Abstract
This practicum report is a summary and reflection of my learning and experiences at Children’s Mental Health Services in Saskatoon, Saskatchewan; a clinical field practicum in partial fulfilment of a Master of Social Work degree. The purpose of this 12-week practicum was to gain graduate level field experience using narrative therapy techniques in working with children and families accessing Children’s Mental Health Services. In addition to working as a member of an interdisciplinary team, I provided family, individual, and group-based therapy, assisted with various groups, and became familiar with an assortment of programs that are connected to Children’s Mental Health Services. The report begins with a discussion of my learning goals and outcomes, an overview of children’s mental health, and a description of the Saskatchewan Health Authority and Children’s Mental Health Services. A literature review of child development, narrative therapy, cognitive behavioural therapy, and trauma-informed care follows. I then discuss how these frameworks were integrated into my clinical social work practicum and include professional development opportunities, and social work values and ethical considerations. The report concludes with a summary and reflection of the personal and professional growth I realized by means of this practicum experience.
Acknowledgements

It is with heartfelt thanks and gratitude that I acknowledge the support and encouragement shown to me, by many, throughout my master’s journey. Thank you to the U of R Faculty of Social Work for offering the MSW program in Saskatoon. Having this program accessible in my home community made this academic goal a possibility and reality. Thank you to Dr. Darlene Chalmers, my academic supervisor, for your guidance, kind encouragement and constructive feedback. Thank you to Dr. Lise Milne, my committee member, for your energy, enthusiasm, and the important reminders that helped me throughout my practicum and report writing. Thank you to the Faculty of Graduate Studies and Research for financial assistance through receipt of a scholarship.

Thank you to my wonderful field practicum supervisors, Barb Afseth and Kate James-Loth, and all the staff at Children’s Mental Health Services. Your combined experience, interests and encouragement helped me feel so welcome and made my practicum such a rich learning opportunity. Thank you to the children and families that welcomed me into their lives and allowed me to learn from and grow with them. You truly made my practicum remarkable!

Thank you to my employer, Greater Saskatoon Catholic Schools, for granting me a leave of absence and providing access to professional development funds to assist in pursuit of my master’s degree. Thank you to the Saskatchewan Association of Social Workers for funding my attendance at the Narrative Therapy workshop I attended during my practicum.

To my wonderful and amazing family, friends and classmates, thank you for all your love, patience, reassurance and encouragement throughout the past four years. The meals, walks, talks, computer support and everything else is so appreciated. Special thank you to my BFF and
academic mentor, Kelli Boklaschuk, for all the proofreading and constructive feedback. Your friendship and support is invaluable.

Most importantly, I thank Creator God for guiding and accompanying me every day. Thank you for blessing me with the ability, perseverance, dedication and enthusiasm to achieve this academic accomplishment. Thank you.
Dedication

This paper, the final step of my master’s journey, is dedicated to my beloved daughter Hailey Rayelle. She is the greatest gift of Love, who helped bless me with experience, interest, perspective and the commitment needed to climb this academic ladder. I will continue to persevere until we are reunited. Thank you my sweet butterfly!
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Chapter 1: Introduction

This paper is a summary and reflection of my clinical practicum experience with the Saskatchewan Health Authority (SHA) at Children’s Mental Health Services (CMHS) in Saskatoon, Saskatchewan from January 6 – March 25, 2020. I chose to immerse myself in narrative therapy literature and techniques, with the intent of applying this knowledge to my work with children and their families accessing mental health services. My goal was to expand my clinical knowledge base and experience by exploring and having fun on the CMHS clinical playground.

I chose to use the metaphor of the clinical playground because of the possibility, engagement and cross-culturally relevant meaning play and playgrounds have to human experience (Slabina & Martínez, n.d.). The CMHS landscape provided me with an array of opportunities to freely join, observe, and immerse myself in this space that assists children with mental health concerns. This “playground” was a place in which I could safely take risks and responsibly grow as a social worker. Thus, the playground metaphor is used throughout this paper to depict my clinical practicum experience.

1.1 Rationale for Practicum Placement

My interest in pursuing a field practicum related to children’s mental health stems from personal and family experiences with mental health challenges, and my love and acceptance of all children. A placement at CMHS in Saskatoon was a complement to my experience working with children and youth in various school-based settings. I chose a field practicum placement because I wished to gain clinical counselling experience that would supplement my knowledge in helping clients access various community-based social services. My goal was to expand my clinical knowledge and experience by completing the 450-hour practicum in an organization that
was available and accessible to residents of Saskatchewan and used an interdisciplinary team approach to working with children and their families.

The placement allowed me to experience, witness, contribute to and participate in much of what CMHS offers for community-based mental health services and supports to children under 12. It provided me with opportunities to integrate theory into my work with individuals, families and groups, as well as become familiar with some of the satellite programs connected to the agency. I also accessed professional development opportunities; including participation in a self-care retreat.

1.2 Learning Goal, Objectives and Activities

Personal experiences of grief and loss have generated my interest in accompanying children through their experiences of grief, loss and bereavement. My initial goals and objectives for this field practicum concentrated on gaining experience with and learning about community supports available to children with mental health issues who have experiences with grief and loss. However, once my practicum began, and I discovered that the clients I would work with did not present with grief and loss as their main concern, I had to adjust my learning objectives and activities accordingly. Thus, my revised practicum goal, objectives and learning activities are as follows.

1.2.1 Learning Goal

The overarching goal of my field practicum was to become familiar and gain experience with using narrative therapy in counselling with children with mental health concerns. To achieve this goal, I identified and engaged in a number of learning objectives and activities. An explanation and discussion of these learning objectives and activities follows.
1.2.2 Learning Objectives and Activities

Six interrelated learning objectives and activities guided my clinical practicum.

1. To become familiar with current literature on the benefits of using narrative therapy with children with mental health concerns. To achieve this objective, I immersed myself in current literature on using narrative therapy with children. I directed much of my energy towards gaining understanding of the benefits and challenges of using narrative therapy with children with mental health concerns. I also attended a narrative therapy workshop, watched relevant videos, and connected with staff who use a narrative framework with children and families. Additionally, the weekly supervision I received provided me with coaching to integrate the concepts of child development, cognitive behavioural therapy, and trauma informed care within a narrative framework.

2. To become familiar with programs and services offered by the SHA, CMHS, in relation to children’s mental health issues. Immersion in the CMHS “clinical playground” enabled me to become familiar with the range of assessment, therapeutic, group, speech-language, behavioural consultation, case management, school, and specialized services that are offered. Being situated in the building where many CMHS services are delivered allowed me to shadow, observe, read, meet, and have conversations with various staff members who work in different capacities and with different programs offered through CMHS.

3. To gain professional experience working with multi-professional teams involved with children who have mental health concerns. Expanding on objective number two, I connected and collaborated with various professionals who work at, for or with
CMHS. The opportunity to collaborate, consult with and learn from professionals trained in social work, psychology, nursing, medicine, psychiatry, recreation therapy, speech and language pathology, education, and nutrition, greatly enriched my practicum experience by presenting me with different perspectives and opinions. This multi-disciplinary team resembled a diverse group of children on a playground. Everyone was moving, communicating, and interacting in unique ways; all with the same goal of helping children and their families address mental health concerns in captivating and meaningful ways.

4. To provide theory-informed direct therapeutic services for children and their families. Further to my first objective of becoming familiar with current literature pertaining to narrative therapy, I consciously and intentionally integrated this methodology into my work with clients and their families. I chose specific clients for whom problems were externalized and therapeutic letters were written. The narrative focus on the art of asking questions also guided much of my work. Additionally, I directed much of my attention to learning about and implementing child development, cognitive behavioural therapy, and trauma informed care into my practice. Weekly supervision provided me with guidance to integrate this knowledge within a narrative framework.

5. To develop individual and family case management skills. I met this goal by carrying a caseload of eight families through my 12-week practicum. I conducted primary assessment interviews, co-created goals and developed case plans with each client, facilitated individual and family-based therapy sessions that aimed to meet these goals, as well as transferred and closed files. I followed CMHS policies, procedures and clinical standards, and integrated social work values and ethics into my daily
practice. The experience and confidence gained using the Partners for Change Outcome Management System (PCOMS) was integrated into my practice, as were the principles of trauma-informed care. The autonomy and creativity I was encouraged to embrace as I worked with my clients and their families, allowed me to grow and learn; thereby increasing my professional skills, clinical competence and self-confidence.

6. To reflect on the ethical issues facing social work professionals working with children with mental health concerns as well as their families/caregivers. Ethical dilemmas I encountered during my practicum were refraining from working with clients with whom I had a previous association or familiarity, as well as custody and access provisions for a child whose parents had matters before the court. To meet this objective, I consulted with my experienced supervisors and colleagues, and referred to the *CASW Guidelines for Ethical Practice* (2005b) and *CASW Code of Ethics* (2005a), to maintain integrity in my professional learning and practice.

This paper follows my clinical and learning experiences throughout the 12 weeks I shared and learned from eight different families and over 30 different multi-disciplinary professionals connected to CMHS in Saskatoon. I begin with an overview of children’s mental health, the SHA and CMHS, and the frameworks, modalities and theoretical perspectives that guided my practice. An integration of theory, ethics and challenges, as well as concrete examples of how I achieved my learning goals and objectives at CMHS, is also discussed. The report concludes with an acknowledgement of the growth I experienced on this clinical playground and a reflection on future goals and opportunities I hope to embark on.
1.3 Children’s Mental Health

Mental health is a continually growing field of work and study that includes concern for individuals of all ages, including children. According to the Government of Canada (2006), mental health is the state of one’s psychological and emotional wellbeing that allows capacity to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. Mental health is described as “a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity” (Government of Canada, 2006, p. 2). The Centre for Addiction and Mental Health (CAMH) (2020) states that mental health is influenced by many factors that can be individual (e.g., genetics, personality traits, social skills, temperament), familial (e.g., attachment, family structure, parenting style, parental health) and environmental (e.g., social conditions and inclusion). The Mood Disorders Society of Canada (2019) states that one in five Canadians will develop a mental illness at some point in their life. Seventy percent of mental health problems have their onset during childhood or adolescence (Government of Canada, 2006).

In relation to children and youth, the Canadian Institute for Health Information (CIHI) (2015) report estimates that 10-20% of Canadian children and youth may develop a mental disorder. However, less than 20% will receive appropriate treatment (Mental Health Commission of Canada (MHCC), 2020). Appropriate early intervention is not only essential, but more psychologically beneficial and cost-effective, as emotional difficulties that arise in early childhood can increase in severity over time (Centre on the Developing Child, 2012). While mental health organizations play a leading role in providing mental health services, mental health services for children are delivered across settings (including community-based, out-patient, and in-patient) by a number of different professionals (including social workers, psychologists,
registered nurses, nurse practitioners, and psychiatrists) (Government of Canada, 2006; MHCC, 2010; SHA, 2019).

The prevalence of Canadian children’s mental health concerns (including mood, anxiety, conduct, and eating disorders) tend to focus on youth and individuals 12 years and older (Government of Canada, 2006; CIHI, 2015). While there has been growth in the use of children’s mental health services related to emergency department visits, hospitalizations, and access to counselling and psychotherapy (CIHI, 2015), more specific data related to children under 12 years of age appears to be lacking. The gap in research and information pertaining to age, gender, diagnosis, and treatment for children under 12 may be due, in part, because mental health concerns in children can be difficult to distinguish from challenging developmentally related behaviours (Centre on the Developing Child, 2012). Harvard University’s Centre on the Developing Child (2007) states that because young children respond to and process emotional experiences and traumatic events in very different ways from adults and older children, a mental health diagnosis in early childhood can be very difficult. Furthermore, while early diagnosis and treatment of mental health concerns contributes to decreased mortality and negative health and social outcomes, cost, a lack of knowledge, extended wait times, fear and the stigma associated with mental health challenges, can contribute to avoidance, under-acknowledgement and/or a lack of investigation into children’s mental health concerns (Children’s Mental Health Ontario, 2020).

Treating mental health concerns in children involves a variety of interventions and integrated services. Psychosocial therapy, counselling and pharmacology, addressing the social determinants of health, strengthening communities, developing personal and parental skills, and preventing trauma, are essential components to improving the health and mental wellness of
children (CIHI, 2015; Government of Canada, 2006; MHCC, 2010). CMHS is one of several agencies responsible for delivering mental health services to children and their families. The multi-disciplinary team at CMHS is structured and designed to offer a range of programs and services that aim to address these factors. Partnerships between the SHA, provincial and federal governments, school divisions, Saskatoon Police Service and various community-based agencies provide CMHS with the opportunity to intervene and meet the diverse needs of children in Saskatoon and area who present with mental health concerns.

The primary presenting concerns for children and families accessing CMHS services in Saskatoon during the SHA’s 2019 fiscal year were behavioural: 44.4%, anxiety: 22.4% and aggressive behaviours: 8.6% (K. Bassingthwaite, personal communication, April 6, 2020). Of the 1,904 children enrolled to receive services, 23.3% received child and family assessment-related services (K. Bassingthwaite, personal communication, April 6, 2020). The primary concerns presented on the client caseload I supported during my practicum were: 38% attention deficit hyperactivity disorder (ADHD); 25% anxiety; 25% a mixture of concerns; and 13% aggressive behaviours. Throughout the 12 weeks of my practicum, I provided child and family therapy and services (e.g. referrals and resources) to this group of clients.

1.4 The Agency

CMHS in Saskatoon is one branch of Mental Health and Addictions Services that is delivered by the Saskatchewan Health Authority (SHA).

1.4.1 Saskatchewan Health Authority

CMHS in Saskatoon, is a part of the SHA. The SHA is an accredited single provincial health authority that is responsible for providing quality and timely health care to residents of the province (SHA, 2020b.). It is governed by a team of 10 Board of Directors who are appointed by
the Minister of Health to oversee the leadership and structure of SHA and ensure it follows its commitment to Truth and Reconciliation and safety (SHA, 2020b). Created in December 2017, the SHA “aims to break down geographic boundaries and service silos, to provide more consistent and coordinated health care services across the province” (SHA, 2020, para.4).

The vision, mission and values of SHA parallel its desire to position itself as a high performer and leader in Canadian public healthcare (SHA, 2020a). As posted on the SHA’s (2020a) website page, its vision is “Healthy People, Healthy Saskatchewan” (para. 1). Its mission is: “We work together to improve health and well-being. Every day. For everyone.” (para. 2). The core values of SHA are safety, accountability, respect, collaboration, and compassion. These aspects align with the SHA’s philosophy of care which is patient and family centered, meaningful engagements and co-creating mutually beneficial partnerships to ensure a supportive public health care system.

1.4.2 Children’s Mental Health Services

CMHS is a branch of Mental Health and Addictions Services that is connected to the SHA. It provides a range of assessment, treatment and case management services to children under 12 years of age in Saskatoon and surrounding area (SHA, 2019). Individual, family and group therapies are provided at no cost to minors and their caregivers in Saskatchewan who have a valid Saskatchewan Health Card and present with a wide range of mental health concerns including but not limited to anxiety, depression, aggression, attention difficulties, and social and emotional concerns (B. Afseth, personal communication, January 6, 2020). A multi-disciplinary team of service providers comprised of social workers, psychologists, physicians, mental health nurses, a speech language pathologist, recreation therapist, and occupational therapist, work together to offer therapy, assessment, behavior and case management services (SHA, 2019). On
average, clients typically receive counselling services for eight to nine sessions, although there is no set time frame during which files are expected to be closed (B. Afseth, personal communication, January 6, 2020).

Referrals to CMHS can be made on-line, in person, or over the telephone by physicians, parents/caregivers, support workers or any other individual who believes a child is in need of mental health support. An intake worker assesses the child and family’s needs and functioning in areas including development, personality, behaviour, social functioning, and emotions. Following this assessment, client files are often created, and families are referred to one or more of eight different service areas that include assessment, therapy, groups, school-based, speech-language, behavioural consultation, case management, and/or specialized services. The service areas of mental health assessment, therapeutic services, and group services encompass multiple modalities that are used to meet the needs of clients and their families. These modalities include behavior, psychological, social, emotional and speech/language assessments, play, pet, individual and family therapy, children’s groups, and parenting programs.

I was able to connect with staff who work in each of the eight service areas. Whether it was through talking, observing, shadowing, attending a meeting or going on a tour, I had the opportunity to learn about several programs and services offered through CMHS. While all areas were interesting and unique, I opted to focus my time and energy on achieving my fourth practicum objective; to immerse myself in therapeutic and group services at CMHS. Therapeutic services offered during my placement at CMHS included play, pet, family and individual therapy. Group services offered included a variety of parenting and children’s programs. I focused on family and individual therapy, as well as three group programs: The Incredible Years Parenting Program, Social Thinking Group, and Friendship Group.
1.4.3 Partners for Change Outcome Management System (PCOMS)

Mandated by the provincial government, Children’s Mental Health Services utilizes a systematic client feedback intervention called Partners for Change Outcome Management System (PCOMS). PCOMS is an atheoretical evidence-based practice developed by Dr. Barry Duncan that solicits client feedback regarding factors proven to predict clinical success (Duncan, 2012). Two four-item scales are used to open up dialogue and provide the client with an opportunity to share their opinion on the therapeutic alliance and experience of receiving services. The Child Outcome Rating Scale (CORS), administered at the beginning of each session, and Child Session Rating Scale (CSRS), administered at the end of each session, provide clients and caregivers with the opportunity to provide the therapist with regular feedback (Duncan, 2012). Both measures provide information that can be used to build rapport, direct conversation, and explore the client’s perception of how therapy is going (Better Outcomes Now, 2020).

While in my placement, I received the training needed to implement PCOMS into my practice. This model can be administered to children ages eight and older (Duncan & Sparks, 2015). Seven of the children, and all of the parents I worked with agreed to complete the measures at the beginning and end of each session on the office computer. One seven-year-old child completed the measures on a laminated scale. The visual graphs included in PCOMS allowed clients to see and track their perception of their progress towards their goals. Regularly using this client feedback measure assisted in the development and maintenance of a strong alliance with my clients; facilitating conversations, hearing their voice, and tailoring services to meet their individual preferences and needs.
1.5 Chapter Summary

My 450-hour MSW field practicum with the SHA: CMHS was a rich learning experience that provided me with numerous opportunities to extend my work with children; a population I deeply adore. Achievement of six learning objectives and related learning activities allowed me to accomplish my goal of becoming familiar and gaining experience with using narrative therapy in counselling with children with mental health concerns. Immersion in the multi-disciplinary “clinical playground” of CMHS allowed me to practice, learn, explore, and grow with others and individually. It introduced me to many of the organization’s programs (including PCOMS) and professionals, and helped expand my knowledge, understanding and experience with children with mental health issues. Additionally, this practicum exposed me to many different theoretical perspectives and clinical techniques; a number of which I integrated into my practice.
Chapter 2: Literature Review

CMHS provided me with exposure to a variety of theoretical frameworks and clinical techniques. Before my practicum commenced, personal interest guided my choice to focus on implementing a narrative framework into my practice. As my practicum progressed and I learned more about CMHS and narrative therapy, it was natural for me to also gain increased understanding and curiosity on the topics of child development, cognitive behavioural therapy (CBT) and trauma informed care (TIC). A literature review on these four topics follows.

2.1 Child Development

Effective work with children and their families requires knowledge and understanding of child development. This vast topic has been examined from many different theoretical perspectives and includes multiple influences, components, and categories (Berk, 2000). CMHS concentrates on integrating trauma informed principles with a brain-based scientific focus on child development. The Centre on the Developing Child (2012) states that “[early] mental health problems merit attention because they disrupt the typical patterns of developing brain architecture and impair emerging capacities for learning and relating to others” (p. 1). This perspective takes into consideration genetic predispositions and environmental factors that have been found to predict the emergence of later physical and mental health problems in children. Integrating trauma informed principles with scientific evidence on child development provides a rich context for understanding and working with children with mental health concerns.

Child development is a multi-disciplinary field that is characterized by three domains: physical, cognitive, and emotional-social development which are influenced by both nature (genetics) and nurture (the environment) (Berk, 2000; Centre on the Developing Child, 2007; Santrock et al., 2005). All three domains are interwoven throughout and beyond the distinct
periods or stages of development (which are commonly divided into age groups: infants, toddlers, preschoolers, school-aged children and adolescents) (Holmbeck et al., 2014). Though there is individual variation within child development, developmental milestones, which are notable life events that mark a specific point in development, are commonly met at predictable points in time (BTEC First Children’s Care, 2015; Holmbeck et al., 2014). These stages and sequences are useful measures which parents, caregivers, and professionals can use to assess and evaluate children (BTEC First Children’s Care, 2015).

According to Harvard University’s Centre on the Developing Child (2007), early childhood development is the science that connects early experiences to future learning, capacity, behaviour, physical, and mental health. It focuses on human development from birth to five years of age. Research shows that adversity in early life can disrupt an individual’s future and the future of society (Butler et al., 2011; Centre on the Developing Child, 2007, 2012; Felitti et al., 1998). Neuro-biological science has discovered that genes and experience shape the brain, which is built over time (before birth to adulthood) from the bottom-up (Centre on the Developing Child, 2007). Development of increasingly complex skills is built on circuits and capabilities that precede them; thereby making early skills and development pre-requisites for later growth and development (BTEC First Children’s Care, 2015; Centre on the Developing Child, 2007). Early learning and experiences are key components that provide a foundation for the learning, behavior and health that follow (Centre on the Developing Child, 2020). Brain architecture is set during the early years of life, and it is crucial that children are nourished and well supported during their formative years.

There are complex interactions among multiple influences on child development. As children and youth are particularly vulnerable to events and situations in their immediate
families, social, educational and community environments, it is important to identify protective and risk factors that potentially influence the development of mental health concerns (Government of Canada, 2006). The Adverse Childhood Experiences Study (ACE) conducted by Felitti et al. (1998) “found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults” (p. 245). Pem (2012) outlines how nutrition, parents' behavior, parenting, social and cultural practices, and the environment impact early childhood growth and development. Child development is impacted by micro factors including individual health, stress, and nutrition; mezzo factors including socio-economic status, family size and structure, exposure to teratogens, and maternal mental and physical health; and macro factors including social policies, environmental conditions, and political movements (Berk, 2000; Santrock et al., 2005; Government of Canada, 2006; Felitti et al., 1998). Clearly, a number of different domains impact child development. Addressing psychological and social determinants of health, strengthening communities, focusing on primary prevention in the early stages of development, and preventing trauma will help in the prevention of mental health issues in children (Government of Canada, 2006). Incorporating narrative and cognitive behavioural techniques with a trauma informed, anti-oppressive lens, provides further opportunity to conduct child-sensitive assessments that contribute to appropriate interventions.

There are a number of different counselling techniques and strategies that take child development into consideration. Throughout my practicum, I primarily used a combination of narrative and cognitive behavioural therapy (CBT) techniques and strategies. Aspects of play therapy, which is a psychotherapeutic form of treatment that involves the use of various items and concepts including toys, miniatures, make-believe, art, and games to help children explore
and solve problems (Eugster, n.d.), were also used to engage the children I worked with. Play therapy is structured to be fun and engaging while allowing therapists to work with children at age- and developmentally appropriate levels. It provides space for teaching and providing encouragement, modelling, and coaching. While the goal of my practicum was to learn about and implement narrative techniques, I followed my clients’ lead with the incorporation of various forms of play and CBT techniques, while maintaining an awareness of trauma-informed principles. Play therapy techniques helped me build a strong therapeutic alliance with my clients and their family members. This methodology also allowed me to incorporate the use of narrative and CBT techniques in fun and playful ways.

2.2 Narrative Therapy

Narrative therapy is a collaborative, non-pathologizing therapeutic approach that was developed in the 1980s by Michael White and David Epston (Kelley & Smith, 2015; Koop Harder, 2017; Madigan, 2007; Marsten et al., 2016). It is a postmodern “story changing” method that draws from the constructivist work of French writer and philosopher Michel Foucault (Besley, 2002; Marner, 1988). It seeks to help people understand the power of dominant stories that influence their interpretation, perception, and experience of the world (Koop Harder, 2017). This therapeutic framework does not have a manual or set of questions to follow, but instead is guided by questions that are led by compassion, curiosity, interest, and appreciation for others (Madigan, 2007). It can be used with individuals of various ages, abilities, cultures, problems and worldviews as it takes development and perspective into consideration (Koop Harder, 2017; Madigan, 2007).

The goal of narrative therapy is to help clients challenge dominant narratives and thus create new realities that are consonant with preferred lives (Kelley & Smith, 2015). At the heart
of this framework is the belief that people are multi-storied; with some stories holding more weight than others, some being choices, and others being thrust upon us (Koop Harder, 2017). It recognizes that problems exist in cultural contexts (e.g., power relations of age, race, gender), identity is fluid, and no problem is absolute (Koop Harder, 2017). Quoting narrative therapy founders White and Epston, the main guiding principle of this approach is: “The person is not the problem. The problem is the problem” (Madigan, 2007; Marsten et al., 2016).

A narrative approach deems clients to be the experts in their lives; with the therapist identifying as a “non-expert” who skillfully asks questions that assist in helping story lines to unfold and be challenged (Koop Harder, 2017). Drawing from feminist theory, sociology, anthropology and post-structuralism, key concepts of narrative therapy include examining and challenging problem-saturated stories, externalizing the problem, mapping the problem’s domains, unique outcomes (moments when the client defies the claims of the problem), and outsider witness practices (real or imaginary witnesses that provide confirmation and support for intentions and preferred actions) (Kelley & Smith, 2015; Marsten et al., 2016). Strategies of interviewing the problem and/or writing a letter to the problem are also important and can yield interesting and helpful insights and learnings (Fox, 2003; Koop Harder, 2017).

Narrative therapy is commonly used in a number of problem areas including mental health, trauma, relationships, and conflict resolution (Dulwich Centre, n.d.; Koop Harder, 2017). It can be used with individuals, couples, families, groups and within community settings (Dulwich Centre, n.d.). However, potential concerns have been raised in regards to this therapeutic approach. Kelley and Smith (2015) point out that limited empirical research supports its use because of its focus on objectivity. They also mention that narrative therapy is naturally at odds with pre-approved treatment plans that have been empirically proven. This is because
narrative therapy’s emphasis is on the therapeutic relationship between the client and therapist, and their co-constructing new realities, rather than conducting problem solving activities designed by the therapist. Stebleton (2010) highlights various studies that found time, incongruent expectations of the helping role between the client and therapist, lack of structure and provision of a therapeutic manual, the western expectation of the linear structure of stories, along with clients’ self-confidence and ability to express themselves, to be limitations of narrative based career and employment counselling approaches. The limitations can be compared against the solution knowledges and problem-solving skills of people who consult with narrative therapists, as well as the effectiveness of narrative practices and services with a variety of populations experiencing various types of problems (Combs & Freedman, 2012). Evidently, a narrative framework has both strengths and limitations.

Narrative therapy is about elucidating local truths that apply to those who construct and live them, even though it does not fit within a specific scientific approach (Stillman & Erbes, 2012). Still, a number of different studies reveal the effectiveness of using narrative therapy with different populations. Beaudoin et al. (2016) and the Dulwich Centre in Australia highlight studies that empirically demonstrate its effective use with adults and children exhibiting stealing behaviours, encopresis, attention deficit disorder, depression, high functioning autism, and eating disorders. In their study, Beaudoin et al. (2016) found that the use of narrative therapy significantly increased 8 to 10-year-old children’s self-awareness and self-management, social awareness/empathy, and responsible decision-making skills. They found that the narrative practices of externalization and re-authoring can significantly contribute to the development of children’s social and emotional skills. A study conducted by Yoosefi Looyeh et al. (2014) demonstrated month-long sustained effectiveness of group narrative therapy in reducing
symptoms of social phobia in fourth grade boys when at home and in school. Busch (2007), in his qualitative evaluation of six narrative therapy case studies, found that this form of therapy is effective and has demonstrated positive changes in clients’ discourses, positionings, and overall outcomes. Thus, there is literature that supports therapists’ use of a narrative framework with clients. As empirical research on narrative therapy expands and continues, additional studies will likely be more diverse and demonstrate additional benefits of this therapeutic approach.

Narrative therapy is compatible with social work values, principles and methods. It incorporates respectful listening, client self-determination that is consistent with their capacity, development and pursuit of individual goals, empowerment, and the avoidance of labelling (Kelley & Smith, 2015). Externalizing or naming problems, and exploring them in relation to their impacts, cultural and societal influences, roles, and relationships, provides space for acknowledgement and pursuit of social justice. Power differentials are minimized as the client’s strengths are drawn out as they are deemed the expert in their life. Though lacking in empirical evidence and privileging client experience in relation to dominant cultural narratives, this playful approach widens the space between persons and problems and can provide transformative experiences (Kelley & Smith, 2015; Marsten et al., 2016).

2.2.1 With Children

The person-centered approach of narrative therapy can be used with a wide variety of peoples, populations and problems; including children with mental health concerns. Marner (1988) explains that the art of narrative therapy with children has preconditions that need to be met in order for this approach to be effective. He suggests four points therapists should consider before using this approach with children. First, children should be at least four years old and have capabilities to engage in “linguistic dissection” of the problem. Second, children should not
be suffering from severe brain injury, autism, or other irreversible mental conditions, nor should there be recent severe experiences of trauma. Third, the child should not be in an abusive environment. Fourth, the therapist must be able to engage the parents’ understanding and cooperation in therapy. Being mindful of child development, individual health and personality differences, and the time frame in which therapy will be delivered, narrative techniques will likely be a good fit for many children.

With curiosity being a central quality, and artful and skillful questioning being key aspects of deconstructing problem-saturated stories to build up preferred identities, therapists using a narrative approach can assess children rather than problems (Koop Harder, 2017; Madigan, 2007; Marsten et al., 2016). By characterizing or objectifying a problem, a child’s imagination can be enlisted to assist in remedying problems in an alternative, creative, and playful way (Marner, 1988; Marsten et al., 2016). By enlisting the imagination, a child’s values and preferred vision for their life can be elicited so problems can be addressed in suitable accordance with their skills and knowledge (Marsten et al., 2016). As such, the plots of new and preferred co-authored stories that emerge can be thickened as they encompass the child’s morals, virtues, talents and vocabulary. Furthermore, while it requires a balance of asking questions with soliciting a problem story, it also provides room to include multiple forms of art and play (Marsten et al., 2016).

Applying narrative techniques to therapeutic work with children allows movement towards preferred knowledge and away from the grip a problem has on a child and their family. This approach is depathologizing and removes labels by often characterizing problems as unjust, tyrannizing and tricky phenomenon (or “enemies”) that can be defeated (Marner, 1988). While some problems are exactly that, Freeman et al. (1997) recommends that therapists be mindful of
using a suitable metaphor to tackle a problem. While it may be appropriate to “outwit” or
“overtake” one problem, it may be more fitting to “come into harmony with”, “befriend”, or
“grow out of” another problem. Thus, this approach validates personhood and experience, and
makes room for whatever sort of liberation fight is needed from the problem. It gives children
power and allows them to speak themselves into a new meaning.

Using therapeutic letters with children can be an important role in achieving positive
results. These letters or “counter documents”, that can expand and enrich a person’s counter
story, should be concise, encouraging, draw from relevant moments in the session, and written in
a language that will be appealing to the child (Fox, 2003; Marner, 1988). Naming the problem
with a capital letter (i.e. Anger) supports externalization of the problem in addition to recording
knowledge and preferred stories in permanent form (Fox, 2003). Letters written between sessions
and/or at the conclusion of therapy, often elicit feelings of respect and intrigue from the
recipients. Fox (2003) reports the effectiveness of therapeutic documents and the value they have
in helping clients continue their work between sessions and beyond therapy.

2.2.2 With Families

Integrating a narrative approach into practice with families can help strengthen and unify
a child and family’s local knowledge, as well as substantiate the child as more than the problem
(Freeman et al., 1997). When families come to therapy, they are often focused on the problem
and its surrounding narrative. The problem-saturated story limits perspective, edits out hope, and
precludes refreshing possibilities and potential (Freeman et al., 1997). Use of the narrative
approach allows families to join forces against the problem. It also reacquaints adults with a
world of possibility they may have forgotten (Marsten et al., 2016).
Narrative therapy with families takes the focus off of children and their labels, and opens up space for consideration of social, cultural, and economic pressures that divide and conquer families (Freeman et al., 1997). Externalizing problems allows families to collectively spot, face and scrutinize the problem, rather than the child, while also allowing them to focus on their values, hopes, and preferences in a collaborative, lighthearted, playful, and often humourous way (Freeman et al., 1997). Narrative therapy provides space and time for each family member’s perspective and experience to be shared, validated and considered. This allows children to be partners rather than passengers who help facilitate understanding about and interruption to the services and roles the problem has been serving (Marsten et al., 2016).

Use of the narrative approach with families allows parents to see their role in the life of the problem. Externalization allows parents to take themselves off the hot seat of self-blame and identify as co-conspirators against the problem, brainstorm ideas and solutions with their child, point out details and positives that are promising, as well as celebrate changes the family experiences (Freeman et al., 1997). Family members help draw out the strengths of the child, which can be used to help address the problem. Externalization recognizes that all family members have relationships with the problem and that children play a central role in problem resolution.

Narrative therapy also considers both local and global knowledge. It allows families to consider the influence society and the outside world have on a problem, and their personal responses to these influences and views (Madigan, 2007). Narrative therapists often prompt conversations that provide children and families with the opportunity to consider their location, what they know, and their experience of knowing, by using phrases such as “I’m wondering…” or “I’m curious about…” (Marsten et al., 2016). This allows family values, moral commitments
and virtues, and many wonderful qualities of the child to be elicited and celebrated. It also allows families to identify how their local knowledge is often healthier though silenced by global knowledge (Madigan, 2007).

Questions and answers lead narrative therapy with families as they call forth issues, positions, views, and answers that facilitate interest, inspire inventiveness, and generate reflection and choice for children and their families (Freeman et al., 1997). When communication about problems can be done metaphorically and/or through play, the relationship with a problem changes and the choice and possibility in the relationship between persons and problems expands (Freeman et al., 1997). The collaborative nature of narrative therapy provides opportunities for families to engage, understand their relationship with problems, develop a preferred narrative, and co-create strategies that can be supported and sustained. This diminishes the hold problems often have on families, establishes a place of honour for the child by reassigning blame to the problem, and allows new and preferred stories to take centre stage.

2.2.3 With Experiences of Grief and Loss

Narrative therapy can be used with children who have experiences with grief and loss. Before a specific therapeutic approach is considered, it is essential that therapists working with grieving children give particular attention to the child’s chronological age, development, linguistic capabilities, and previous experience with death (Boles & Kronaizl, 2019). This is because the ways children express grief are widely varied and closely related to their developmental stage (Schoenfeld & Demaria, 2016). Children's concepts of death and grief are unique and multi-faceted, and are impacted by individual, cultural, and religious influence (Longbottom & Slaughter, 2018).
Narrative strategies can be used for promoting adaptation to loss in the context of grief counselling (Neimeyer, 1999). By approaching bereaved children from a position of “not knowing”, therapists using a narrative-style invite children to see and story their experience in a more accepting and facilitating fashion (Moules & Amundson, 1997). Problems related to experiences of grief and loss can be externalized and deconstructed to assist children in living their preferred narrative (Moules & Amundson, 1997). Fareez (2016) suggests using “The Life Certificate” (which is a twist on the death certificate) to deconstruct “bad” memories and access alternate stories that can redefine relationships with loved ones who have died. This creative tool is a unique way to say “hello” again, to a loved one who has passed away. It can be developed and modified to suit each unique individual (with respect to age, ability, language, culture, etc.) according to how they want to remember one who has passed. Similarly, Neimeyer (1999) suggests that individuals can reconstruct a world of meaning through the creative making of an epitaph, journaling, creating a life imprint, using metaphorical images, linking objects, and writing poetry. Playful and artistic means such as these are compatible with a narrative approach to grief therapy, and when suitably modified, can be used in grief work with children.

While I did not work with children and families for whom grief and loss was the presenting concern, I chose to integrate this information into my report because it is a topic that I am interested in and a field in which I would like to practice in the future. I am interested in directing some of my future work towards children who have experiences of grief and loss; to help address and prevent unresolved grief, minimize vicarious trauma and promote successful adjustment following the loss of a loved one.
2.3 Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) is a practical short-term evidence-based form of psychotherapy that aims to replace maladaptive cognitions with realistic and positive ones (Beck Institute, 2019; Rector, 2010; Vonk & Early, 2015). Developed in 1964 by American psychiatrist Aaron T. Beck, this form of problem-focused and goal-oriented therapy, is based on a proactive and collaborative therapeutic relationship between the client and therapist (Fenn & Byrne, 2013; Rector, 2010). With the focus of CBT being on the “here and now”, automatic negative thoughts, core beliefs and cognitive distortions are identified and questioned to elicit change (Fenn & Byrne, 2013; Rector, 2010; Vonk & Early, 2015). CBT trained therapists educate clients about thoughts, emotions, and behavior, and encourage those they work with to comprehend thoughts as ideas, rather than facts, and consider situations from different points of view (Rector, 2010). Through use of behavioural techniques such as self-monitoring, activity scheduling, mindfulness and relaxation training, behavior can be changed (Rector, 2010; Vonk & Early, 2015).

Like narrative therapy, CBT can be used with children who present with a diverse set of problems. Njoroje and Yang (2012) highlight various evidence-based psychotherapies that have been used with pre-schoolers with psychiatric disorders. They acknowledge the impact parenting and early adverse experiences have on brain development, and present both benefits (coping skills training and emotional regulation) and challenges (verbal discussion, expressing verbal narrative, understanding concepts) of using CBT with this young population. Flannery-Schroeder and Kendall (2000) extend and replicate the efficacy of CBT with children with anxiety disorders receiving individual and group treatment. In their review of contemporary meta-analyses examining the efficacy of CBT, Hoffman et al. (2012) found that that this form of therapy is the preferential treatment for anxiety disorders in children and adolescents. They found CBT to have
a medium size effect for depression and anger problems, and some efficacy for ADHD. Due to it being the most widely researched, referenced and empirically tested form of psychotherapy, CBT has been deemed the “gold standard of treatment” in the contemporary psychotherapy world (David et al., 2018). Thus, empirically speaking, it is a suitable form of therapy to use with young clients presenting with diverse mental health issues.

CBT is unique in that it can be delivered in a number of different ways and formats. Wood et al. (2006) compared family-focused CBT (FCBT) with traditional individual child focused CBT. While they found FCBT was associated with greater improvement in the reduction of child anxiety, they found that both groups improved on all measures of anxiety at post-treatment. Wergeland et al. (2016) examined predictors of CBT treatment outcomes in children with anxiety disorders who presented at a community clinic. Although they found no significant difference between individual and group-based CBT treatment, they did find that children with higher anxiety levels, higher functional impairment, higher levels of parent internalizing symptoms, and diagnosis of social phobia or separation anxiety were associated with less favourable outcomes at post treatment. Grist et al. (2018) researched the effectiveness of mental health interventions delivered via technology (computers or internet) and found that there was limited evidence in favour of technology-based intervention with kids under 12. They found that technology-based CBT does not replace face-to-face CBT, however, treatment outcomes can be improved with parental and therapist involvement. They also found that this form of psychotherapy is beneficial where access to face-to-face CBT or other forms of psychotherapy are limited or delayed. Given the strong evidence in support of CBT, this form of psychotherapy is largely and commonly used at CMHS.
Further to the evidence already presented, there are a number of additional reasons why CBT is a suitable form of therapy to use at CMHS. First, numerous studies have shown its effectiveness (Beck, 2019; David et al., 2018). Second, it is an effective therapeutic approach used to treat a variety of different psychological and emotional conditions including depression, mood, anxiety, and eating disorders (Fenn & Byrne, 2013; Njoroje & Yang, 2012; Rector, 2010). Third, its use has been found to be effective with individuals of all ages, genders, races, ethnicities, education levels, income levels, and cultures (Rector, 2010). Due to the diverse nature of the clientele that access CMHS, CBT is the strong and effective therapeutic framework from which all programs and services are delivered. It guided much of the work I did with children and their families. It also provided the framework for The Incredible Years Parenting Program, Friendship Group, and Social Thinking Group that I helped facilitate.

2.4 Trauma-Informed Care

Trauma-informed care (TIC) is the framework that is used to guide pediatric mental health care practice at CMHS. According to Substance Abuse and Mental Health Services Administration (SAMHSA) (2014):

- Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being. (p. 7)

Studies have shown the profound negative effects trauma has on children’s neurobiological stress systems (limbic, adrenal, hypothalamus and pituitary) and cognitive and brain development (De Bellis & Zisk, 2014; Klinic, 2013). The ACE study by Felitti et al. (1998) highlights the graded relationship between childhood trauma and risk factors for the leading causes of death in adults.
A trauma-informed approach integrates research, practice-generated knowledge, and lessons articulated by survivors who have had involvement with multiple service sectors (SAMHSA, 2014). As there are high rates of trauma among those accessing mental health services (Klinic, 2013), it is essential that children’s mental health care organizations and providers are educated about trauma and its effects.

CMHS continually works to integrate the five core trauma-informed principles: awareness, safety and trustworthiness, choice, collaboration and connection, and strengths-based skill building (CMHS Trauma Informed Priority Group, 2019; Klinic, 2013) across all settings in which services are delivered. Acknowledgement of ACEs provides an opportunity to address and prevent them as well as promote safety and healing. Utilization of a trauma-informed approach includes realizing the widespread impact of trauma, recognizing signs of trauma in clients, families and staff, responding to trauma by integrating knowledge into policies, practices and procedures, and actively seeking to resist re-traumatization (SAMHSA, 2014). CMHS is currently implementing TIC in the following ways: the preparation and distribution of a trauma informed survey to clients and staff, awareness and integration of environmental components of TIC, and professional development and education to all staff (including support staff) regarding the importance of incorporating the principles of TIC.

2.5 Chapter Summary

This chapter reviewed the literature on child development, narrative therapy, cognitive behavioural therapy, and trauma-informed care. Attention was drawn to multiple concepts within child development, including brain-based development, the influences of nature, nurture, and ACEs, and typical patterns of development. Aspects of how these factors influence children’s mental health and wellbeing was included. Narrative therapy, which is a relationship-based form
of therapy that aims to bring to light the power of dominant stories, was described. Its use with children and families, and regarding the topic of grief, was highlighted. CBT, which has been deemed “the gold standard of psychotherapy” (David et al., 2018), and aims to change thinking and behavior, was also presented. The strong evidence base for this form of therapy makes it a widely used technique at CMHS. Finally, principles of trauma-informed care were acknowledged, the negative impact trauma has on children’s development was described, and the integration of trauma informed principles at CMHS were shared. Demonstration of how this knowledge and theory was integrated into my practice, is discussed in the next chapter.

Before discussing how I integrated theory into practice, I want to mention three points that connect this literature review to the analogy of the clinical playground. First, the array of therapeutic techniques and principles that I learned about, described and explored, parallel the idea of using various pieces of playground equipment in unique ways. I think it is comparable to playing on a playground; there are countless ways games can be played and equipment can be explored. Similarly, using an eclectic mix of psychotherapy techniques allowed me to help children and families explore mental health concerns in unique and relevant ways. This helped keep our meetings interesting, fun and engaging. Second, the research and learning required to do the literature review, required acceptance of guidance and suggestions from others, questions to be asked, and sources to be referred to and referenced. Like a child on a playground, when they join in a new game they have not played before, they need to ask questions, listen, watch, and observe before they truly understand and feel a part of the game. Guidance from a supervisor, parent, teacher, or leader provides additional support that assists in learning and providing safety. Third, the literature review assisted me in making new connections with knowledge I already possessed and new information and ideas I gained. Like playing on a
playground, children’s previous experience with games and play often influences the rules they
incorporate and those which they dismiss. Similarly, the four topics discussed in this literature
review section are vast, and thoughtful consideration and selection influenced the review. This
helped me focus on areas of interest and relevance; thereby expanding my professional scope of
practice.

Upon reflection of the analogy of the CMHS clinical playground, I realize the playground
has extended beyond the walls of the building and into my experience with this literature review.
This literature review has allowed me to think through and better understand how I integrated
theory into my practice, and gain greater appreciation for how my ever-growing theoretical
knowledge influenced my clinical skills, abilities, choices, and focus. A discussion of how I
integrated theory into my practice, follows.
Chapter 3: Integrating Theory into Practice

A significant component of my MSW practicum experience involved integrating theory into practice. Throughout the 12-week practicum I immersed myself in the literature and, on a weekly basis, received supervision and guidance as I learned and explored on the CMHS playground. These opportunities encouraged and allowed me to practice newly acquired skills, refine and further develop my perspective, and experiment with different approaches and techniques. In alignment with my practicum goals and objectives, I implemented and practiced using numerous aspects of narrative therapy, while also gaining experience with CBT and keeping child development and the principles of trauma-informed care at the forefront of my practice. A discussion of how these theoretical approaches, principles and techniques were integrated into my practicum, follows. Specific examples are shared and explained within five subsections: Caseload, Supervision, Clinical Skills, Groups and Tours, and Professional Development.

3.1 Caseload

At the start of my practicum, I reached out to 11 different families who were on the “non-urgent” waitlist (since July 2019) to be seen for child and family assessment and therapy at CMHS in Saskatoon. Shortly after initial contact, three families opted out of receiving services, thereby providing me with the opportunity to work with eight families. Of these eight families, two girls and six boys between the ages of 7-11 years, were the primary clients. One child joined a family after international adoption in early childhood. The other seven children were biologically related to their family members. Clients self-identified from multiple backgrounds including Caucasian (50%), Canadian (25%), Ethiopian (13%), and Pakistani (13%). Five (63%) of the primary child clients lived in a family in which their parents are married and cohabitate.
Three child clients (38%) regularly went between the separate households of their separated or divorced parents. In accordance with CASW (2005b) Value 1.3, all parents provided written informed consent to work with me, a practicum student. Each family also provided written consent to allow me to include elements of our work together in this final report.

Completing my practicum at CMHS provided me with the opportunity to learn more about the principles of TIC and consciously implement them into my practice. I intentionally gave each client a tour of the building; with the intent of providing familiarity and comfort as well as promoting safety. I was made acutely aware of the importance of this practice after receiving different comments during separate tours. During one tour, a seven-year-old said “it’s like a hotel”. On a separate tour, a nine-year-old stated “I thought it was going to be like a jail”. These examples coincide with the principles of TIC and provide insight into the importance of clinician sensitivity, calmness, and acceptance in strengthening client engagement and connection.

I was fortunate to facilitate over 60 sessions with the eight clients and members of their families. Depending on their availability, clients received a minimum of five therapeutic sessions. Primary assessments, which occurred solely with parents, were roughly 90 minutes in duration, while each of the following sessions were 60 minutes in length. Most days I had between one and four in-person appointments with clients. All appointments started and ended in the office; with parts of many sessions occurring in a playroom setting. Sessions were conducted primarily with the child client and one or both of their parents. A few clients received one-on-one counselling, while less than a handful of sessions were conducted with entire families.

A primary assessment was conducted with one or both parents of each client prior to meeting their child. Background information, strengths of their child, definition and challenges
of the presenting concern, and concrete goals were discussed and recorded. Following principles of TIC (Butler et al., 2011), trustworthiness and collaboration in the therapeutic alliance was initiated, choices for intervention were provided, externalization of the problem commenced, and a focus on wellness (rather than illness) was highlighted. Adherence to CMHS clinical standards was maintained as these reports were placed on file within three business days of the assessment. Clients were informed that weekly appointments would maximize the opportunity for intervention. Subsequent appointments were scheduled according to family availability.

Throughout my practicum I worked hard to be mindful of the unique developmental stage of each client, as well as cognizant of environmental stimuli that could impact each session I conducted. I was attentive to providing developmentally appropriate options (i.e. complexity of a book, use of pictures versus words, amount of time I could reasonably expect a child to concentrate). I purposefully arranged the room to help clients feel welcome. I regularly asked clients for their preference on the lighting and temperature in the room. I also ensured a number of different sensory objects were always available. Implementing these strategies provided me with many opportunities to build a strong alliance with my clients and their family members. Awareness of child development and trauma informed principles allowed me to attune to the child and their family, and develop respectful and trusting rapport.

Each client on my caseload enhanced my experience on the CMHS clinical playground. Their differing interests, experiences, personalities, and challenges provided me with intrigue and opportunities to experiment with various therapeutic techniques and approaches. Their energy and playfulness was often invigorating. When I felt “stuck” or was unsure with how to proceed with a client, supervision provided me with a safe place to discuss ideas, receive encouragement and practice skills I could use in upcoming sessions.
3.2 Supervision

I was fortunate to receive both clinical and peer supervision throughout my practicum. Two MSW supervisors provided me with weekly supervision, while peer supervision was offered on a monthly basis. The differing backgrounds and experiences of my two supervisors enhanced my learning and opportunities to learn. While both supervisors had training in narrative therapy, one had a focus on trauma and child development and the other had a more general background with an interest in collecting resources. Supervision offered me the opportunity to ask questions, receive guidance and feedback, and debrief. It was during these times that narrative and CBT approaches were explored and discussed, and principles of trauma-informed care and child development were reinforced and highlighted. The SASW Standards of Practice for Registered Social Workers in Saskatchewan (SASW, 2020) and CASW ethics documents (CASW, 2005a, 2005b) were used as considerations, and values and principles of social work practice were often highlighted. These weekly meetings greatly enhanced my competence and contributed to advancement of specialized professional knowledge in the field of children’s mental health. They also greatly assisted me in developing constructive and appropriate interventions, honouring and maintaining confidentiality, obtaining recommended literature, and practicing skills I could use in sessions.

Both regular clinical supervision and peer supervision were new experiences for me. They helped me step outside my comfort zone by learning to engage in debates and grow in my own clinical and self-confidence. Supervision provided me with the idea and skills to use a heart rate monitor with children so they could learn how heart rate and body sensations are related. It provided me with a time and space to talk about ethics and custody and access issues for a child on my caseload. It also allowed me to learn and hear from other clinicians who have questions
and struggles and need support too. I appreciated how supervision appointments were scheduled, maintained and honoured.

Supervision was definitely a highlight of my practicum experience. It coincides with the analogy of a “buddy bench” on a playground. Whenever I “sat on the bench” my supervisors or other colleagues were always there to help. For example, when I wanted to use a video to explain ADHD to a child and their family, several colleagues gave me different suggestions. Ethical dilemmas, understanding of theoretical perspectives, and integration of various clinical skills regularly brought me to the “buddy bench”; where a great deal of my learning took place.

3.3 Clinical Skills

Primary presenting concerns for the children I worked with included: anxiety, attention deficit hyperactivity disorder (ADHD), sadness, anger, frustration, focus, and friendship. Through the use and integration of an eclectic mix of therapeutic strategies, techniques, and principles, much of the work I did with clients and their families was related to self-awareness (especially bodily sensations), self-regulation (i.e. self-calming methods and transforming negative to positive thoughts), building emotional literacy (identifying and naming different feelings and sensations) and improving self-esteem (by drawing and building on client strengths and assisting in cognitive restructuring). Use of narrative therapy and CBT was primarily used in combination with child development and trauma-informed principles. Aspects of integrative body psychotherapy (IBP) and somatic experience (SE) techniques (which I gained through professional development opportunities during my practicum), and practices adopted from play and art therapy were also used. This allowed me to purposefully integrate specific questions, observations, activities and techniques into my practice. Incorporating imagination and creativity with conversation, games, stories, videos, worksheets, art projects, movement, and experiments,
provided the children and their family members with the opportunity to better understand themselves, their situation, relationships with others, and the problem that brought them to CMHS.

### 3.3.1 Narrative Integration

Externalization, letter writing, and mindful questioning techniques were narrative strategies I was drawn to and regularly incorporated into my practice. “I’m curious…”, “I wonder…”, and “What would a friend say about…” preceded many of the questions I asked and statements I made. These types of questions and statements allowed me to be investigative about dominant and preferred narratives, as well as draw out client strengths, stories, and experiences. In line with the principles of TIC (Butler et al., 2011), these questioning techniques also allowed the client to be the expert of their reality, make choices regarding the direction each therapy session would take, and explore and name problems in developmentally appropriate ways. Externalization and letter-writing helped me to further develop a therapeutic alliance with clients. Naming and separating the problem from the person was often visibly empowering for the children and liberating for their parents. Letters that were written between sessions also proved to be encouraging as they highlighted client strengths and preferred stories, contained words and ideas the client had shared in session, and included questions for the client to consider.

There were a number of “ah-ha” moments I experienced when using narrative strategies and techniques with clients. When I asked one nine-year old boy if there was anything in the playroom that he could use to explain Anger, he retrieved a colourful abacus from the shelf and went on to tell me that when all the beads are on one side, Anger is really strong. He added that Anger can be lessened by moving just one bead to the other side. When I asked how to move just
one bead to the other side, so Anger could lighten its grip, he told me it was by “taking a deep breath”. This was a clear example of utilizing play to externalize anger. This client also integrated the use of self-regulation techniques that had been shared, modelled and practiced.

I wrote two narrative letters to a seven-year old boy who was challenged by Anger. After he had received the first letter, he bounced into the office, acknowledged receiving the letter, and shared that Anger did not come on his trip to Mexico because it was not invited; instead it was locked up in jail at home! This externalization allowed us to talk about Anger, its traits, who it likes to bug the most, and when. It provided opportunity to explore Anger without labelling the child and by locating the problem outside of him. The child was much more willing to talk about the problem when it was separated from him. In fact, this energetic boy sat and calmly told me about Anger for over 5 minutes! After receiving the second letter, he again externalized anger. This time it was by drawing Anger by on the whiteboard; including the sounds it makes – “ggrrrrr”. These examples provided me with confidence in the benefits of using narrative letters to support the therapeutic process (Marner, 1988). They also reinforced the usefulness of letters beyond the walls of the therapy room (Fox, 2003). Please see Appendix A.

3.3.2 CBT Integration

Various cognitive behavioural techniques were integrated and used with all eight clients throughout my 12-week practicum. Use of reframing techniques, addressing “automatic negative thoughts” (ANTS) (Children’s Anxiety Institute, n.d.) and inspiring replacement with “positive energizing thoughts” (PETS) (C. Tarko, personal communication, March 9, 2020), integrating mindfulness and relaxation techniques, encouraging self-monitoring, and education via bibliotherapy and videos allowed for positive collaboration during each session. I was curiously intrigued when a 10-year-old girl attended her first appointment and brought along her “Mood
Tracker”. She shyly shared it with me near the end of our first hour together. She explained how she had been colourfully tracking different feelings of frustration, anger, annoyance, fear, and sadness. It was amazing for me to learn, after less than one hour with this young lady, how keenly interested she was in self-improvement. Throughout our time together, CBT guided much of our work with continued self-monitoring (homework) and the introduction of relaxation, mindfulness and activity scheduling. Grounding and breathing techniques adopted from IBP and SE professional development opportunities I attended, were also used with this client and several others.

Analogies were also helpful and fun to use with clients and families. A 10-year-old boy with whom I shared a video explaining the ADHD “race car brain with bicycle brakes” analogy (Hallowell, 2011), proudly relayed that he has an amazingly fast brain and it’s ok to receive help to build the strength of his brakes. He explained how important it is to be able to use his brakes on corners, or else there will be a big “spin out” or “crash”. I could see him visualize this understanding as he spoke. During this family therapy session, the client’s five-year-old sibling referred to the family as the “pit crew” of helpers. This playful analogy was easy for all family members to understand, and they all agreed that it “made sense”. This analogy was developmentally appropriate, respectful, playful, and engaging.

Additionally, an energetic nine-year-old boy with a diagnosis of ADHD, whose family was greatly challenged and frustrated with an unpleasant morning routine, agreed to do an experiment. He willingly and excitedly agreed to be a detective and observe how the family’s morning schedule and relationships were impacted by a new approach he would take. Using the work of Gaete et al. (2020), which extends Dr. Karl Tomm’s work on patterns in interpersonal interactions, some of the family’s pathologized interpersonal patterns (PIPS) were
acknowledged. Through conversation with the child and his mother, transforming interpersonal patterns (TIPS) were identified and practiced via role play. Both the mother and child were encouraged to recognize the healing interpersonal patterns (HIPS) (by selectively noticing if and how the morning routine was becoming more enjoyable and manageable by all the family members) brought about by the experiment. One week following the implementation of the experiment the child and his mother reported that co-construction of this mutually acceptable version of their relational preferences elicited a significant improvement in the family’s relational patterns. The child and his family were ready for intervention; and through involvement with and assistance from the primary parent, positive changes were implemented. Both the child and parent reported that calmer and more manageable mornings contributed to more relaxed and enjoyable days. They reported that successful mornings increased from one or two (roughly 20% of the time) to five or six days (roughly 79% of the time) out of seven! Due to my practicum ending, I was not able to witness the longevity of the HIPS. However, this family experienced positive change that would surely assist them going forward.

As revealed through the examples provided, creative and imaginative therapeutic interventions and responses were facilitated through the use of narrative and family therapy and CBT techniques. Implementation of trauma-informed principles and awareness of developmental stages assisted in the effective use of these techniques with children and their families. The use of an eclectic mix of theories and techniques supported the development of enlightening conversations and meaningful collaboration. In addition to being fun and playful, these approaches assisted in meeting the clients where they were at.

Identification of these diverse clinical skills accentuates the suitability of the clinical playground metaphor. Though children may have the same diagnosis and similar challenges,
each person requires an individual and personalized treatment plan. Enhancing my professional knowledge and clinical skills allowed me to work and play with each client in distinct and unique ways. It also helped me gain a deeper appreciation for and understanding of the multi-disciplinary approach of CMHS.

3.4 Groups and Tours

Throughout my practicum, I had the opportunity to learn about services and programs offered by the diverse multi-disciplinary team of professionals at CMHS. I was fortunate to join a number of groups (focus group, parent group, and two different children’s groups) as well as go on a few tours (Early Learning Centre, Children’s Therapeutic Classroom, Saskatoon Children’s Centre). While all the groups and programs were different, the commonality between them was that they all follow evidence-based practice and employ multi-disciplinary professionals to meet the needs of the young clients they work with. Experiencing these groups, programs, and services exposed me to the wide range of support that is available to children in Saskatoon and area, who are experiencing mental health concerns.

3.4.1 Groups

The focus group was a new initiative that was conducted in response to the need for receiving more client feedback as recommended by both the Saskatoon CMHS department manager and the health accreditation board. Fourteen parents/caregivers who responded to a poster advertisement and/or clinician invitation, participated while their children were provided with care in an adjoining room. Questions regarding experiences related to services at CMHS were posed and much dialogue ensued. My role was to record participant responses. This focus group revealed that having a time and space to meet with other parents with children with mental health concerns was important and meaningful to participants. While it was surprising to learn
that participants said they are “ok” with the long wait times, it was informative that they appreciate having the opportunity to connect and provide feedback. Information and data gathered from this focus group will be shared with the staff, clients and the SHA accreditation body. CMHS hopes to conduct focus groups more often in the future.

The Incredible Years® Parenting Program was facilitated by two CMHS employees (a clinical social worker and a provisionally registered psychologist) and me. It was delivered to a group of parents whose children currently receive therapeutic services at CMHS. This intense parenting program is recommended for treating childhood behaviour problems (Children’s Health Policy Centre, 2016). It is typically delivered over 12-20 two-hour sessions, focusing on strengthening parenting competencies and fostering parent involvement in children’s experiences (The Incredible Years, 2013). The goal is to promote wholistic wellbeing and reduce conduct problems. Six parents attended the first three weeks of this program. Conversations related to experiences with schools, “battles”, parental self-blame, and co-regulation and attunement were engaging and promoted self-reflection. Parents were exposed to the importance of being emotionally available to their children as well as having a team of support. Using narrative and cognitive behavioural techniques, parents were encouraged to counteract existing stories by intentionally creating positive experiences and connections with their children. Use of the Incredible Years Parenting Pyramid® (The Incredible Years, 2013) formed the foundation for the group. Its emphasis on the liberal use of problem-solving, attentive communication skills, empathy, attention and involvement, provided a framework which parents could understand and visually refer to. The suggestion of selective use of consequences (i.e. time out, loss of privileges) resonated with many of the participants. Unfortunately, due to the COVID-19 pandemic, this group ended before the full 10-week program was delivered.
Friendship Group (FG) and Social Thinking Group (STG) are two separate eight-session groups for children that were co-facilitated by two CMHS employees. FG was a program for children ages 5-8 years who struggled with peer relationships. This group provided children with the opportunity to develop cooperative behavior alongside social, emotional and inter-personal problem-solving skills. The STG, directed towards children ages 8-11 years of age, addressed deficits in emotional and sensory regulation, impulse control and social cognition. It was designed to help children understand how their behavior affects others as well as learn what tools they can use to manage their feelings and behaviours. My involvement in both groups included co-teaching, responding to, modelling and coaching the children. I asked and answered questions, recorded participants’ ideas about group rules on a flip chart, assisted in role plays, provided feedback regarding participation in the group, and helped teach different cooperative games. I met with the facilitators before each session started, and debriefed after each session ended. I perused the facilitator binders and contributed to decisions regarding books that would be used, games that would be played, and when snacks would be distributed. Incorporation of CBT and play therapy techniques provided opportunities for participants to learn about and experience the interplay of thoughts, feelings and behaviour. One of the facilitators in the STG introduced the CBT concept of ANTS (automatic negative thoughts) (Children’s Anxiety Institute, n.d.) and her thoughts on transforming them into PETS (positive energizing thoughts). It was an easy and fun way to capture the children’s attention and promote understanding about how thinking affects behaviour. It is a concept that I later shared with a child on my caseload. Group programming provided the children with increased opportunity to build emotional literacy, practice what they were learning, as well as observe feedback given to others. It also
allowed me to interact and learn from other members of the CMHS team. Unfortunately, these programs were also forced to end early due to the COVID-19 pandemic.

3.4.2 Tours

Accompanying a provisional psychologist working with Behavioural Consultation Services (BCS) to an Early Learning Centre allowed me to observe how mental health supports are provided to children under five years of age who attend daycare. Working in conjunction with educators and parents, self-regulation and emotional literacy were highlighted to be common primary concerns and goals for children accessing BCS services. Observations of and recommendations for the target child’s interactions, language, behavior and play, were made by the consultant. Provision of these services is the SHA’s response to the daycare community’s request for support (R. Bell, personal communication, January 10, 2020). I learned that challenges encountered in this role include the high turnover in daycare staff, increased number of early learning spaces without an increase in staff, and balancing the role of consultant vs clinician.

The Children’s Therapeutic Classroom (CTC), which was first opened in 2004, is offered at Roland Mitchener School for children age six to 12 who are experiencing significant mental health issues (Q. Lambe, personal communication, February 6, 2020). Through a partnership between the Saskatoon Public Schools, Greater Saskatoon Catholic Schools, Prairie Spirit School Division and SHA, CMHS supports students by providing short-term assessment, individual programming, and intervention that involves the child's parents/caregivers (S. Nadon, personal communication, Feb. 24, 2020). This program is staffed by multi-disciplinary professionals (including a teacher, community mental health nurse, and educational assistants) and supported by psychiatrists, psychologists and other professionals as needed and available (i.e. Parent Aide,
The focus of the classroom is coping and regulation. Up to eight students with complex mental health needs can be admitted to this program. Duration of time in this classroom is based on individual needs. The integration of CBT, self-regulation, mindfulness and play facilitates success that can be transferred and implemented into a regular classroom setting, with the goal of having the child return to their home/neighbourhood school.

The Saskatoon Children’s Centre (SCC) is a division of the Saskatoon Police Services (SPS) that works in partnership with the Ministry of Social Services (MSS) to provide seamless, trauma-informed investigation by trained professionals in reports of children who are victims of or witness to crime. They also connect identified children experiencing difficulty related to the reported event, to counselling. The SCC was created in the mid 1990’s in response to intense criticism regarding the interviewing and investigative process of suspected child abuse in a famous court case known as ‘the Martensville Scandal’ (The Fifth Estate, 2003). The SCC uses the Child and Youth Advocacy Center model (Shaffer et al., 2018) as a guide to develop and support their service delivery. This model brings together various sectors and involves a coordinated and integrated multi-faceted response that is client centered, trauma informed, developmentally sensitive, and minimizes revictimization. It aims to be efficient and productive while also providing education, outreach, prevention, research, and policy development (Shaffer et al., 2018).

In 2012 CMHS joined the SCC partnership in a project funded by Justice Canada. The funding provides access to a senior social worker (.6) who is trained in trauma-informed practice and trauma therapy to support the children and families that are involved with SCC. This was a response, in wake of the Martensville scandal, to the significant shift in the availability of counselling services to children if they were identified as victims and involved with police. This
partnership project has made a significant positive difference to children and their families affected by abuse and violence as it is voluntary and connects them with multiple supports in a single location (B. Afseth, personal communication, February 5, 2020). It reinforces the need for and value of multi-disciplinary partnerships and collaboration when children have been exposed to abuse, sexual violations, violence, and severe neglect.

Exposure to various groups and programs offered in partnership with SHA-CMHS allowed me to witness many different avenues in which children’s mental health is supported in Saskatoon. Programming at CMHS, in schools, alongside police and the MSS, as well as in various community-based settings (including early learning centres and SCC) is available and well accessed. While continued long wait lists demonstrate the need for additional staff and services, the diverse nature of programs and services that are offered through CMHS meet many of the challenges children and families with mental health concerns encounter.

These programs and services help extend the metaphor of the clinical playground beyond the walls of the building I worked in. The “CMHS playground” exists in various locations, buildings or, metaphorically speaking, “parks”, throughout the city. Daycare centres, schools, public and professional buildings house and deliver various programs and services that are offered by or in conjunction with CMHS. Exploring various extensions of the CMHS playground further diversified my knowledge of and appreciation for this field of work.

3.5 Professional Development

Throughout my 12-week practicum I engaged in numerous professional development opportunities. I attended three different workshops, was present at a variety of in-services, was provided with numerous pieces of literature to review, toured different programs, participated in individual and peer clinical supervision, and enjoyed a half-day self-care retreat. I was
introduced to integrative body psychotherapy (IBP), narrative therapy, TIC, somatic experience (SE), play therapy, and different CMHS satellite programs. I also got to connect and build relationships with CMHS staff during a fun and relaxed self-care afternoon. In accordance with Value 6, Competence in Professional Practice (CASW, 2005a), my practicum experience allowed me to be fully invested in increasing my professional knowledge and skills, as well as apply them to my practice. These growth-related opportunities allowed me to recognize, expand, and work within my areas of competence, as well as offer my clients the highest quality service.

All of these professional development opportunities allowed me to integrate new perspectives and techniques in my practice. I learned about many commonalities that exist between IBP and the SE method. Both of these models integrate grounding and breathing techniques along with expanding one’s “window of tolerance” (Gill, 2017). I have personally used some of these methods, so it was natural for me to share them with my clients. For example, I taught and modeled different aspects of breathing (deep belly breathing, feeling the rise and fall of the belly while breathing, noticing dizziness or lightheadedness when breathing deeply). Whether sitting in a chair or lying on the office floor, having my eyes open or closed, or pretending my fingers were flowers (breathe in, smell the flowers) or candles (breathe out, blow out the candles), clients often readily joined me in trying different breathing techniques. Playful approaches to teaching calming and breathing techniques often elicited curiosity and a willingness to try. Although children were always provided with the option to participate, when the child’s parents and I were encouraging and took part in the activity, clients often willingly became involved too.

Attending a two-day workshop on narrative therapy allowed me to interact with other learners, ask questions and acquire more knowledge about and experience with this framework.
It confirmed my interest in continuing to learn more about this model that fits well with my personality. Gaining information from a workshop on trauma and the environment, enhanced my overall knowledge of TIC. It prompted me to be mindful of how my office was configured in addition to increasing my awareness of how CMHS aims to work from a trauma-informed perspective. Receiving individual supervision on a weekly basis and assembling with colleagues to attend peer supervision and consultation, expanded my knowledge, provided me with a multi-disciplinary perspective, and allowed me to gain a new appreciation for colleagues and their knowledge. The rejuvenating and invigorating self-care retreat reminded me of the importance of connecting with colleagues, having fun, and taking care of one’s self. Touring various programs, two of which were highlighted at staff in-services, allowed me to see how a diverse set of models, techniques, and perspectives are used within the vast array of services delivered through CMHS.

These professional development opportunities augmented the knowledge I gained from the direct therapy I provided and supervision I received. They were interesting, inspiring and will allow me to expand my service delivery beyond the CMHS playground. Professional development opportunities also provided me with occasions to meet and connect with other human service providers. This learning served as a good reminder that on-going education and training is not only important but can also be energizing and fun.
Chapter 4: Values and Ethical Considerations

Social work values and ethical considerations greatly influenced the way I provided services to children and families accessing CMHS. As I gained and integrated knowledge about narrative therapy, CBT, child development and principles of TIC into my practice, I became more aware of how these modalities and principles align with social work ethics, values, and standards of practice. Following an overview of how these approaches integrate values into social work practice, examples of ethical values and consideration are shared.

Narrative therapy acknowledges power dynamics and views the client as the expert in their lives (Madigan, 2007). It privileges client knowledge, promotes respect, externalizes problems, and avoids labelling (Freeman et al., 1997; Kelley & Smith, 2015). Guided by questions, answers, and reflections, narrative therapy acknowledges personhood, development, socio-cultural factors, and oppression (Freeman et al., 1997; Madigan, 2007; Marsten et al., 2016). Thus, narrative therapy aligns with the CASW Code of Ethics (2005a). It parallels Values 1 and 2, Respect for Inherent Dignity and Worth of Persons and Pursuit of Social Justice (CASW, 2005a), as it upholds the right to client self-determination, respects diversity and decision making, and challenges injustices. It is compatible with Value 3, Service to Humanity (CASW, 2005a), in that it promotes individual goals and development while acknowledging and aiming to minimize power differentials. It harmonizes with Value 4, Integrity in Professional Practice (CASW, 2005a), by encouraging clinicians to be accountable, set clear boundaries, and develop honest and reliable relationships with clients.

CBT also aligns with social work values, principles and the CASW Code of Ethics (2005a). Its evidence base, collaborative nature, and focus on empowerment make it an important model of treatment for emotional and behavioural disorders (Vonk and Early, 2015).
Its versatility and adherence to core social work values and principles ensures a client-centred process that promotes health and well-being, aims to prevent the progression of problems, and is multi-modal and multi-contextual (Vonk and Early, 2015). Like narrative therapy, CBT aligns with Values 1, 2, and 3 (CASW, 2005a). Its inherent diverse nature also encourages the pursuit of Values 4 (Integrity in Professional Practice) and 6 (Competence in Professional Practice).

Child development and principles of TIC also align with the \textit{CASW Code of Ethics} (2005a). They take into account the prevalence of early traumatic experiences and their association with psychological and physical health difficulties later in life (Butler et al., 2011). The principles of TIC, which include safety, trustworthiness, choice, collaboration and empowerment, also suggest an awareness of triggers and reactions to triggers (Butler et al., 2011). Like narrative therapy and CBT, child development and principles of TIC align with CASW (2005a) Values 1, 2, and 3. They include the provision of resources, services and opportunities to benefit clients and protect them from harm, reduce barriers, and expand choices. Both frameworks provide special regard for the most vulnerable. Applying the principles of TIC eases the integration of social work values with understanding the involvement and impact of development, violence, and victimization in mental health concerns (Butler et al., 2011).

4.1 Examples

The \textit{CASW Guidelines for Ethical Practice} (2005b), which is a companion document to the \textit{CASW Code of Ethics} (2005a), outlines social workers’ ethical responsibilities to clients, in professional relationships, to colleagues, in the workplace, to the profession, and to society. I integrated my ethical responsibilities with these guidelines, in numerous different ways.

First, I intentionally worked to maintain the best interest of my clients. I did this by acknowledging their unique identities, family composition and experience, honouring their
cultural background (through acknowledgement and questioning), letting them lead conversations, and collaborating with others (school staff and colleagues). I thoroughly explained my student status to all clients prior to receiving valid informed consent to work with them. As all of my clients were children under 12 years of age, I explained confidentiality, informed consent, and note-taking to both the children and their parents. I was conscious of maintaining client privacy and confidentiality by ensuring the office door was closed during each session, consultation with my supervisors and peers maintained client confidentiality, files were stored in a secure double-locked location at the end of each day, and that clients were aware of the limits of confidentiality. Prior to commencing therapeutic services, and throughout my practicum, all clients were made aware and reminded that our therapeutic relationship would terminate upon the completion of my practicum (late March 2020). Near the completion of my time at CMHS, one family decided to terminate services as they felt their goals had been met. Another family received a referral for family therapy at CMHS. The files of the other six clients were returned to the wait list, for the next available clinician. These examples provide evidence to the integration of the CASW Code of Ethics (2005a) in relation to ethical responsibilities to clients, to the workplace, and to the profession.

Second, I recognized and declared a conflict of interest before meeting with a few potential clients. While I did not have a close personal relationship with any of these potential clients, I knew them from other areas in life and did not feel comfortable starting a professional relationship with them. I discussed this issue with my supervisors and was supported to resolve the issue by refraining from taking on those files. I was encouraged to trust my professional judgement and discretion; especially because there were several other client files on the wait list. My decision to decline those files was validated after I saw the parents of potential clients both at
CMHS and in the community. It reinforced the importance of ethical responsibilities in professional relationships. It also helped me consider how fortunate I was to have a practicum placement in a mid-sized city that allowed minimization of conflict of interest and dual or multiple relationships.

Third, I became acutely aware of ethics when I encountered an active file with which custody and access issues were becoming a potential issue. CMHS does not work with clients who have active files before the court (B. Afseth, personal communication, January 6, 2020). This is to ensure that any issues related to custody and access do not interfere with the services provided by CMHS. The custody and access matter that arose was brought to my attention after one parent called to inform me that lawyers were in the process of preparing legal documents for a separation agreement. After receiving this information, I consulted with my supervisors, the CMHS Policy and Procedures, and CMHS Work Standard for Referrals Pertaining to Custody and Access Issues. Through supervision I was coached to remind the parent who called in with the information, about the custody and access form that had already been signed, and to re-iterate that CMHS works to function in a family context, not isolation. I shared this information with the parent and informed them that the child’s file may have to be suspended as the court process unfolds, but “continuation of services may be assessed based on the mental health needs of the child” (SHA, 2016). As my practicum was nearing completion when this issue arose, I ensured this client’s file included information that would guide the next clinician working with this child and her family. I recorded my belief that despite her parents’ conflict, the client was still in need of continued mental health support.

These examples expose the ethical dilemmas I encountered during my 12-week practicum. They demonstrate the importance of integrating ethical awareness and practice in
every professional encounter. Ethical values and considerations further reveal how clinical outcomes on the CMHS playground can be impacted. Adherence to the values of honesty, integrity, respect, confidentiality, and competence in professional service to humanity (CASW, 2005a) can only enhance effective delivery of services within this unique and playful field.

4.2 Reflection

Integration of ethical values and principles is a key aspect of both social work and respectful daily living. I continually strive for excellence in my professional and personal life, and aim to uphold respect, practice and live with integrity, enhance my competence and skills, and pursue social justice in my service to this world. The values of dedication, maintaining confidentiality, fulfilling responsibilities, and maintaining and advocating for safety, align with being a just and caring member of society. For me, ethical values and principles are an extension of who I am as a human being. The *CASW Code of Ethics* (2005a) and *CASW Guidelines for Ethical Practice* (2005b) are necessary and valuable resources that provide guidance and accountability for the work all social workers do.
Chapter 5: Conclusion

The emergence of the COVID-19 pandemic occurred near the end of my time at CMHS, having some impact on my practicum experience. COVID-19 is a respiratory illness that is transmitted in the same fashion as influenza, but caused by a novel coronavirus (Government of Canada, 2020). As the SHA acquired new information regarding this unknown virus, daily e-mail communications regarding its transmission, treatment, prevention and ways to protect oneself, were received. Illness prevention and symptom management were the primary goals of SHA and CMHS as the virus evolved and my practicum ended. Following the direction of SHA, CMHS quickly implemented various measures to minimize the impact of the virus on staff and clients. The most significant change included beginning to work with clients remotely.

Fortunately (for me), changes that were implemented during my last two weeks at CMHS allowed for minimal disruption to the closure and transfer of the files I was working with. While increased cleaning and sanitizing measures, physical distancing, and self-isolation resulted in fewer face-to-face meetings, I was able to complete my final client counselling sessions by telephone and FaceTime. I responded to the quickly changing situation by researching on-line and telehealth resources and options. I was fortunate to learn about tele-play therapy through the on-line teachings of child therapists Wolfe and Danhoff (2020) and social worker and play therapist Tammi Van Hollander (2020). I learned that there are many considerations regarding virtual and telephone appointments. There is a need to address issues related to appointment scheduling (e.g., flexibility allowing for meetings to take place in the car or while at another person’s home), distractions (e.g., siblings, pets, toys, e-mails), interruptions (e.g., telephone or door bell ringing), and security and confidentiality concerns (e.g., HIPPA compliance, multiple phones accessible for one line). They also highlighted the benefits of using new and familiar
games, books and charts, client’s and therapist’s still being able to see each other despite not
being in the same room, and having parents/caregivers help children prepare for sessions by
having an available and accessible quiet space which they can use when meeting with their
counsellor. These practical strategies were ethical, useful, and helpful. I will surely resort to
using these teachings as I move forward in my social work practice.

In addition to talking with families and providing information about the increasingly
concerning virus, I was able to implement a number of the aforementioned suggestions (e.g.,
read a book, play a game, show the same feeling charts as used during in-person sessions,
encourage the child to use their favourite fidget, and/or show their family pet) gained from on-
line learning. While this unexpected pandemic forced schools, businesses, churches, retail stores,
and daycares to close, it also required me to grow in new and unexpected ways that I will be able
to carry forward and use in the future. I gained valuable knowledge and experience with
providing remote therapeutic services, implementing regular sanitizing practices, and being
flexible with changing times and circumstances. I was also reminded about the importance of
having patience with myself, clients, CMHS, SHA, the university, and everything else.

The COVID-19 pandemic did not “shut down” the CMHS clinical playground; instead, it
required many non-voluntary adaptations and changes to be made to service delivery and access.
Face-to-face, in-person appointments were halted and remote (video and telephone) sessions
were initiated. All groups were indefinitely suspended. Schools, classrooms and daycares were
shut down and access to services became even more limited. Similar to the “caution tape” that
obstructed and discouraged citizens from using community playgrounds in Saskatoon, I was
instructed to refrain from attending the CMHS “playground” for the final three days of my
practicum. As the files of the clients I had been working with had already been closed or transferred, I completed my final practicum hours from home.

In summary, my practicum experience at CMHS provided me with a wide range of opportunities that greatly enriched my knowledge base and enhanced my skill set in direct social work practice with children with mental health concerns. The “clinical playground” analogy truly resonated with me and proved to be a playful and suitable representation for my experience at CMHS. The numerous and diverse programs, opportunities, and pathways that CMHS encompasses, provided me with space and support to use my imagination and creativity (with assessments, therapy sessions and putting together a Social Work Week display), experiment (with narrative, CBT, play and family therapy techniques), as well as “play” both individually (individual therapy, immersing myself in literature, supervision and reflection) and with others (peer supervision, team meetings, family therapy, group therapy and program tours). Focusing on the use of a narrative approach, and simultaneously learning about CBT, child development and principles of trauma informed care, allowed me to develop an understanding of multiple frameworks and how they align with my personal and professional values and ethics. Daily interactions with multi-disciplinary professionals placed within me a deep appreciation for and interest in working as a member of a close knit multi-disciplinary team.

The vast array of programs and services offered through CMHS exposed me to theoretical frameworks and social work practices and techniques that I had not previously been exposed to. This clinical setting was a stimulating environment that integrated evidence-based practice with ethics, standards, and individual clinician creativity and autonomy. Overall, this rich practicum experience facilitated fulfillment beyond my practicum goals and objectives. I also gained more experience balancing growth and learning. The fun and self-care I enjoyed on
this playground makes me excited about the potential of returning and continuing to play and learn!

The following two quotes resonate with me and succinctly summarize my personality, practicum experience, and this practicum report. In Steven Madigan’s (2007) words:

I think you can teach people all the narrative skills, or whatever, you want. But you can’t teach them compassion and love. And my sense is that therapy needs to be based around an idea of therapeutic love as opposed to therapeutic violence. And you can’t teach that. (1:20 48 – 1:21 10 / 3-17).

Eric Hoffer (n.d.) said, “It is the child in man that is the source of his uniqueness and creativeness, and the playground is the optimal milieu for the unfolding of his capacities and talents”. I truly and deeply adore and appreciate children. My clinical practicum experience on the CMHS playground allowed me to share my therapeutic love and build my social work capacities in a setting that was invigorating and matched my personality and interests.

When I secured my practicum placement at CMHS I knew I was embarking on a learning journey that would be close to my heart. Loving, accepting and working with children and families with mental health concerns is exactly who I am and what I want to do. This experience was a perfect fit for me to be myself and grow as a social worker.
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Appendix
Dear [blank]

Hello again! How are you today? It was so nice to see you last week and hear some stories about your adventures in Mexico. I’m glad you had a wonderful trip and arrived home safely!

I’ve been marveling (that means thinking and smiling at the same time 😊) about how relaxed and calm your body, voice and energy were last week when you, [blank] and your mom came to meet with me! I noticed how you carefully drove the plasma car to the office and playroom! How you kindly shared and played in the Kinetic Sand with [blank]. And how willingly you brought the accordion chair to the office after you noticed your plasma car had been used by someone else! Way to work with Calm and Self-Control! They are helpful companions to have!

I was especially intrigued (that means curiously interested 😊) in learning that Anger did not join you on your trip because he was “not invited...as he was locked up in jail at home”. Wow! How did you do that? Now that you are back at home, is Anger where you left him? Still locked up in jail? How would you know if he was “on the loose”? You mentioned that you and [blank] have a special card trick that can help keep Anger away. Have you had to use it lately? Could the trick help you “tackle and tame” Anger if he was on the loose? How? Would you be willing to teach the trick to others so they can help you outsmart Anger and welcome Calm? I’m so excited to hear your thoughts!

Here is the picture you drew of Anger. Feel free to bring another one to our next appointment. The better we can get to know Anger, the better we can work together to tame it!

Keep being the playful, energetic and kind person you are! Please say hi to your family members from me too! See you on Friday March 13, 2020 at 1:30pm!

😊

Kristin