s mindfulness teachings and practice. The first few weeks of the group started with very basic tools such as the use of daily mood trackers and eating mindfully, and the participants were required to practice these skills at home. Each week, these skills were built upon, and clients learned additional CBT tools such as behavioural activation, exposure ladders, thought records and behavioural experiments in addition to numerous mindfulness practices such as sitting and walking meditations and body scans. As a facilitator, this opportunity allowed me to teach many of these skills for the first time and allowed me to be creative in how I implemented and taught to the group.

I learned very quickly that one of the main roles as a facilitator was to ensure that the room was safe for all participants. It became evident that safety and respect were key to ensure that participants felt comfortable sharing. For instance, there were times that I needed to step in to help guide conversations, so participants all had equal opportunities to speak and prevent any members from overtaking the group dialogue.

It was a balance to make certain that each participant had an equal opportunity to share and ensure that the learning needs that each participant brought into the room were respected. Balancing these learning needs was a challenge as some participants were able to learn the fundamentals much quicker than others. For example, there were participants that struggled to understand and implement thought records while others in the group already mastered the tool prior to starting the group. I also noticed when individuals did not do their homework, they fell behind, and it became difficult for them to understand and implement the tools in the following week. To manage these challenges, it was key to acknowledge the learning pace of each participant by ensuring that there were a variety of skills taught to guarantee that they fit the integration needs of each participant. Additionally, encouraging and supporting the integration of skills within the participants' everyday life was key. I could see the benefit of creating group dialogue focusing on the challenges and successes of between session implementation. I could see that these conversations helped participants to build on each other's motivation.

The group numbers were very low for this session, which was believed to be because it was during the summer months. The group started with ten, and with the attrition, it whittled down to five for the final few weeks. Attendance became a challenge, as we saw many participants take a leave from the group. This can be particularly challenging in group CBT, as research shows that more than one drop out can often disrupt group cohesion and can lead to a multitude of additional dropouts and, in turn, lead to insecurity and worry amongst many of the remaining participants (Sochting, 2014). I also noted that when individuals missed a week, it became very difficult for them to catch up with what they missed. Fortunately, we had a small group so we were able to spend time reviewing to try and allow for catch up; however, I

recognized with larger groups, it would be a challenge. This experience illustrated the importance of implementing rules around attendance.

There were both pros and cons to having small group numbers. The small numbers allowed for the group to build a closer relationship and allowed for more discussion and process. However, it became a challenge when individuals were having a difficult day, as it did affect the entire group. For example, there were a few instances where participants did not want to participate due to personal reasons, which did create some tension within the group as it applied pressure to others as there were only a small few people to keep the dialogue going.

The CBT group provided me with additional knowledge, skills and resources that I could apply in my individual CBT sessions. However, there were notable differences when applying CBT in a group versus individual settings. In individual CBT counselling, it was much more imperative to create a strong therapeutic relationship to ensure trust and openness before beginning to use CBT and its tools. In group counselling, the therapeutic relationship was not as vital as the group was much more educationally focused and did not require the same trusting relationship, which allowed us to begin teaching skills early in the group sessions. Secondly, within individual CBT counselling, the skills and tools were used in a much more personalized manner and opened up more holistic dialogue surrounding other aspects and challenges taking place within the client's life. In the group, we required that everyone apply these tools to their own challenges. However, I think that the processing of these tools was much deeper in individual sessions as it allowed for more openness within the dialogue. The group setting limited the depth and length of dialogue that took place when reflecting on the use of the skills and tools.

Anytime that I introduced the treatment modality, within individual sessions, I would begin with some psychoeducation around the use of the theory to create some understanding and buy-in from the client. Many of the clients in which CBT applied were diagnosed with depression, generalized anxiety, social anxiety, OCD and trauma, to name a few. In addition, it was applied to treat such things as sleep disturbances, panic attacks, chronic pain, substance use disorders and family issues, which each also tie in too and correlate too many of the previous diagnoses.

I have become very familiar with both behavioural and cognitive-based interventions utilized within CBT. I was able to observe the use of them and implement them within the individual sessions that I conducted. Two behavioural interventions used regularly were the daily mood tracker and behavioural activation. These interventions are largely used in the treatment for depression, as it examines the behavioural patterns of patients and looks at activating behavioural changes (Chawathey & Ford, 2016). Moreover, it helps patients to develop daily activities and structure in small steps, to focus on the improvement of their moods with the increase of pleasurable and productive activities within normal behavioural routines (Somers, 2007).

Sasha was one of the clients on my caseload who participated in the use of behavioural activation. One example we utilized was daily mood trackers in which the client recorded their mood and activity for two weeks and returned with the completed tracker. Sasha developed a deeper awareness of the connection between behaviour and mood. She noted that when she had planned activities outside of the home, such as job search classes, walking in the park and shopping, her recorded mood was better than on the days that she stayed home and watched Netflix. Sasha began to see the benefit of increasing her activity, rather than isolating at home.

One behaviour that was a challenge for Sasha was personal hygiene. She struggled to participate in a daily personal hygiene routine which in turn prevented her from leaving the house regularly. Together, we completed a behavioural activation focusing specifically on daily teeth brushing. In doing this, we broke down the behaviour of brushing teeth into small steps, and Sasha pre planned each of these steps into the upcoming week using her mood tracker calendar. Sasha reported that this process made implementing this behavioural change feel less overwhelming. This change did not take place over one session, and it took multiple conversations to implement a daily hygiene routine. For me, this experience created a deeper awareness around some of the everyday struggles that people with depression face and it taught me the importance of slowing down our care and ensuring that we are meeting the patient where they are at.

One of the most used cognitive interventions was cognitive restructuring. Cognitive restructuring is the process in which the individual and therapist begin to examine the thinking process that is taking place to maintain the negative automatic thoughts which both impact and maintain poor mental health (Chawathey & Ford, 2016). The process of cognitive restructuring identifies challenges and replaces these negative automatic thoughts with more balanced thoughts (Chawathey & Ford, 2016). This is largely done with the completion of thought records in which individuals break down their experience by examining their situation, feelings and thoughts. Clients then examine the evidence for and against their automatic negative thought and then work to implement a more rebalanced thought (Chawathey & Ford, 2016).

Sasha also participated in the use of thought records after she understood the use of behavioural activation. She began to use both the behavioural and cognitive interventions alongside each other. When introducing thought records, I would complete this tool within the

session, alongside the client, to ensure that they had a good understanding. With Sasha, one of the first thought records we completed was focused on the negative automatic thoughts she had, surrounding an upcoming visit from her parents. In the session, we were able to utilize this tool to break down and determine what her hot thought was and provide both evidence for and against this thought, and in turn, she was able to determine a more balanced thought. Sasha took this tool home and completed over 10 thought records while her parents had visited and reported that her awareness around her negative cognitions had increased, and she had started to see some patterns.

Throughout my experience of implementing CBT, I could see that there were several specific factors to consider to better ensure success in treatment and decrease barriers. Firstly, I found it extremely beneficial to provide education around the interventions utilized to help create understanding around the benefit that it has on the client's mental health symptoms. Secondly, it was clear that it is extremely important that individuals have some insight into their mental health as CBT is a very insight-oriented type of therapy (Chan et al., 2015). Thirdly, I could see the benefits of the dual treatment of CBT alongside medication. For many, it became much easier for them to participate in the therapeutic interventions when their mind became a bit clearer with the medication that they were taking. Lastly, I also recognized that CBT was developed for English speaking clients. In a few of the sessions I co-facilitated, I could see the difficulties that clients, whose second language was English, had with the implementation of CBT interventions.

DBT was the second most used treatment I applied while practicing at the NW Community Mental Health and Addictions Clinic. This modality was commonly used with personality disorders, which included borderline personality disorder, histrionic personality

disorder, avoidant-dependant personality disorder, narcissistic personality disorder. In addition, it was also utilized for the treatment of self harm behaviours, and impulse control concerns which included such things as stealing and sex, in addition to relational and family issues.

I had three clients on my caseload that I utilized DBT with, and I noted that I had less opportunity to practice DBT independently with clients compared to CBT. However, I did have the opportunity to observe and co-facilitate DBT with some patients on my professional associate's caseload. I believe that this was largely due to the fact that my practicum was only four months long which was extremely difficult for some individuals to accept, specifically those with a personality disorder as they often have a lot of difficulty with attachment and trust (Skinner, 2005). For those that I did have the opportunity to work with, I noticed that due to the trust and attachment concerns, it often took a bit more time to develop my therapeutic relationship. Since it took more time to develop a therapeutic relationship, in turn, it left less time to implement DBT interventions in the sessions.

When implementing DBT, my professional associate would often remind me of the importance of focusing on the dialectics of acceptance and change. I brought forward a lot of experience working with clients faced with personality disorders, so I believe that I had a lot of strengths in implementing validation and mindfulness-based interventions, which promoted acceptance. I struggled with implementing change, which I believe was due to my inexperience in therapy and implementing DBT and was also due to the limited time I had with clients to build a relationship. In order to focus more on the dialectic of change, it is key that the therapeutic relationship is strong.

Throughout my practicum, I gathered more knowledge around the use of DBT specific skills, which included distress tolerance, interpersonal effectiveness, emotion regulation and

mindfulness (Linehan, 1993a, 1993b). Furthermore, these DBT skills were important to understand to ensure that I was able to best support clients in implementing them into their life. I would often show clients Marsha Linehan's online videos that would describe each of these skills in full, to help better explain. A few of the DBT specific interventions that I utilized within my individual therapy included; the Skills Diary, chain analysis, wise mind and mindfulness-based interventions (Linehan 1993a, 1993b).

It became very clear to me that it was extremely beneficial to utilize MI techniques within all my clinical work. I witnessed the benefit from the time of the initial assessment all the way to the discharge session. Not only was it extremely helpful to build and maintain clients' motivation, but it was also an extremely positive way to build a therapeutic alliance with clients. I could see that the use of validation and complex reflections were truly helpful in developing not only a therapeutic relationship, but it was beneficial when moving the conversation and relationship forward (Miller & Rollnick, 2013). This type of reflection helps to foster the individual's own motivation and direction rather than providing a solution (Miller & Rollnick, 2013).

In addition, I found that MI techniques became very helpful when assessing and discussing homework with clients. While working with my caseload, it became evident that active participation is key in the recovery and ultimately leads to many improvements in symptoms and treatment results. Homework is one of the key aspects of active participation, and there were numerous benefits to those patients that would actively implement the clinical interventions and skills into their everyday life. In many situations, I used MI techniques such as pros and cons and rolling with resistance to support clients who were unsure about making these changes at home or struggled with participating in therapy homework (Miller & Rollnick, 2013).

With my client Sasha, I utilized MI techniques to help strengthen the behavioural interventions that were being implemented. A specific behaviour that we focused on within one of our sessions was isolation. We were discussing the lack of social relationships she had in her life, and during this conversation, I noted a lot of contemplation when discussing making changes to her social life. This was a great opportunity to use motivational interviewing techniques such as reflections and pros and cons to investigate some of her hesitations around this change and, in turn, build more motivation based on her own values and beliefs.

Chapter 5: Challenges and Ethical Practice in Community Mental Health and Addictions

As I embarked on this practicum journey, there were a multitude of professional challenges that arose throughout the months that I practiced at the clinic. In this chapter, I will discuss each of these professional challenges, and ethical considerations faced and examine how I steered through each.

5.1 Professional Challenges

One of the biggest challenges I encountered from the beginning of my practicum was confronting my confidence. I found it to be very intimidating to begin therapy in this large system with these very advanced clinicians. Being as this was one of the first situations in which I was observed on an ongoing basis, I believe that it increased my negative self doubt. Over and over, I found myself having a conversation with my professional associate about my confidence and how it created a barrier in my therapy practice. There were multiple times when I questioned my ability to do advanced clinical social work and would criticize my own decisions and practice in therapy.

It was extremely helpful to have these conversations within supervision, as it created a sense of normalization for me, as my Professional Associate acknowledged having many moments of self doubt throughout the beginning of her clinical social work practice. As we had these conversations, I began to accept the learning process and acknowledged what the expectations were. I believe that the trusting relationship that I held with my professional associate allowed me to be vulnerable and confident not only in supervision, but also within therapy sessions with clients (Thériault, Gazzola, & Richardson, 2009).

Being a 'student clinician' was something I deemed as challenging, as it created some difficulty in the setting of my practicum for a few reasons. Firstly, as an outpatient clinic that

provides therapy once every 2 -3 weeks, it was not possible for me to do more than 5 -10 sessions with each client during the four months that I was there. I was very transparent with each client during their assessment, and I would inform them that I was an MSW student and would be in the clinic until the end of August. This became a challenge for some clients, as they became aware that they would have to switch therapists when I left. This arose a few times; each time, I explained that my professional associate would be observing my sessions and would be fully aware of where the therapeutic process was and would pick up where we left off. Some clients agreed to this and others did not and would deny having the ‘student’.

Secondly, holding the term ‘student’ also created some barriers, as there were clients who held preconceived notions around my capabilities and would request a more experienced therapist. Through this experience, I would inform clients that I was a Registered Social Worker with multiple years of experience, and this was my advanced level practicum. Additionally, I would always inform them that I am consistently supervised by my professional associate and confirm that she will always guide my practice if needed. There were some clients that were open to having a student, and others were not.

These conversations would often reinforce my lack of confidence; however, I found that I was able to manage these negative thoughts by focusing on the therapeutic relationship and progress I developed with other clients. My experience was similar to other novice clinicians, as explained in research by Thériault et al., (2009), “Counsellors realized that feelings of inadequacy were reduced when they focussed on the relationship with the client rather than...on themselves” (p. 113).

Challenges also took place while I observed my professional associate’s sessions, as there were many clients that did not feel comfortable with having a student or a second person in the

room during therapy. However, there were others that revealed that they enjoyed the idea that I was learning with them. Having two therapists in the room did come with some challenges, and it became evident that for some clients, it was best that we used the one-way mirror for observations. This was all navigated with the use of clinical judgement and by implementing client centered care to ensure that we were fostering self determination for each of the client's we supported.

Through my reflexive practice, I was able to recognize both the challenges and successes I faced throughout my placement. As defined by Rosin (2015), "...reflective practice can be defined as a form of practice in which counselors problematize and reflect on professional situations, themselves and their personal experiences, in order to gain new knowledge and improve their practice" (p.90). The need for self reflection in the counselling field is emphasized by the requirement of counselor self-awareness for competent and ethical counselling practice (Wong-Wylie, 2010).

I can see that it was imperative that I had this awareness surrounding my doubts, challenges and learnings both within the professional work and within my own personal experiences and social location (Wong-Wylie, 2010). Moreover, this awareness helped to ensure that I was practicing in a competent and ethical manner and ensured that I was not only focusing my reflection on my professional development and skills but also my role within each therapy session on both a personal and professional level (Wong-Wylie, 2010). I believe that through this self reflection, I continued to exercise openness which allowed me to be proactive in my practice rather than complacent (Wong-Wylie, 2010). For many novice clinicians, self doubt is a very common feeling, and I believe that it increased my motivation to continue to learn and evolve my skills and competency (Thériault et al., 2009). The ongoing support and understanding

provided by my professional associate, along with my willingness to be open, lead to a normalization of these feelings which only helped me to move through this self doubt and flourish in my confidence and self awareness (Thériault et al., 2009).

5.2 Ethical Considerations

It was key that I utilized the Canadian Association of Social Workers Ethics and Alberta College of Social Workers, Standards of Practice throughout my practicum. We continuously reviewed and referenced these standards anytime we conducted supervision or came across an ethical or professional challenge. Each of the ethical decisions made by myself and my professional associate, on an individual client basis, were based on these standards. Even though our individual practices were based on the CASW Code of Ethics, the program did not always follow the same guidelines in their decision-making process.

One of the most important ethical considerations in social work practice is confidentiality, which is outlined as Value 5 in the CASW Code of Ethics which emphasizes, Confidentiality in professional practice and the protection of privacy of the people that they serve (CASW, 2005). In ensuring that clients understood the terms of confidentiality, I was extremely transparent and would always outline the confidentiality guidelines in the very first assessment session which is one of the key principles of this value (CASW, 2005). During this initial session, I would request that each patient sign a consent to treatment form, which was required through Alberta Health Services, and would then explain that their information was protected, private and confidential and would explain the limits to this. I would clarify my reporting mandate, in the circumstance of imminent risk of harm to themselves or others and additionally discuss the obligation to report any abuse of children or seniors (CASW, 2005).

The CASW Code of Ethics Value 1 states that social workers respect the inherent dignity and worth of persons (CASW, 2005). This value recognizes and accepts the self determination of the people we serve and acknowledges that clients' rights and choices should be respected (CASW, 2005). Anytime that I was planning to observe or co-facilitate a session, we always asked the client for their consent as it was imperative, they made this decision themselves. Even though it was extremely important for my learning that I was able to conduct or observe as many sessions as possible, the self determination of the client came first.

Another ethical consideration that arose regarding self determination was surrounding programs requirements, which require that clients book their psychiatry appointment through their therapist and not independently. The justification for this program requirement was based on the needs of the program's model. Furthermore, the model deems that psychiatrists are contractors within the clinic which means that their services must be requested by the therapist employed by the clinic. Not only does this requirement prevent clients from practising self determination, it is not a patient centered program model.

For many clients, they followed this program guideline with no concerns; however, a few clients came forward with a complaint surrounding this limitation. When examining the ethical consideration of this, I believe that this program regulation did not hold to the principles of Value 1. As CASW (2005) states, "Social workers uphold each person's right to self-determination, consistent with that person's capacity and with the rights of others" (p. 4). If the client had the capacity to decide to book an appointment, we should not be limiting their self determination to do so. This ethical challenge was brought forward to upper management by another therapist on the team. When I completed my practicum, they were still considering what could be changed to ensure to meet the needs of the client; however, I am unsure how it ended.

Lastly, one of the ethical considerations that I always held in high importance throughout my practicum was Value 6: Competence in professional practice (CASW, 2005). Due to the fact that this was the first time that I had ever done clinical therapy, this was something that I would often talk to my professional associate about to ensure that I was practicing in an ethical manner. I was always transparent and honest with the client about my role and the limitations that I had within my professional practice. Secondly, I had continuous supervision, observation and feedback from my professional associate to ensure that I was providing the best possible care to clients. If there was a client that had an array of complexity that I was not able to serve, such as complex trauma, we followed this ethical value and referred them to work directly with my professional associate who was able to provide the highest quality care needed for their specific needs (CASW, 2005).

The challenges I faced throughout my placement created several learning opportunities. I believe that these challenges helped me to grow as a clinical social worker as I was required to continuously deepen my self awareness and strengthen my ethical assessment skills. I believe that supervision and consultation are so important to overcome challenges, as this was key in my development and continues to be. The opportunity to consult allows for the clinicians to look at challenges from multiple angles, ensures that they are examined critically and strengthens accountability.

Chapter 6: Conclusion

I am beyond thankful for the opportunities and experiences that I received through my field practicum experience at the NW Community Addictions and Mental Health Clinic. I believe that this experience helped me to grow into a well rounded clinical social worker and deepened my skills in a multitude of ways. Both my Professional Associate, as well as the clinic, provided me with guidance, knowledge and skills that I will take forward into my career.

Social work in an outpatient clinic, such as the NW Community Addictions and Mental Health Clinic, is extremely valuable. I believe that social workers bring a diverse number of strengths that only improve the mental health care provided. For instance, the social justice and human rights framework that drive our ethics is imperative when treating this population. There were multiple instances in which we needed to use this lens when supporting our patients to ensure that they were provided holistic and well-rounded care they required. In addition, the critical thinking and self reflection that is engrained in social work practice, are also imperative when providing counseling to those touched by mental health and addiction. In order to provide high quality mental health treatment, we must always examine our practice and the environment in a critical way to ensure that we are providing the best possible service to our clients. Lastly, I believe that the self determination, strength based, and empathetic approach rooted in social work practice and ethics are essential when providing services in a clinic, such as this. Many clients who face mental health and addictions, are faced with many barriers, judgments, stigmas and challenges, and it is our responsibility to create change for our clients.

My field practicum experience only deepened my gratitude and passion for this area of social work, and it helped to secure my plan to continue to pursue a career in this area as a graduate level social worker. I believe that there are so many positive impacts that social workers

can have on the lives of people touched by mental health and addiction, and I want to continue to have that privilege. I believe that the therapeutic, assessment and diagnostic skills, which I developed and strengthened throughout this experience, will only deepen the work and support I can provide clients, which excites me when I consider the future of my career.

This experience also increased my motivation to continue to work towards change and advancement in mental health and addictions care. As I moved through my practicum, it became evident that mental health is still treated differently than physical health in a multitude of ways. In my opinion and experience, I could see that mental health treatment is still considered to be less of a priority than some of the physical health concerns that arise in people's lives. For example, when someone is diagnosed with cancer, they receive appropriate treatment until it is no longer needed, and normally, there is no time frame attached to the treatment. On the other hand, if someone is diagnosed with a concurrent disorder of Borderline Personality Disorder and substance use, they are given a maximum of 15-20 treatment sessions at an outpatient mental health clinic and are cut off if they miss two appointments (Alberta Health Services, 2016). These types of constricting requirements often do not happen in physical health treatment, which I believe illustrates the need for even more advocacy in mental health and addictions care. There are many clients that have complex and chronic mental health that need ongoing therapy, and these program requirements do create a barrier in creating long lasting effective treatment.

Moving forward, I would like to continue to dedicate my career to breaking the stigma around mental health and addictions and continue to advocate for the needs of this population within the larger system. I believe that social workers are key players in this area of work, and will continue to be the advocates, caregivers and the voice that is needed for many. The

experience that I have been privileged to receive has equipped me with even more advanced level knowledge and skills that I can move forward into this area of work.

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