A Reflective Review of a Practicum Placement

at the Regina Mental Health Clinic,

Regina Qu'Appelle Health Region

A Practicum Report Submitted to the Faculty of Social Work

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By

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Introduction

The following is a reflective paper that chronicles my practicum experience at the Regina Mental Health Clinic from September 3, 2013 to February 20, 2014. My primary objective of the practicum was to acquire graduate level social work knowledge of severe and persistent mental illness and the supports and programs available to clients and their families. This paper follows the Direct Practice Framework recommended for Integrative Practicum Reports as outlined by the University of Regina, Faculty of Social Work. The framework includes the following headings: Ideology, Theory and Models of Practice, Values, Ethics, Relationships, Strategies, Skills and Vision. This paper is a reflective review of my observations, experiences and acquisition of knowledge, along with the integration of theoretical and practice implications experienced during my practicum.

1.1 The Rationale for this Practicum

Prior to starting my practicum I had been employed with the Regina Mental Health Clinic for a period of two years in the Adult Therapy Program. This program provides mental health services to individuals affected by mental disorder, severe stress or other problems in living. Both physician referrals and self-referrals for service are mostly for depression, anxiety, eating disorders, severe stress reactions or adjustment difficulties. Service is also available for individuals dealing with issues related to emotional, physical, or sexual abuse. My employment in this program was focused on providing individual counselling to this clientele. I also co-facilitated the Dialectical Behavior Therapy (DBT) Skills Training Group during this time. My employment in the Adult Therapy Program was quite fulfilling and I had the opportunity to perfect my counselling skills and also learn DBT and to facilitate groups.

I started considering my options regarding my field practicum in the spring of 2013. The Regina Qu'Appelle Health Region had numerous exciting practicum opportunities to offer. Given that I was employed in mental health, an area that I am very passionate about, I felt that it was of great importance to broaden my knowledge in regards to severe mental health issues. I had limited knowledge about service delivery in this area and, I felt that further learning about severe and persistent mental health issues would be instrumental in my future social work practice.

The Rehabilitation Services Program at the Regina Mental Health Clinic provides long term case management for individuals affected with severe and persistent mental health issues. This was an attractive and exciting field practicum opportunity because it would provide extensive learning plus focus on the recovery model of case management. An important

consideration was that although the Rehabilitation Program was separate from the program I was employed in, I was familiar with the agency policies and how it operated. I also knew the staff, which I thought was an advantage as I would not have to establish new relationships and could concentrate on immersing myself in the practicum experience.

I consulted with both the clinic director Fiona O'Connor, and the Rehabilitation Services Program manager Cathy Keenan-Arp regarding a possible field practicum opportunity. I was fortunately accepted, and we agreed that the practicum would commence on September 3, 2013.

1.2 Learning Goals

My learning goals were developed to both meet my practicum objectives and also to adhere to the MSW guidelines for a practicum report. My primary objective of this practicum was to acquire graduate level social work knowledge of severe and persistent mental illness and the supports and programs available to clients and their families. The following outlines the goals of my practicum along with a brief general overview of how the goals were met.

- *To learn about severe mental health disorders with adult populations; become familiar with treatment methods; policies; and procedures utilized in the Rehabilitation Program at the Regina Mental Health Clinic and with the Mental Health Services Act.*
- *To become familiar with the research and literature on adult mental health disorders and treatment methods.*

These goals were met by reading extensively about mental health disorders, and reading the *Mental Health Services Act* and Policies and Procedures utilized in the Rehabilitation Services Program. I also acquired knowledge of severe mental health disorders by observing case managers and directly working with these clients of the Rehabilitation Services Program. I

learned more about various treatment methods by reading the current literature, and sitting in on consultation with psychiatrists and having the opportunity to observe them in session with their clients. I also attended an orientation session and an in-service with the pharmacist to learn about pharmacology and what drug treatments were available to clients. In addition, I reviewed the literature to learn about counseling theories utilized in the Rehabilitation Services Program, such as Solution-Focused therapy, Strengths Based Therapy, Client-Centered Therapy, Choice Therapy, Cognitive Behavior Therapy and the Recovery Model.

- *To learn about the Supportive Residential Placement Program; Vocational Program; Family Education and Support; Injection Medication Clinic; Financial Services and Case Management available to clients.*

This goal was met by spending time in all of the Rehabilitation Program services and learning about the services that they provided to clients and families. The Supportive Residential Program provides placement and consultation to Approved Home Operators, and the Phoenix Residential Society. Referrals to Residential Services and Approved Homes are routed through the Residential Assessment Coordinator who facilitates placements. Placement into Approved Homes or the Phoenix Residential Society is facilitated when clients are unable to live independently and require support. The Residential Assessment Coordinator also provides licensing and monitoring of the Approved Homes.

The Vocational Program offers rehabilitation planning focusing on the vocational (as appropriate), recreational and social needs of the clients. Referrals are made to the most appropriate resource in the community, enabling the client to achieve their highest level of independence and potential.

Family Education and Support Services are provided by the client's case manager. In

addition, groups are offered to clients and their family, and community members seeking education on mental illness. The groups provide education on living with a mental illness and resources available to the client and their family.

The Injection Medication Clinic is staffed by psychiatric nurses and provides service to clients that require injection medication, but do not require case management services. Clients that are case managed by psychiatric nurses receive their injections by their worker at their appointment. The rational for injection medication is that it is a simple way of administering medication. Some clients in the program do not have the capacity to manage their medication and by receiving their medication through injection makes it possible for them to receive the pharmacological treatment they require in a safe, consistent manner. Clients that are placed on Community Treatment Orders (CTO) are required to receive their medication through injection to ensure compliance with treatment. "A CTO is an order issued by a physician which allows the individual to receive care and treatment in their own community, which is less restrictive than being detained in a psychiatric facility. A CTO is for those who have had repeated psychiatric admissions and who do not voluntarily engage in outpatient follow-up" (Canadian Mental Health Association, 2014, p. 1),

The Financial Support Services Program provides both emergency and ongoing assistance under the auspices of the Saskatchewan Assistance Plan (SAP) and Saskatchewan Assured Income for Disability (SAID) for clients of the Rehabilitation Services Program that require financial aid. The focus of the Financial Support Services Program is to assist clients in maintaining as much stability as possible through flexible and responsive case administration. The financial worker works closely with the case manager to ensure collaboration in following through with the rehabilitation plan.

Case managers assist individuals in accessing appropriate mental health services and achieving optimal functioning and participation in the community. The case manager facilitates the coordination of care and ensures that clients actively participate in decision-making. The case manager provides assessment, counselling, medication management, family support, planning, coordination and referral, monitoring, patient education, outreach and advocacy.

- *To learn to complete Community Treatment Orders for clients of the clinic.*

This goal was met by reviewing the Mental Health Act and learning about Community Treatment Orders (CTO) and how they are utilized. I initially observed case managers make arrangements for a CTO renewal which entailed preparation of the legal documentation and ensured coordination of the client having to meet with two psychiatrists on the same day to provide assessment and to complete and sign the CTO documentation. During my placement I attended a few CTO renewals of clients and I also facilitated the renewal of a CTO of a client that I had been assigned during my practicum. I had an opportunity to attend a Review Board hearing for a client of the Rehabilitation Program who was found Not Criminally Responsible (NCR) and required a CTO renewal.

- *To gain knowledge about services in the community available to support adults and their families who live with mental illness.*

This goal was met by researching organizations that could provide support to both clients and their families. I made arrangements to visit agencies such as the Canadian Mental Health Association, Schizophrenia Society of Saskatchewan, Mental Health and Addictions (Brief and Social Detoxification Services), Autism Resource Centre, Mobile Crisis Services and services offered by the Regina Mental Health Clinic such as the Crisis Response Team and Transition

Care Team. I also visited agencies that provide emergency/long term housing such as Carmichael Outreach, Salvation Army, Phoenix Residential Society, YMCA, YWCA and Regina Pioneer Village.

- *To learn about the recovery model in order to provide recovery orientated care.*

This goal was met by completing a literature review on the recovery model and learning about recovery oriented care. Utilizing the recovery model in practice was often discussed in morning meetings as well as in monthly team meetings. During team meetings a designated case manager would share a recovery story of one of the clients. These stories of recovery were very helpful to understand how the recovery model could be applied in different scenarios. I also engaged in discussions during debriefing opportunities with case managers as well as my field supervisors regarding recovery oriented care.

- *To provide a critical analysis of mental health services and gaps in services for adult clients and their families living with mental illness.*

This goal was met by shadowing case managers in all of the Rehabilitation Program services such as the Supportive Residential Placement Program, Vocational Program, Family Education and Support (Bipolar Group), Injection Medication Clinic and Financial Support Services. I received a comprehensive orientation and was able to observe and participate with case managers in all of the programs. Some of the activities involved visits in the community to meet clients, liaising with other agencies and meeting with approved home operators. I believe that by spending time in all of the Rehabilitation Program services provided me with an opportunity to understand all of the services offered to clients and their families. The knowledge to provide a critical analysis of the services and the gaps in services that will be discussed further in this paper.

1.3 Regina Mental Health Clinic

The Regina Mental Health Clinic's roots go back to the establishment of the Psychopathic Ward at the Regina General Hospital in 1930. The Psychopathic Ward eventually became the Munroe Wing of the Regina General Hospital with a bed capacity of 33. In the early 1950's the Saskatchewan Mental Health Plan wished to develop regional psychiatric services across the province to end reliance of institutionalization of persons with mental illness. It was not until the *Mental Health Act* was amended in 1970 that formally organized out-patient programs were legislatively established. In 1975 the Munroe Wing moved to a wing of the Regina General Hospital and the Regina Mental Health Clinic was split-off to form a separate out-patient facility at 1942 Hamilton Street (Regina Mental Health Clinic Policies and Procedures, 2002). The Regina Mental Health Clinic provides a wide range of treatments and support services for adults (age 18 and over) who are having significant problems related to their mental health and well-being. Services are provided free- of- charge to Saskatchewan residents.

The clinic employs approximately seventy staff comprised of psychiatrists, a pharmacist, psychologists, social workers and psychiatric nurses. The clinic is also a teaching site and accommodates medicine students, resident psychiatrists, as well as social work, nursing, psychology and pharmacy students.

The programs offered at the clinic include Adult Therapy (individual counseling), Dialectical Behavior Groups, Alternatives to Sexual Offending Program, Alternatives to Violence Program, Rehabilitation Program, Psychiatry, Crisis Response Team and the Transition Care Team. Individuals can self-refer to the Adult Therapy Program and the Alternatives to Violence Program by contacting the Intake Department. Individuals experiencing a crisis can directly contact the Crisis Response Team for service. Physician and or psychiatry referrals are required to access the remainder of the programs.

The Rehabilitation Services Program is staffed by an interdisciplinary team that offers specialized services congruent with the goals and principles of psychiatric rehabilitation. The Rehabilitation Services Program is an integral part of a coordinated system of care that includes a number of district funded agencies. While the primary focus of the Rehabilitation Program is case management, other services offered include the following:

- Financial Support Services
- Medication Management
- Family Education and Support
- Vocational Services Program
- Assessment, consultation and support services to continuing care/special care facilities, placement and consultation services to Approved homes, and Phoenix Residential Society
- Licensing and monitoring of Approved homes
- Public Education

Program staff works with other community agencies to develop and maintain a wide array of psycho-social, residential, and vocational opportunities that address the complex needs of this client population.

2. Ideology

The goal of this Integrative Practicum Report was to acquire graduate level social work knowledge of severe and persistent mental illness and the supports and programs available to clients and their families in the Rehabilitation Services Program. The overarching ideology that guided this practicum was Recovery oriented care.

The Mental Health Commission of Canada defines the concept

of recovery as being built on the principles of hope, empowerment,

> self-determination and responsibility. In a recovery-oriented system, people who experience mental health problems and illnesses are treated with dignity and respect. To the greatest extent possible, they control and maintain responsibility for their mental health and well-being, and they make their own choices about which services, treatments and supports may be best for them, informed by the advice of professionals, as well as family and peers (Mental Health Commission, 2009, p. 12).

The Rehabilitation Services Program has the following mission statement: "To improve the quality of life of persons with severe and persistent mental illness by enabling them to function as independently as possible in the living, working, learning and social environment of their choice" (Regina Mental Health Clinic Policies & Procedures, 2000, p. 1). The mission statement includes a recovery vision. For many conditions recovery refers to cure, but for lifelong mental illness recovery refers to developing a valued sense of self and purpose within and beyond the limits of one's symptoms/disability. The recovery process is the foundation upon which rehabilitation services are built, with individuals being active and responsible participants in their own rehabilitation.

In the Regina Qu'Appelle Health Region (RQHR) initiatives have been implemented to deliver recovery oriented services for clients. One of the initiatives in the RQHR is community involvement in the Mental Wellbeing Steering Committee. The committee is comprised of representatives from organizations, agencies, education, and local agencies such as Mental Health and Addiction Services and municipal government. A Call to Action – A Collaborative Mental Wellbeing Strategy for Regina and Area is a community owned initiative. The goal is to improve the mental health and addictions service delivery system and to

collaboratively strengthen the current system. The Strategy is the collective commitment of many organizations that deliver services and/or advocate for mental wellbeing. The impetus for change is rooted in A Call to Action Toward Recovery & Well-Being - A Framework for a Mental Health Strategy for Canada (2012).

This report identifies strategic objectives underpinning the changes required at a nationwide systemic level. The goals are as follows: The first goal is that individuals of all ages who live with mental health problems are actively engaged and supported on their journey of recovery. The second goal is the prevention and promotion of mental health illness. The third goal is that the mental health system responds to the diverse needs of Canadians. The fourth goal is the importance of recognizing and supporting families in their role in promoting well-being and providing care. The fifth goal is for individuals to have timely access to appropriate programs, treatments, services and supports. The sixth goal is for program delivery to be grounded in evidence based practice. The seventh goal is for inclusion of individuals living with mental health problems and illnesses as valued members of society (Mental Health Strategy for Canada, 2012).

The objectives for the Mental Health Strategy for Canada Towards Recovery and Wellbeing compliment the Canadian Association Social Work Code of Ethics core social work values in the Pursuit of Social Justice.

> For CASW (2005), states that social workers believe in the obligation of people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity and to afford them protection from harm. Social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand

> choice for all persons, with special regard for those who are marginalized, disadvantaged, vulnerable, and/or have exceptional needs. Social workers oppose prejudice and discrimination against any person or group of persons, on any grounds, and specifically challenge views and actions that stereotype particular persons or groups. (p. 5)

2.1 Image of the Client

The clientele that receive services from the Rehabilitation Services Program are required to meet the program mandate. The rehabilitation clientele are defined by the following criteria: an individual experiencing a major mental disorder that has resulted in the significant loss of functional capacity in relation to primary aspects of daily life such as: personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, recreation, economic self-sufficiency and requiring ongoing psychiatric follow-up (Regina Mental Health Clinic Policies & Procedures, 2000). This also includes clients that have been placed on a Community Treatment Order and individuals that have been found not criminally responsible requiring case management. Clients that are referred to the Rehabilitation Services Program most commonly have diagnoses of schizophrenia or bipolar affective disorder. In the last year, there has been an increase of referrals for individuals that have a diagnosis of autism.

The image of the clientele of the Rehabilitation Services Program is reflective of society at large because mental illness spans across all age groups, ethnicities, genders and socioeconomic statuses. In this section I have provided statistical information for both Canada and Regina which illustrates the breadth of individuals requiring mental health services and receiving service. The Rehabilitation Program currently has 639 registered clients that receive service. There are approximately 33, 000 adults diagnosed with mental health and addictions disorders every year in the Regina Qu'Appelle Health Region. Out of the adults diagnosed with

mental health and addiction disorders, 1/6 have a single severe disorder; 1/6 have more than one severe disorder; and 1/3 have a moderate disorder and 1/2 have a mild disorder (Regina Qu'Appelle Health Region, 2012). The criteria for diagnosis of severe disorders are individuals at high risk to harm themselves or others, who are highly symptomatic, have inadequate supports, resources and coping skills and who require psychiatric consultation or hospitalization. The criteria for a moderate disorder is an individual who is at low risk to harm themselves or others, who is moderately symptomatic, having some difficulty managing current stressors and has resources and supports in place. The criteria for a mild disorder are low risk to harm self or others, mild symptoms, minimal impairment on daily functioning and who has adequate resources and supports in place (Regina Qu'Appelle Health Region, 2012).

In terms of national statistics, 1 in 5 Canadians will personally experience a mental illness at some point in their life (Canadian Mental Health Association, 2014). Three percent or nearly 1 million Canadians live with a severe and persistent mental illness (Smetanin et al., 2011). Of that population 1% is affected by schizophrenia and 1% will experience bipolar disorder (Canadian Mental Health Association, 2014).

2.2 Beliefs about Client Worker Status

The RQHR is highly committed to providing Recovery focused services across Mental Health and Addiction Services.

> The Canadian Mental Health Association of Ontario (2014) states that Recovery is the personal process that people with mental health conditions experience in gaining control, meaning and purpose in their lives. Recovery involves different things for different people. For some recovery means the complete absence of the

> symptoms of mental illness. For others, recovery means living a full life in the community while learning to live with ongoing symptoms. (p.1)

The case managers of the Rehabilitation Services Program are committed to a client-driven, proactive model of service delivery. Case managers seek to adapt services to the client's needs and priorities, instead of the client to the program. Recovery-based services highlight the personal qualities of professionals as importantly as their formal qualifications. It looks to nurture the workers capacity for hope, care, creativity, compassion, practicality and resilience (Shepard et al., 2008).

Clients of the Rehabilitation Services Program work collaboratively with their case manager to develop their community support plan. As this is a client driven process, client input at this planning stage is identified as critical for future success. Clients are requested to identify personal goals and then the case manager helps the client link up with services or agencies that are necessary for achieving the goals of the plan. The client/worker relationship in the Rehabilitation Services Program can range in duration for a period of months to years, depending on the individual needs of the client. Case managers can be quite involved in the client's life depending on the required level of support and if the client identifies that they would like assistance. One long term client of the clinic jokingly shared with me, "I literally have grown old with my worker". Achieving treatment goals does not necessarily signal the end of involvement. Often new needs and aspirations emerge as goals are achieved.

Mental illness is not experienced in the same way by everyone. Therefore, just as case managers need to increase services as needed, they also recognize the need to facilitate decreasing services and helping people move on when they no longer need the support. For many

clients, continuous access to the Rehabilitation Services Program and case workers whom they know and trust is integral to their recovery.

A recommendation from the Mental Health Strategy for Canada was for the establishment of guidelines to ensure that individuals who live with mental illness and their families are involved in the process of developing and implementing mental health policies. In 2012, the RQHR established Recovery/Resiliency Principles for staff of Mental Health and Addictions Services. A process was established to ensure that client representatives are included in participating in continuous quality improvement activities as equal partners with professionals. This action was taken, to ensure that there was meaningful engagement of people with lived experience of mental illness and their families. Workers of the Rehabilitation Services Program have since received education, direction, mentoring and coaching in recovery/resiliency practice. Client representatives are now actively involved in making changes and improvements in service delivery, and have the opportunity to provide feedback based on their lived experiences.

2.3 Determinants of Problems

"It is harder to crack a prejudice than an atom"
Albert Einstein

Diminishing stigma continues to be a major challenge within mental health organizations. The predominant negative attitudes and behavior towards individuals with mental illness are primarily due to lack of knowledge and awareness, resulting in fear of the unknown.

Stigma can be experienced from within the agency or organization from which the individual with mental health problems receive services. This can cause more devastating effects on them than the illness itself (Mental Health Strategy, 2009). The stigma that people with mental illness experience is oppressive and isolating; it acts as a barrier and prevents many from accessing services. This consequently denies them access to treatment and the support they

require to recover (Mental Health Strategy, 2009). The majority of individuals diagnosed with 'schizophrenia' or 'depression' expect to experience negative reactions from their environment (Angermeyer et al., 2003). Approximately 75% of individuals with mental illness experienced stigma when applying for a job and one third of these individuals will be rejected as job applicants or as potential tenants (Wahl, 1999).

Stigma can be experienced at a micro, mezzo and macro level. Self-stigma is the prejudice that individuals with mental illness internalize (Corrigan et al., 2002). These individuals often make attempts to hide their mental illness, resulting in isolation. Stigma is a contributing factor that deters individuals with mental illness from accessing services. Public stigma is the attitudes and reactions that the general public hold of individuals who have mental illness (Corrigan et al., 2002). These views are often rigid and discriminatory and assumptions are made that individuals with mental illness can never recover or contribute to society in a meaningful way. Structural stigma occurs in policies, laws and institutions. "Intentional institutional discrimination manifests itself as rules, policies, and procedures of private and public entities in positions of power that consciously and purposefully restrict rights and opportunities" (Pincus, 1996, p.481).

Preventing stigma and changing attitudes necessitates greater action than just improving education about the signs and symptoms of mental health problems and illnesses. In the pursuit to break down stigma, 'contact-based education' which entails meeting and talking with individuals who can share their personal experiences of mental illness and recovery is essential (Canadian Alliance on Mental Illness and Mental Health, 2007). Such strategies can impact how society views individuals with mental illness and can prevent discrimination along with removing systemic barriers. In addition, increasing funding in mental health would further help

the reduction of stigma. Mental health services have a long history of being inadequately funded at a national level. Currently 1 in 5 Canadians live with a mental health illness, yet funding for mental health is not a priority. Saskatchewan currently only funds five percent of its provincial budget on mental health services (Saskatchewan Ministry of Health, 2010).

3. Values

Values are a group of beliefs and attitudes that are influenced by our environment and personal experiences (Bogg, 2010). Some of my personal values are respect, acceptance, inclusiveness, service to others and self-determination. These values are in accordance with the Canadian Association of Social Work values of : respect for inherent dignity and worth of persons, pursuit of social justice, service to humanity, integrity of professional practice, confidentiality in professional practice and competence in professional practice (CASW, 2005, p.5). Social work has been identified "among the most value based of all professions" (Reamer, 2006), a position shared by the National Association of Social Workers (1996) which stated that professional ethics and core values provide "the foundation of social work's unique purpose and perspective" (p.3).

3.1 My Value Base and Social Location

I was born and raised in Montréal, Québec and am the daughter of a French Canadian mother and Italian father. I was very privileged to have had parents that were emotionally present and provided opportunities for me and my brother to grow into caring and generous adults. My family had strong values of commitment to family, respect and independence. These are values that are still very important to me. My personal experience with having an aunt who lived with mental illness and was stigmatized has had a strong influence in my decision to work in mental health.

My academic social work journey commenced at Lakehead University in Thunder Bay, Ontario, where I obtained my Honors Bachelor of Social Work. As a new graduate I initially worked as a child protection worker for the Children's Aid Society - Aboriginal Division. Following my work as a child protection worker, I was employed by St. Joseph Healthcare in the Chronic Disease Program providing individual and group counselling to individuals that were newly diagnosed with a chronic illness. Subsequently I was employed at the Haldimand Family Health Team in a counselling position.

In September 2013, I started my field practicum in the Rehabilitation Services Program at the Regina Mental Health Clinic. The same month my contract position in the Adult Therapy Program ended and I secured a part-time position with the Transition Care Team at the Regina Mental Health Clinic. My employment as a social worker has been diverse providing me with numerous skills including assessment skills, strong case management skills, clinical skills and group facilitation skills**.**

3.2 Value Base of Client Constituencies

Mental health services have historically been delivered utilizing the medical model which is based on professional expertise and aims to eliminate symptoms and restore social functioning. Utilizing this model to deliver psychiatric services left clients with little power in their roles as patients, resulting in poor involvement in their recovery plan (Fischer, 2013). The recovery model where clients are actively involved in treatment planning and recovery goals is an alternative to the medical model.

The historical roots of *The Recovery Movement* started in the 1980's and later became known as the User Movement. It was led by users, researchers and user-advocates that had concerns about how services were being delivered and the policy that was being written. Through the collaboration of numerous stakeholders, consumers were involved in research that

was user-controlled and user-led, which consequently brought about evidence-based outcomes and comprehensive assessments were presented to the mental health field for service development and policy (Rose et al., 2006).

The consumer movement has given clients a voice: “People with severe mental illnesses are people. This provides a fundamental orientation for mental health services. People with mental illness want all the normal entitlements, roles and responsibilities of being a person. The task of mental health services is to support progress towards these goals” (Slade, 2009, p.10). Both the Mental Health Strategy of Canada (2009) and the Mental Health Strategy for Regina and Area (2012) have included the voice of consumers in their recommendations. Client values are clear, they value the right to be heard and have their needs and interests respected. They value not being discriminated against or stigmatized based on their illness. They value the ability to obtain services that are prompt, dependable and accurate. They value experiencing an equal partnership with service providers and being supported in the goals that they set for themselves. Clients value their cultures, their families and the opportunity to involve family members in their treatment plan.

3.3 Potential Value Clashes between Self and Client

Potential value clashes can happen in any therapeutic relationship. As counselors we strive to create a safe environment for clients to review their strengths, feelings, cognitions, behaviors and formulate treatment goals. It is our responsibility to help clients identify their values in order to come up with the right answers for themselves. It is important as counselors to be aware of our personal values and how they influence therapeutic interventions with clients. A potential value clash between a worker and client would be if the client’s goals were dismissed or narrowly considered and replaced with the counsellor’s personal agenda for treatment. Value

clashes sometimes occur in the Rehabilitation Services Program between the worker and the client in circumstances when individuals are placed on Community Treatment Orders (CTO). Although this extreme measure is taken in order to keep the person safe, it interferes with the client's own self-determination. During my practicum experience, clients that were placed on CTO's were unhappy about being ordered to take their medication by injection and to be monitored. Although client's have the opportunity to appeal the CTO, appeals are often denied when it is reasoned that it in the best interest of the client. The clients in these circumstances tend to be upset with their psychiatrists who place them on CTO's. I handled these situations by not pushing my values and provided the client the opportunity to share their frustrations and feel heard. I reviewed the reasons the psychiatrist believed that a CTO was in their best interest and offered alternative ways of looking at the situation. Although this did not change the situation, clients were reminded that they had control in other areas of their lives and were encouraged to continue working towards the recovery goals that they had set for themselves.

3.4 Potential Value Clashes between Client and Society

There are potential value clashes between clients and society when it comes to issues of stigma and discrimination. The face of mental illness is often associated with homeless and disenfranchised populations (Wilde, 2012). Society makes condemnatory generalizations that these people are unwilling to actively participate as productive members of society, and they are consequently looked down upon which perpetuates issues of classism, ableism, power and privilege (Holley et al., 2012). Individuals with mental health issues or disorders continue to be discriminated and misunderstood. The lack of understanding fosters an environment of fear and rejection that severely impacts individuals living with mental health issues (Corrigan et al., 2012).

People with mental health disorders are often stereotyped by society, their workplace, family and friends and at times by the healthcare system that provides them treatment. Stereotypes are reinforced by frequent media coverage that systematically associates mental illness with acts of violence (Sieff, 2003). This consequently nurtures an atmosphere of fear which causes harsh views and judgments of individuals with mental illness that are involved in acts of violence. Often, the general consensus is that these individuals should be treated using the full extent of the law in the same manner as any other criminal offense, despite their mental illness (Wahl, 1996).

3.5 Potential Value Clashes between Client and Agency

Clients that have been referred or are receiving service from the Rehabilitation Services Program often have expectations in regards to accessibility, frequency and quality of services. Value clashes between clients and the agency were evident a year and a half ago when mental health services were bottlenecked at the point of entry by long waitlists. This accessibility issue was a direct result of insufficient funding in mental health, numerous referrals and shortage of psychiatrists. The issues clients encountered were as follows: being waitlisted for assignment to a rehabilitation worker, waitlisted for consultation with a psychiatrist and long wait periods for follow-up appointments with psychiatry. Unfortunately some clients encountered all the above waitlists.

Within the last two years the recommendations made by the Mental Health Strategy (2012), have been put into effect in conjunction with the “lean” approach. Since this time, positive changes have transpired in terms of reducing wait times for service users and building capacity in order to provide mental health services in a timely manner.

The Mental Health Strategy reports that as part of a broader provincial

> initiative, mental health and addictions services in Regional Health Authorities (RHAs) across Saskatchewan have been using the 'Lean' approach to reduce wait times. Lean is an approach to evaluating service delivery in a workplace, which focuses on services users in order to make processes and procedures more efficient and more responsive (Mental Health Strategy, 2012, p. 44).

The implementation of the *Lean* principles started the year prior to my field practicum in the latter part of 2012. *Lean* initiatives continue to be implemented on a regular basis to improve service delivery. The outcome was reduced wait times for clients accessing services such as psychiatry and improved client satisfaction due to receiving more timely service.

3.6 Potential Value Clashes between Agency and Worker

The RQHR Living Our Values Document (2007) proposes that "by living our values, we will achieve a safe, supportive, quality workplace" (Regina Qu'Appelle Health Region, 2007, p. 11). Although the RQHR strives to live by its values, there are certain situations that render this more challenging. Value clashes can occur between agency and workers. These clashes tend to transpire when there are variations in working conditions due to budgetary cuts. The consequences of financial deficits within the mental health agency resulted in significant repercussions in numerous areas including service delivery, fewer opportunities for professional development, and changes in service delivery and morale in the workplace. Financial constraints within the agency resulted in job loss and vacancy management of positions, where vacant positions were not filled.

In my experience at the clinic, it was difficult for workers to see members of their team lose their employment and have these positions remain vacant. Workers are consequently faced

with an increased caseload and may feel like they are spread thin, creating value clashes as they are unable to provide the same quality service to their clients. The impact on the staff is increased stress, discontent, and low work place moral which can impact psychological safety in the workplace. However these issues did not negatively impact my field practicum experience even though I was aware of the challenges that staff were having at the clinic. The staff coped by talking about their frustrations and providing one another support. What kept workers going was hope that the stressful work situation would eventually improve and they derived satisfaction from the meaningful work they did with their clients. In addition, workers engaged in a variety of self-care activities such as leaving the clinic on their lunch break and going for a walk or to the gym. I think that these issues are an unfortunate reality for many workers in social work agencies which face lack of funding. Although the clinic is presently going through funding difficulties, they are not a result of the *lean* initiatives that have been implemented.

My practicum experience at the clinic taught me that despite the systemic challenges that were being experienced, that meaningful work with clients was still possible. Through the dedication and commitment of workers I learnt how to make the most of the resources offered, and closely collaborate with co-workers in order to provide the best service possible given the circumstances.

3.7 Impacts of Values

Contracting/Goal Setting – The Rehabilitation Services Program is multifaceted in the broad range of services it offers. Services are provided on-site at the clinic as well as in the community. These services include long-term case management, rehabilitation services for

clients who have a long-term serious mental illness, ongoing counselling and support, supportive residential placement program, vocational counselling, family education and support, medication management (including an injection medication clinic) and financial services.

The values of the Rehabilitation Services Program encompass working with the whole person, therefore contracting and goal setting often occurs in the community. At the time of referral clients may still be in hospital, residing at a shelter, or with family and receiving services from other agencies. There is great value in meeting and getting to know the person in their environment. It is not uncommon for clients to minimize or dismiss their problems for reasons such as feeling unwell, poor insight, embarrassment, shame and guilt. Meeting clients in their current place of residence provides layers of additional information that possibly would not have been captured immediately. Additional information such as issues relating to sub-standard housing, no heat or water, lack of furniture, and food are often identified. In addition, for the case manager it provides opportunities to liaise with and involve support people in that person's life and other service providers. These meetings are invaluable as they not only help to identify additional resources that need to be implemented in the treatment plan but also provide an opportunity to get numerous perspectives of the clients strengths, resiliency and goals that they are currently working towards.

3.8 Success of Interventions

Success of interventions will be distinctly unique for each client and can be measured differently by each worker, their support team and the client. Success may be assessed by professionals in terms of medication compliance, maintaining sobriety, being free of psychiatric symptoms and working closely with their support team. However the clients may view success as finding supports, inclusion, finding a job, and creating meaning and purpose in their lives.

Although success may look differently whether you are the professional or the client, with the application of the recovery approach in practice, professionals can challenge themselves and consider that client success does not need to be a specific outcome, but rather a personal journey of self-determination.

4.0 Theory

Theory in social work practice provides an explanation as to why individuals act the way they do. Theory also explains what is transpiring in a therapy session between a social worker and client. Theories help social workers to understand their roles and inform what to do in different situations (Payne, 1997). Theoretical orientations provide a framework to guide our work, however all theories have limitations. It is essential for social workers to be knowledgeable of a wide range of theories in order to carry out informed interventions. Cornisi and Wedding (2008) stated "Clinical effectiveness is predicted on the clinician's flexibility, versatility and technical eclectism" (p.369).

One of my MSW practicum learning goals was to understand and apply counseling theories used in the Rehabilitation Services Program. The primary theories that are utilized are the recovery model, solution-focused therapy and strength based therapy and client-centered therapy. In addition, I was able to utilize other theories in practice such as cognitive behavior therapy and dialectical behavior therapy. My personal theoretical framework for practice is based on an integrative approach. I consider every client on an individual basis in order to determine which approaches would work most effectively for the client and their personal therapy goals. Corey (2009) states "Multimodal therapists take great pains to determine precisely what relationship and what treatment strategies will work best with each client and

under which particular circumstances. Multimodal therapists are constantly adjusting their procedures to achieve the client's goals in therapy" (p. 252).

The following section will provide an outline of the theories and approaches that I utilized during my practicum. It must be noted that dialectical behavior therapy is not a theory that is customarily utilized in the Rehabilitation Services Program because it can only be utilized with certain populations.

4.1 Recovery Model

"The goal of recovery is not to become normal. The goal is to embrace the human vocation of becoming more deeply, more fully human" (Deegan, 1996, p. 93). The conception of the *Recovery Model* originated in Paris, France over 200 years ago, when Philippe Pinel implemented the concept of "traitement moral" in asylums (Davidson et al., 2010). The recovery model has been successfully utilized for some time in the field of addictions treatment (Davidson & White, 2007). Until recently, the medical model was primarily utilized in healthcare and in the treatment of mental illness. The recovery model differs from the traditional medical model in that individuals living with mental illness have an active role in their own recovery. The traditional medical model is based on an expert stance of the professional and focuses on initially treating the illness followed by a rehabilitation process, over which the client has no control and is expected to passively comply. Often the recovery process is paused for individuals, while waiting for advances in medicine (Fischer 2013).

There are a number of key differences between the medical model and the recovery model. The medical model exercises power over the client and labels the individual with a diagnosis. Treatment plans are made without involving the client. The client is often reduced to a diagnosis and viewed as having a chemical imbalance. The person is viewed as a disease to be

solved by medicine. The medical model believes that the way to solve problems is through the lifelong use of medication administrated by professionals to address the chemical imbalance (Fischer, 2013).

The recovery model views empowerment as vital to a person's recovery, not chemical imbalance. The person is respected and viewed as an expert in their life and are included in decision making. They are viewed as being in distress and needing assistance. The goal for recovery is for people to fully participate in the community which may involve medication. By engaging in peer activities, people/clients are able see other individuals that have had similar difficulties and have recovered which creates hope for their future (Fisher, 2013). There is a significant paradigm shift from the medical model which focuses on the individual's physical body while the recovery model allows individuals living with mental illness to be active participants and decision makers in their treatment plans. Amering and Schmole (2009) state:

> Recovery does not refer to an end product or result, neither does it mean that the person is cured, nor that he/she is simply stabilized or maintained in the community. Recovery often means a transformation of one's self, whereby a person both accepts their limits and discovers a new world of possibilities. Recovery is also a process, a way of life, attitude and a way of approaching everyday challenges. (p. 78).

The Recovery Model provides a framework of opportunities for clients to be self-directive in their recovery journey. People living with mental illness are encouraged to look beyond their current struggles and set goals that will bring meaning to their lives. Recovery can be about personal self-discovery and setting new goals. Pat Deegan (1987) shares her own personal experience and states "we find that our personal limitations are the ground from which

spring our own unique possibilities. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do" (Deegan, p. 13).

4.2 Solution Focused Brief Therapy

The grandfather of Solution Focused Brief Therapy is an American psychiatrist by the name of Milton Erickson, who successfully utilized unconventional therapy practices (Erickson, 1980; Erickson & Rossi, 1979; Rosen, 1982). Erickson was not a believer in diagnostic labels and believed that people had the capacity to resolve their own problems. It is now evident that his concepts pointed towards the ideology of the solution-focused approach (Visser, 2013). In the 1980's Steve de Shazer, Insoo Kim Berg, and their team at the Milwaukee Brief Family Therapy Centre in Milwaukee, Wisconsin developed the Solution-Focused Brief Therapy approach.

The principle concept of solution focused therapy (SFT) is grounded in a positive orientation. It is a behavioral, goal-directed, future-focused strengths-based model which looks at an individual's current resources and future goals, instead of focusing on current troubles and historical problems (Robbins et al., 1998). SFT focuses on what is working and finding solutions to problems. Clients are supported in uncovering exceptions to their problems as they are viewed as being the experts in their lives and having the capacity to find their own solutions. Similarly, using the strengths perspective Saleebey (1996) suggested that a diagnosis should not be ignored or denied, but should not be the focus of therapy. Social workers must ensure that the person's diagnosis does not become their identity. In order for this to happen, social workers need to help clients become more aware of how they have survived and managed in the lives, and help them to further develop skills to think in more constructive ways.

The therapist assists the client in shifting discourse, meanings and relationship dynamics into a state of solution. The following are SFT techniques (Dolan, 2014):

- Looking for previous solutions: Are there times when this has been less of a problem?
- Compliments: How did you do that? (clients self-compliment answering the question).
- Inviting the clients to do more of what is working.
- Exception question: Requesting that the client reflect on a time in their life when the problem did not exist.
- Miracle question: If while you were sleeping a miracle occurred and the problem you are experiencing was solved, what would be different?
- Scaling questions: Utilizing a scale of zero to 10, zero is the worst you have been and 10 represents resolution of your problem, where would you position yourself?
- Coping question: How have you managed to go on? (Dolan, 2014, p.2).

SFT is respectful of client's individuality and circumstances from which they find meaning. Therapists assist clients and guide them in envisioning and building a new future (Walter & Peller, 1992). Empowerment of clients and belief in the goodness of people are key tenets of SFT. When resistance is encountered in therapy it is not viewed as something to work on but a cue for the therapist to try something different.

4.3 Strengths Based Approach

The strengths based approach was introduced to social work practice in the early 1980's at the University of Kansas School of Social Welfare.

> Saleebey (1996) suggests that the Strengths Based Approach was a stance taken to oppose a mental health system (a new model, the strengths based case management, was developed to deal with the main problems faced in the social

> work practice when applying the traditional deficit-focused perspective) that overly focused on diagnosis, deficits, labelling, and problems, initially implemented in case management, moving into other areas of social work and the helping professions. (p. 298)

The emphasis in practice is a partnership between clients and social workers (Early & GlenMaye, 2000). The literature suggests that the strength based approach positively affects the welfare and the coping of individuals living with mental illness (Saleebey, 1996). The strengths based approach is both future and goal oriented and focuses on an individual person's strengths in relation to problems and difficulties. This approach does not ignore problems, but seeks to resolve issues while fostering optimism and purpose in solving problems. The strength based approach believes that individuals have the existing skills, resources, and the capacity to learn new strategies to solve problems. Smith (2006), states that "Individuals' recognition of their own resilience provides the route to authentic self-esteem. Such self-esteem is based on individuals recognizing their actual accomplishments and identifying how they have used and can use their strengths" (p. 32).

Graybeal's (2001, p. 237) Ropes Model is a tool utilized for the assessment of strengths. The acronym of Ropes stands for resources, opportunities, possibilities, exceptions, and solutions. When evaluating people's strengths, resources such as family, social environment and community are assessed. The individual's present options are reviewed, resources that can be accessed now and options that are available, but have not been tried. Possibilities are looked at, such as their future focus, imagination, creativity and things that they may have considered trying but have not tried yet. Exceptions are also reviewed such as when is the problem not happening, when is the problem different and how have they survived and thrived. Lastly,

solutions are explored with a focus on what is working now, what the person's successes are, what they are doing that they would like to continue doing and the counsellor posing the miracle question.

The strength based approach reduces the power dynamics between the individual and therapist by situating the clinician in more of an egalitarian role. The client is considered the expert regarding past and present problem solving.

4.4 Cognitive Behavioral Therapy

The pioneers of cognitive behavioral therapy were Aaron Beck (Cognitive Therapy) and Albert Ellis (Rational Emotive Behavior Therapy). In the utilization of Cognitive Behavior Therapy (CBT) the clinician and the client collaboratively work together to identify problems and solve them; the client is taught the interconnection between thoughts, feelings, and beliefs and how they influence behaviors and actions. Clients learn that emotions arise based on how events are interpreted, not because of the event itself. In order to achieve lasting change in the client's mood and behavior, therapists explore "the client's beliefs about themselves, their world and other people" (Beck, 2011, p. 3).

Therapists utilize the Socratic dialogue to promote new learning. "This type of questioning defines the problem, identifies thoughts and assumptions, examines meanings and evaluates the consequences of maintaining maladaptive thoughts and behaviors" (Beck & Weishaar, 1993, p. 363). Guided Discovery is described by Beck and Weishaar (1993) as the way in which a therapist gently assists a client to clarify errors in logic through a testable hypothesis. By exploring clients automatic thoughts which are often referred to as thinking errors or cognitive distortions, the therapist can evaluate and help change the clients thought processes

utilizing cognitive restructuring. Clients are helped to gain awareness about their automatic thoughts, how to challenge their negative automatic thoughts and how they play a role in their emotional difficulties. Some of the main points of CBT are that the framework is shared openly with clients. CBT offers a straight-forward practical approach that focuses on the here and now and tends to be short term. There is an emphasis on homework where clients practise the skills they have learned outside of therapy sessions.

CBT is used for a wide range of conditions as well as for severe and persistent mental illness. There are some differences when utilizing CBT with clients that have psychosis, such as flexibility in agenda setting and the length and frequency of sessions may also differ (Wright, 2004). Interventions would include reality testing, shifting hallucinations and delusions and exploring causes that lead to relapse, and the management of relapses (Borrego et al., 2009).

4.5 Client-Centered Therapy

Carl Rogers was a humanist psychologist in the 1940's and 1950s and is the founder of client-centered therapy. In 1942, Rogers promoted the term 'client' for individuals who accessed psychotherapy, an initial shift away from the medical model utilized with mental illness (Rogers, 1942). Client-centered therapy takes a non-directive approach and encourages and motivates clients. It places the client as an expert in their own lives and believes that they have the innate ability to find their own answers. An integral role of Client-Centered therapy is the self-direction of the client. Carl Rogers, says "it is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried" (Rogers, 1961, p.11). The therapeutic process focuses on developing the client's self-awareness and to empower them to understand how their way of thinking, feelings and behaviors affect outcomes. Rogers viewed

the human experience as a process rather than as an outcome. In this approach, the individual is always evolving.

According to Rogerian theory, there are six factors necessary for growth. 1. Therapist-client psychological contact: a therapeutic relationship must exist for the client to make personal change. 2. Congruence: the therapist has to be genuine about who they are and what they are feeling, it is necessary for the therapist/client relationship to be integrated. 3. Unconditional positive regard: the therapist is non-judgmental and essentially accepts and cares for the client. 4. Therapist empathy: the therapist is required to relate to the client's internal frame of reference, and be able to communicate their understanding to the client. 5. Client incongruence: when incongruence exists between the client's experience and awareness 6. Therapist unconditional positive regard (UPR): when the therapist communicates empathy and UPR to the client. The therapist accepts all of the clients' experiences non-judgmentally (Rogers, 1949). Rogers emphasized that in recognizing client's experiences and providing support in a non-directive way, change will naturally occur for clients.

4.6 Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) was developed by Marsha Linehan, a psychologist in the state of Washington. The therapy was originally developed for women who had a diagnosis of borderline personality disorder and a history of self-injurious behavior. DBT has since been adapted, and is used as a therapy method for numerous other populations. DBT combines basic cognitive-behavioral approaches (such as emotion regulation and reality testing) with acceptance approaches (such as distress tolerance and mindfulness). DBT stems from three schools of knowledge, each contributing important principles. Behaviorism provides the means for change, Zen provides the means for acceptance, and dialectics provides a worldview and a motivation to

acquire balance between acceptance and change (Koons, 2008). DBT is a behavioral therapy that is used to identify maladaptive behaviors and replace them with new, healthier behaviors (Koons, 2008).

Koons (2008) further explains the marriage of these three schools of knowledge that are the foundation of DBT. Behaviorism: Modeling techniques in DBT include both skills training and individual therapy. Therapists model healthy coping skills with personal examples, to avoid overwhelming the clients with issues they have yet to resolve.

Conditioning: DBT explores behaviors, including thoughts, emotions, urges and body sensations associated with past experiences and consequences, then finds and applies solutions to modify challenging associations, stimuli and responses as they happen. In DBT the therapist and clients look at behaviors and try to find solutions by exploring how patterns repeat themselves. They explore specific stimuli, and evaluate the client's cognitions, feelings and experience. The experiences result in actions or non-actions, with consequences that are neutral, rewarding or un-rewarding. DBT uses conditioning to reward the client's adaptive behavior and not reward maladaptive behavior. Zen values inform the DBT skills training and the therapist's approach towards clients and treatment. Zen highlights the intrinsic wisdom that everyone possesses. "Wise Mind" is a synthesis of information gathered from facts and emotions.

Dialectics is a philosophical practice that proposes that truth is discovered in the differences of opposites. Dialectical truth ensues from the difference between the thesis and antithesis to move towards synthesis. In DBT, the dialectical dilemma is that the client needs to change behaviors that are destroying their lives and to accept their current situation as it is. The tussle between the opposites directs the course of treatment.

Clients willing to engage in DBT need a high level of pre-treatment commitment as well as motivation. Clients must demonstrate a willingness to learn behavioral skills, agree to work on decreasing parasuicidal and therapy interfering behaviors such as verbal aggression, poor attendance and suicidal threats (Linehan, 1993). DBT is both time and labor intensive; it is customarily offered in a group format. Groups require co-facilitation of therapists and can range in duration from 24-52 weeks. DBT skills training can also be delivered in individual sessions for clients that may not be ready or appropriate for group therapy. DBT is comprised of four modules that include Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal Effectiveness (Linehan, 1993). The skills that a client learns in these modules help regulate their emotions and behaviors. As in most behavior therapy, homework is assigned, and clients are required to track mood and emotions on their diary cards and to practice the skills learned in group in their day to day life (Linehan, 1993).

4.7 Case Example

The following is a case example of how I utilized an integrative approach with one of my assigned clients. My client was a 26 year old single male that was diagnosed with severe Obsession Compulsion Disorder (OCD), a learning disability and depression. He started experiencing mental health difficulties as a teenager and had previous admissions to hospital due to psychosis. He described himself as being socially awkward and being a “loner” with no friends. This client had been receiving services from the Rehabilitation Services Program for a period of eight years. His treatment goals were to make friends and to find a girlfriend. He reported feeling lonely, sad and often jealous towards others for having and achieving things that he wished he had. When we began treatment he was pre-contemplative in terms of starting

medication. He was hesitant because he had negative experiences in the past with medication, and was not convinced that medication would help his mood. Utilizing recovery principles he was provided education about the benefits and side effects of medication and the decision was left for him to make. He was not pressured or made to feel like he was not making the right decision in not starting medication.

In our therapy sessions I primarily utilized CBT as well as the strength based perspective and solution focused therapy. As this client had a tendency to isolate and stay home, behavioral activation strategies were implemented such as riding his bicycle, going to the park and participating in activities at the university. This client was provided education on communication skills as he had a tendency to be passive aggressive. We worked on shifting to a more assertive communication style. In addition we reviewed body language and communication strategies so that he would be able to engage others and carry a conversation more easily. We focused on his self-defeating automatic thoughts. He firmly believed that he was ugly and that no one would ever want him. A few examples of his cognitive distortions were magnification, where he magnified the fact that he had never had a girlfriend and believed that it would never happen. He also had another cognitive distortion (mindreading) and believed that he knew what other people were thinking and feeling and this would stop him from talking to others and participating in activities (Beck, 1963). We worked on modifying his thought process by cognitive restructuring. This was achieved by helping him become aware of his distorted thoughts and pointing out how they contributed to his emotional distress. The strengths based perspective was weaved into therapy sessions as this client had achieved some of his goals within the last year and had numerous personal strengths.

Throughout the course of therapy, problems or crises would arise that would require problem solving. Solutions focused therapy and strengths based perspective was utilized in these situations. On a few occasions my client would forget to pick up his food hamper from the food bank and would need to wait until the following month for his next allocation. In these situations he was asked what he has previously done in similar situations and was helped to problem solve the issue. Towards the end of my practicum he informed me that he had received an eviction notice from his property manager at his apartment complex because he had not been paying his rent in time due to difficulty managing his money. In addition he owed in excess of two hundred dollars in late fees. My client was encouraged to explore possible solutions by thinking of things that were available to him but he had not yet accessed. He had great difficulty managing his money due to his learning disability. As a result we explored having his rent withdrawn from his income support money. The client thought that this would work for him and he asked me to advocate on his behalf to his landlord. I informed the landlord that our financial program at the clinic could arrange for the client's rent to be automatically withdrawn from the clients income support and be directly deposited in the landlord's account. The landlord was agreeable to this arrangement and we worked out a payment plan for his late fees. Solving this issue promptly meant that my client averted eviction.

This experience was also valuable as he realized that he had the capacity to solve his problems. By the end of our therapy sessions my client had started taking his medication and reported feeling that his mood had improved and that he was motivated to reach his goals. He had been successful in participating in social activities and making acquaintances. In addition he had taken steps to start dating such as on-line dating and asking a girl out.

In the above case example I provided an example of using an integrative model in therapy, in which I used CBT, SFT, strength based perspective and the recovery model.

In the following section I will outline how utilizing these various approaches in therapy sessions help compliment the weakness or short comings of the other approaches.

CBT was the primary modality utilized in sessions to work on my client's depression and anxiety. CBT focuses on thoughts, feelings and behaviors in a structured manner and does not focus on the exploring client's strengths. It is not a straight forward approach to dealing with situational crises. Additional theories such as SFT and a strength base perspective help to deal with such issues. Both SFT and the strength based model have similar values to the recovery model because they do not focus on what is wrong with clients but instead look at their resiliency and strengths. These two approaches emphasize personal empowerment and self-determination of clients.

SFT was utilized with my client in problem solving life's issues and in working towards his goals. Although SFT was utilized in sessions, the use of other approaches was necessary as some of SFT limitations are that it has a tendency to overlook gender and power differences. McConkey (1992) suggests that SFT usually does not integrate individual and family development or sufficiently consider influences from larger systems. The client's individual and family history is only discussed if the goal is to find past solutions. In addition SFT acknowledges family contexts and behaviors but tends to overlook the broader frameworks in which families function. I incorporated the strength based perspective in sessions to draw out his inherent strengths and promote self-awareness. This model was used in conjunction with SFT because SFT focuses on current issues in the here and now, and how his life would look once he

had attained his goals. SFT was not used in isolation because it tends to focus solely on the individuals abilities and ambitions in all facets of their lives (Weick et al, 1989).

5.0 Ethics

The staff of the Rehabilitation Services program is comprised of social workers, psychiatric nurses and a psychologist. Each discipline is required to adhere to the Ethical Guidelines and Codes of Conduct of their professional associations. During my field practicum, I encountered an ethical dilemma while attending an interdisciplinary meeting in the community when shadowing a staff of the Rehabilitation Services Program. For reasons pertaining to confidentiality, specific details will not be disclosed.

The purpose of the interdisciplinary meeting that I attended was to identify specific needs of clients and coordinate care for them. It was identified that one of the clients required ongoing funding for caregiving services due to the nature of her illness. As part of the funding renewal process, any new information regarding the client is reviewed. The new information that was shared was that the client had relocated and was now renting a suite from her caregiver. In addition, the caregiver had moved in with her and it was unknown if they were involved in a romantic relationship. The ethical dilemma that I and another Rehabilitation Services Program worker identified was that the client was in a vulnerable position and could possibly be taken advantage of.

The Canadian Association of Social Workers Code of Ethics (2005) states “Social workers uphold the right of every person to be free from violence and threat of violence” (p. 5). In addition it asserts that “Social workers demonstrate adherence to the values and ethical principles of the profession and promote respect for the profession’s values and principles in

organizations where they work or with which they have a professional affiliation" (p. 7). This ethical dilemma was discussed with the committee however they did not feel that there was a problem. This dilemma was discussed with the management team at the Rehabilitation Services Problem who suggested that this matter should be looked into further. The outcome was that the Mental Health Clinic did not agree with this situation and wanted their concerns formally documented at the next meeting.

Encountering this ethical dilemma during my field practicum was a good learning experience. We often reflect on the Code of Ethics in relation to the work we do in our day to day practice with clients. However encountering this issue at an interdisciplinary meeting was an important reminder that adhering to the Code of Ethics extends beyond everyday practice and that ethical issues can occur in every facet of the social work profession. It also illustrated times when we are faced with competing codes of ethics when practicing in multidisciplinary settings. This experience was an important reminder for me that it is our responsibility as social workers to keep ourselves accountable to our code of ethics in our own practice in order to avoid causing undue harm to the individuals that we seek to help.

6. Relationships

Relationships are an integral part of the social work profession. They facilitate communication and are the foundation of human connections. "The social work profession is dedicated not only to building positive and empowering individual relationships; social workers are also committed to strengthening our communities and acting as catalysts for change" (CASW, 2012, p.30). The dynamics of relationships make it that they can be positive and transformative or can be negative and oppressive. The followings sections will speak to the

interconnection and complexity of relationships that social workers, clients, agencies and communities engage in.

6.1 Worker and Client

The desire to be a helper and work with people is often driven by the interpersonal aspect that social work practice has to offer. As social workers we are required to utilize a variety of communications skills with the clients we work with. In order to establish therapeutic relationships and assist clients, the worker needs to be able to communicate understanding, respect, dignity, and provide encouragement. It is also important for the worker to share power with the client, fostering a relationship that is more egalitarian (Dominelli, 2002).

6.2 Worker and Agency

In the last few years the implementation of *Lean management* has been put into practice to improve delivery of services throughout the RQHR. *Lean* management principles have been utilized in the manufacturing sector (Toyota) for a number of the years and are now being applied to healthcare. This initiative necessitates exploring new and innovated methods of providing service delivery (Regina Qu'Appelle Health Region, 2014). When implementing such significant changes, it is important for organizations to be transparent and communicate a clear vision including the reasons why change is necessary and how it will benefit the agency as a whole. Change within organizations can sometimes be received by staff with disapproval and resistance. It can bring about fears, uncertainty, disapproval and loss of control. In order for the successful change to transpire it is important for workers to be able to share their thoughts and opinions regarding service delivery. Workers must be able to rationalize how the proposed changes will affect clients and themselves as front line workers. It is only in having a joint vision and working as allies that meaningful change is to likely to emerge. The result of not involving

workers in agency changes can result in low workplace moral, resistance and workers feeling overburdened.

6.3 Worker/Worker

As previously mentioned the Rehabilitation Services Program is comprised of a multidisciplinary team. Subsequently, professional workers bring different theoretical frameworks and ways of thinking based on their profession. During my practicum I had the opportunity to work with workers from other professional backgrounds besides social work. This provided an opportunity to learn different ways of conducting assessments, treatment planning, learning about medication/side effects and diagnostic criteria. This experience required me to be reflective of my own professional experience and how it informed my practice. It also highlighted how other professions have similar or opposing views. Working in a multidisciplinary team gave me the opportunity to acquire new skills that I will be able to utilize in my clinical work.

The Rehabilitation Services Program is structured in a manner that professionals work collaboratively and provide case coverage of each other's case loads. In my observations, I noticed that the team was close and supportive of each other. Although the case managers all had heavy caseloads and were quite busy, they would offer colleagues support when they were encountering difficulties or crises in their work. Given the nature of the job, case managers' worked together closely, and many workers had friendships outside of the workplace. As in any relationship, conflicting ideas and differences of opinions sometimes arose. Identified problems were often discussed at team huddles or in team meetings in a constructive manner so that problem solving and resolution of the issue.

An example of this would be that there were sometimes opposing views between workers on recovery practice. The implementation of the recovery model is still fairly new to the RQHR and there are still aspects of the medical model that are utilized in various aspects such as documentation. Primary assessments still have a section outlined as “Treatment Plan” for the worker to complete. This issue was brought up by a worker who suggested changing this section to “Recovery Plan”, for the worker and client to jointly complete. Some workers felt that it was important for them to complete this section on their own without the input of the client, because they thought that clients may have unrealistic goals or make decisions that go against the social worker’s clinical judgment. It was outlined that this practice is not necessarily in congruence with recovery principles. Pat Deegan states that “workers have to learn to embrace and support the dignity of risk and the right to failure of the individuals that we work with” (1996, p. 11). This issue was presented at the end of my practicum and I am unsure of the outcome, however I am aware that Rehabilitation Services Program team was reviewing current practice to be more consistent with recovery model principles.

6.4 Worker and Profession

Reflecting on my past personal experiences, maintaining my professional identity can be challenging when working on multidisciplinary teams. I was initially unsure of what my experience would be like in the Rehabilitation Services Program. My experience as part of this team was a success due to a variety of factors. The program manager of the Rehabilitation Services Program is a social worker and thus manages her team by upholding social work values and ethics. Although the team is comprised of different disciplines, the expectation is that overarching recovery principles will guide everyone’s practice. The recovery framework has

many similarities to those of social work, such as social inclusion, empowerment, self-determination and social justice.

6.5 Worker and Community

The Rehabilitation Services Program is focused on supporting clients in all aspects of their life. Jointly, both the client and case manager identify recovery goals and other services that should be implemented as part of the treatment plan. The services offered at the clinic are only a portion of services and supports that clients require. Issues pertaining to housing, food security, education and vocational needs, long-term care needs and specialized services are all accessed through community agencies and organizations. Case managers rely on numerous community agencies to meet the complex needs of their clients. They engage in a variety of activities with agencies including case conferencing, participating in interagency working committees, and providing educational workshops and presentations. Case managers formally and informally educate agencies and organizations on mental health illness and stigma. Workers continually work at strengthening community partnerships, working together to identify gaps in services and advocate for changes in policy for additional funding and programs.

6.6 Client and Community

Community resources play an intrinsic role for the clients of the Rehabilitation Services Program. Clients are often introduced and encouraged to access community services by their clinic worker. Client needs are diverse and often surpass the support that they receive at the clinic. Client outcomes and successes are heavily weighed on the services available in the community and the relationship that clients had with their resources. Lack of services or the inability to access them will leave clients unable to meet certain needs and this negatively

impacts them. In addition, how service users are treated by the agency will also affect outcomes. For instance, if clients feel supported and included by the agency, they will likely continue to seek services. If however they feel misunderstood, judged or stigmatized they are likely to stop utilizing the service. The Mental Health Strategy (2012) states:

> The primary role of the community is an understanding that individuals living with mental illness and addiction are valued and worthwhile members of the community. Ultimately, friends, family members, and community partners play an integral role in the recovery process. Although mental illness and addiction affect an individual; effective recovery relies on the supports and services of all those within the community. (p. 18)

During my practicum experience clients readily accessed community services and maintained good relationships with them. It was not uncommon for clients to mention a staff member at another agency that they identified as part of their support system.

6.7 Client and Society

Clients report that mental health services are not meeting their needs. Discontent is expressed regarding long wait times for service and lack of services that support individuals with mental illness. There continues to be a disconnect within society and macro level systems regarding the urgent need for additional funding for mental health programs in Canada. Mental health services continue to be the least funded programs in health care. Not only does the lack of funding and services impact clients, it impacts the Canadian economy. The Mental Health Commission of Canada, (2012) reports that more than 6.7 million people in Canada are living with a mental health problem or illness today. If we include families and

caregivers, mental health problems and illnesses impact almost everyone in some way. People in their early and prime working years are among the hardest hit by mental health problems and illnesses. About 21.4% of the working population in Canada currently experience mental health problems and illnesses, which can affect their productivity. There is strong evidence that investing in effective programs can make a difference to the economy and to the health of the population.

7.0 Strategies

While the primary focus of the Rehabilitation Services Program is case management, other important services include: financial support services, medication management, injection medication clinic, family education and support, licensing and monitoring of approved homes, placement and consultation services to Approved Home Operators and Phoenix Residential Society and public education. The program staff works collaboratively with other community agencies to develop and maintain a wide array of psycho-social, residential and vocational opportunities that address the complex needs of this client population.

7.1 Case Management

For the staff of the Recovery Support Program case management involves coordination of clinical and administrative functions including assessment, counselling, medication management, family support, planning, coordination and referral, monitoring, patient education, outreach and advocacy. The focus is on the totality of a person's needs (medical, social, vocational, residential) and ensuring that their basic needs are met. The process involves building and maintaining a trusting relationship; assessment of needs and functioning; developing a rehabilitation plan; referral to appropriate health and other services; developing basic living

skills; and crisis intervention. Vigorous outreach is required to assist clients in reaching their highest possible level of functioning in the least restrictive setting.

7.2 Assessment & Planning

Clients that are referred to the program will have an Initial Assessment and Community Support Plan that includes a complete social history, psychiatric history and overall assessment of social function and community involvement. The expectation for case managers is to have the Community Support Plan completed within a three month period from the time the client is registered in the program. The three month period allows the case manager and client the opportunity to get to know one another and establish a therapeutic alliance. The case manager is able to gather all of the necessary information to make informed decisions pertaining to treatment, planning (crises planning, relapse plan) and goal setting in conjunction with the client. The Community Support Plan is a living document that is kept on the clients chart and jointly reviewed and updated with the client on an annual basis. Involving the client fosters independence and self-determination as they can determine what they require in their recovery journey as well as determine their short and long term goals.

7.3 Counselling

Case managers of the Recovery Support Program often meet with clients in the community; counselling appointments are not limited to clinic visits but often occur at the client's residence. It is not unusual for clients to attend counselling sessions accompanied by a family member or peer support. Clients are encouraged to involve as many support persons in their recovery plan as they deem necessary. Counselling sessions are usually an hour in length, depending on the client's presenting issue and overall wellbeing. In terms of frequency of

sessions, case managers and clients jointly decide how often they should meet. Frequency of appointments is never static as clients may require closer spaced appointments if they are experiencing more acute symptoms.

As already stated, the over-arching framework in counselling sessions is the recovery approach which is utilized to guide all interventions. As previously mentioned, case managers utilize a range of theoretical models which are not limited to a client-centered approach, cognitive behavioral therapy, solution focused therapy and a strengths based approach. Clients therapy needs are specific and unique and consequently require different approaches based on the clients presenting issues and capacity for learning.

7.4 Medication Management & Monitoring

The clientele of the Rehabilitation Services Program are individuals that have been diagnosed with severe and persistent psychiatric illness, which requires pharmacotherapy for management of their condition. A function of case management in the Rehabilitation Program is medication management for clients. Anti-anxiety, anti-depressives, antipsychotics and mood stabilizers are primarily utilized depending on the client's illness. Case managers regularly check in with clients regarding their mood and overall functioning as well as the medication they are prescribed. It is important for case managers to be aware of whether the client is compliant with medication, note side effects and detect medication interactions to avoid relapse or complications. This information provides the opportunity to quickly intervene if clients are experiencing difficulties. Case managers can consult with the psychiatrist, pharmacist, general practitioner etc., for direction. Awad and Voruganti (2004) state that amongst

psychiatric clients, non-compliance to prescription medication is common, and can undermine the success of treatment.

As mentioned earlier in the paper, case managers in the program are comprised of nurses, psychiatric nurses and social workers. Nurses in the program have the capacity to give advice and direction to clients regarding the medications that they are prescribed as well as administration of injection medication. Unlike nurses, social workers are not trained in pharmacology and cannot give advice or instruction on medications. However as social workers we are able to educate ourselves on pharmacology to be able to identify early symptoms and be able to discuss this with the interdisciplinary team. It is helpful for the social worker to know which medications the client has tried in the past, which medications worked or did not work as well as be aware of the client's drug coverage and whether she/he can afford the medication. The acquisition of this knowledge enables the social worker to effectively advocate for clients so that they receive the best treatment.

Active monitoring of clients enables the case manager to identify any challenges that the client is experiencing and provide the appropriate interventions that the client requires. Crisis situations can often be averted when early interventions are put into place. Lukoff et al., (1986) state that:

> by regularly assessing patients, rehabilitation staff can improve the effectiveness of their interventions. Patients can be screened for high levels of symptomatology which might preclude assignment to rehabilitation programs with high levels of social stimulation. Monitoring the prodromal symptoms of relapse can sometimes prevent florid relapses and sustain a rehabilitative trajectory. (p. 578)

Clients on a CTO tend to be more frequently monitored. They may attend the clinic either weekly, bi-weekly or a monthly schedule depending on when they need their injections. These appointments provide an opportunity for the social worker to check in with the client and see how they are doing. For individuals on CTO's the process of frequent assessment is not only for therapeutic reasons but also as a means of ensuring that they are meeting the conditions of their order. In instances where clients fail to attend their injection medication appointment or are not adhering to the conditions of the CTO, it is the case manager's responsibility to take appropriate action. Compliance of CTO's in The Mental Health Services Act (1993) is as follows:

> Where a person who is the subject of a community treatment order fails to comply with the community treatment order and refuses to submit to a psychiatric examination to ascertain whether or not she should be admitted to an inpatient facility pursuant to section 24, the attending physician may order that the person be apprehended and immediately conveyed to a place where the attending physician may examine the person. (p. 17)

7.5 Family Support and Client Education

A key aspect of the Recovery Approach is the inclusion of family and friends as well as other individuals with whom the client maintains meaningful relationships. Having a broad support network contributes to personal wellness and enhances the skills to cope with rising situations. Clients can also benefit from having peer supports who are on a journey of recovery themselves. Family members and peer supports are encouraged to be active participants in the recovery planning. Their personal knowledge of the client can help formulate a personalized plan by taking the individual's strengths and difficulties into consideration. Clients identify benefits of having family involved in their treatment plan. These benefits include additional help in

management crisis situations and having these support persons inform the client if they notice signs of relapse. Clients also find that sharing their treatment plan and recovery goals often help them stay accountable and on track.

Clients that are referred to the Rehabilitation Services Program may have been living with mental illness for some time or be newly diagnosed. It is not uncommon for the client to have very little knowledge of mental illness. Client education is delivered primarily in individual counselling sessions which focus on defining mental illness and treatment options. Family members of clients who are involved in their treatment often attend these sessions to gain knowledge and awareness of their loved ones illness and how to best support them.

The Rehabilitation Support Program also offers clients and their family/support access to the "Depression & Bipolar Group" which I had the opportunity to co-facilitate. This group is five sessions in duration and focuses on specific education pertaining to depression and bipolar affective disorder, pharmacotherapy, treatment options as well as wellness, self-management strategies and recovery stories. My experience in this group was very good; I was expected to co-facilitate the group with another worker. The group was equally comprised of clients and family members. This was a new experience for me as I have always led only client groups. It was important to ensure that the information that was being presented met the needs of both the individual experiencing mental health problems and the family/support persons.

The group process went quite smoothly, the only challenge that was encountered was a client that did not feel like they should attend the group because they were doing fine but the family/support persons who thought the individual was unwell and poorly coping. These issues were resolved by meeting with them after group and problem solving. After some discussion the client disclosed that they were unwell and were willing to meet with their psychiatrist or

pharmacist the following week. The family/support person was encouraged to come to group on their own to gain knowledge and receive support. The group provided hope, support, education and accessible resources such as community agencies that offer consumer/family education and support groups such as the Schizophrenia Society.

7.6 Coordination and Referral

Case managers are required to coordinate services and referrals with other agencies for their clients. Coordination of services can be with a variety of stakeholders in the community. For example, when clients are hospitalized it is the case workers responsibility to have regular contact with the client and nursing staff at the hospital. The case manager is expected to provide assistance as required and attend case reviews and discharge planning meetings. The case manager is responsible to advise family members (if applicable) and residential service providers of the client's current circumstances. When appropriate, community resources (i.e., employer, vocational placement, service providers, etc.) are notified to ensure continuing involvement following discharge from hospital. Coordination of services is an intrinsic need of the client because it assures that a variety of needs such as any programs the client is involved in, basic needs etc., continue seamlessly regardless of the client's situation.

The mission statement of the Rehabilitation program is to improve the quality of life of persons living with long-term illness by enabling them to function as independently as possible in the living, working, learning and social environments of their choice (Regina Mental Health Clinic, Policies and Procedures, 1996, p.1). Client's needs are identified and reviewed on an ongoing basis and referral to other agencies is required to support the various needs of each client. Referrals to other agencies can pertain to any needs of the client related to housing (residential services, approved homes), food security, income support and medical needs.

The Rehabilitation Support Program also provides support for clients that seek vocational, social and recreational programming. The clients that have vocational goals are often referred to our vocational worker who helps the client identify short and long terms goals related to finding employment or education. Often referrals are made to the agencies such as the Neil Squire Society, Partners in Employment, Regina Work Preparation Centre, Saskatchewan Abilities Council, Autism Centre and the Canadian Mental Health Association to help meet the client's needs.

7.7 Outreach and Advocacy

Each case manager in the Rehabilitation Services Program is assigned the responsibility of liaising with another agency or group of service providers who are involved in the continuum of rehabilitation services for individuals who are mentally ill. Case managers are expected to maintain collaborative relationships with service providers in the community to facilitate better utilization of resources and a more effective response to the clientele that we serve. The purpose of outreach is to increase community awareness and understanding of individuals with mental illness and to facilitate communication between the Regina Mental Health Clinic and other service providing agencies. The goal of liaising with other agencies is to have a more coordinated and responsive community case management service. This results in better access to community resources and more effective utilization of services for our clients.

Case managers advocate ensuring that the agencies and organizations with who we liaise with are equally familiar with the mental health needs of clientele and the program and services that are offered in the Rehabilitation Services Program. Collaborative partnerships are essential in developing services that meet the needs of individuals with mental illness by ensuring the flow of pertinent program and policy information between agencies. Case managers also deliver

presentations to agencies and groups to inform and educate the community on mental illness, with the goal of eliminating stigma and oppression of individuals that live with mental illness. The Canadian Association of Social Workers (CASW) Code of Ethics (2005) states that, "Social workers oppose prejudice and discrimination against any person or group of persons, on any grounds, and specifically challenge views and actions that stereotype particular persons or groups" (p. 5).

During my practicum I had a few opportunities to advocate on behalf of my clients and help them with challenges that they were experiencing. A client was attending university and was unable to complete all of his assignments due to a learning disability. By writing a letter in his support he was able to successfully receive a deferral and was given additional time to complete his course work without a penalty. Another client had been issued a notice of eviction, due to not paying his rent on time and owed hundreds of dollars in late fees. I met with the client and we discussed his budgeting difficulties and were able to problem solve the situation. I contacted the landlord and suggested that we could arrange for the client's rent to be automatically deposited by the Saskatchewan Assured Income for Disability program (SAID) into the landlord account, which would prevent late payments for my client and provide for timely payment of his rent. The landlord consequently agreed to withdraw the eviction notice as he knew that he would be receiving payments on time.

8.0 Skills

The workers of the Rehabilitation Services Program are experienced case workers that possess skills necessary to invoke change in clients they work with. The skills that social workers require for this position are numerous. In addition to having sound knowledge of counseling theories and therapeutic interventions, workers must have strong advocacy and resource

brokerage skills. Social workers must also possess excellent case management skills to provide timely and comprehensive support to their clients. Case managers need to understand mental illness as well as know about interventions and treatment options. In addition, workers must have knowledge of the *Mental Health Act* and the *Health Information Protection Act* that provide legislative guidelines for working with people with mental health disorders in health care and protect the rights of these individuals.

The entire team of the Rehabilitation Services Program made it possible for me to reach all of my learning goals for my MSW practicum. Case managers were readily willing to let me assist them with cases which they felt would be rich learning opportunities. The interdisciplinary team permitted me to gain invaluable knowledge and be exposed to individual practice styles of case workers.

Learning about the *Mental Health Act* and how this legislation is utilized in practice (i.e., Judges Warrant and CTO's) was invaluable. My practicum experiences offered me the opportunity to work with a client who was on a CTO and observe the process of obtaining a Judges Warrant. Judges Warrants can be accessed by concerned citizens and professionals that identify that a person's mental health is decompensating and jeopardizing their safety and the safety of others. Citizens/professionals can document their concerns and meet with a judge who decides if the person requires medical attention. If the judge deems that they require medical attention they will contact the police and have the person apprehended and evaluated by a psychiatrist. These experiences provided me with a greater knowledge of the *Mental Health Act* as well as an understanding of the circumstances in which this piece of legislation can be utilized. Although I already possessed knowledge and experience working in mental health, I had not worked with clients with severe and persistent mental health disorders or clients that required

case management. My practicum experience provided opportunities to learn about treatment options for numerous disorders including schizophrenia and bipolar affective disorder. My learning goals were met by shadowing case workers, working with my assigned clients, reading literature, attending client's appointments with their psychiatrist/pharmacist and supervision sessions with other workers and my professional associate.

My work in the Rehabilitation Services Program made me reflect on my past learning and notice how powerful language can be. In my previous employment in mental health we referred to ourselves as "therapists". In the Rehabilitation Services Program case managers refer to themselves as "workers". I found the shift from "therapist" to "worker" to be enlightening. Adopting a new title fostered a more egalitarian relationship between myself and the clients and diminished the power differential in the therapeutic relationship.

My case management involvement proved to be instrumental to my learning. The pace of practice was different from my individual work as situations were changing on an ongoing basis. Crisis situations presented themselves frequently which necessitated rearrangement of schedules and dropping everything on a dime. This experience refined my crisis intervention, organizational, prioritizing, problem-solving and time management skills. Since the program is based on providing longer term service and supporting clients in all areas of their life, I had the opportunity to get to know clients and their families very well and foster strong therapeutic relationships. I really appreciated being involved with the "whole person" by using the recovery model.

What I most aappreciated during my practicum was learning about the recovery model and how it is applied in a mental health agency and in practice. The recovery model is very empowering for clients and their families because they have a voice and are actively involved in

their recovery plan. Utilization of the recovery model is still fairly new to the Regina Mental Health Clinic, and was often discussed in morning huddles, monthly team meetings as well as in supervision. It was very helpful to be involved in discussions of how to apply the recovery model when there are still aspects of the medical model that are being utilized in the RQHR. As a social worker I found that the recovery model tenets are very similar to social work values as this model seeks to eliminate oppression, break down power relationships and empower individuals in their self-determination.

My practicum experience helped broaden my knowledge base as a social worker in the area of severe mental health disorders, in the application of counselling theories, in clinical interventions, in case management and resource brokerage. I believe that the skills that I acquired and honed make me a more adaptable and well-rounded social worker. I feel that I have acquired the knowledge and confidence to be able to work successfully within a diverse range in mental health.

9.0 Vision

This experience not only contributed to my learning and growth as a social worker, but also made me further consider the importance of the social work profession. Having the title of social worker equates to a deep sense of responsibility to the individuals that we work with, to the community and overarching systems. By working with clients we are able to identify systemic problems and barriers and advocate for changes that will improve the quality of life, and human rights of all people with mental health disorders. By doing so, we are advocating for social justice. All social workers have the capacity to initiate changes in the micro, mezzo and macro levels of society as they are all interconnected and influence one another.

The Rehabilitation Services Program offers a vast range of services for clients focused on stabilization, wellness and meeting their recovery goals. The clinic maintains strong relationships with community stakeholders to ensure that clients receive seamless access to services that they require. The Rehabilitation Services Program staff are a group of highly trained and knowledgeable workers who are dedicated to the clients they serve and provide an ongoing commitment to improving the quality services to clients of the clinic.

A goal of my field practicum was to successfully identify gaps in service and areas that continue to require attention. The gaps that I identified were at a systemic level related to wait times for access, fiscal constraints and funding. Mental health services continue to be underfunded, which results in not being able to comprehensively meet the needs of individuals living with a mental illness. The Mental Health Commissions Strategy (2009) suggests that in order to change mental health in Canada and not to repeat historical neglects, that new investments are required by the private sector, social spending and government health in mental health.

The repercussions of inadequate funding are staffing difficulties which affect all aspects of service delivery. Subsequently, clients are placed on a waitlist and services are inaccessible and do not meet the needs of those suffering with mental health disorders. These issues were frustrating for me and other workers as the solutions to these issues revolves around the allocation of funds and the importance that is placed on certain programs.

Moving forward, social workers are likely to encounter similar issues unless mental health is finally given the recognition it deserves and starts to receive the funding that it requires. As social workers, it is essential that we continue to have a strong voice and advocate for fair allocation of resources, and eradication of stigmatizing and equality for all.

10. Conclusion

My MSW practicum provided an opportunity to enhance my clinical and case management skills, as well as my knowledge of mental health illnesses and available treatments. I feel that my MSW academic learning and clinical placement has thoroughly prepared me to be able to competently practice as a social worker. My MSW practicum experience made me realize that I truly enjoy working with clients in a clinical setting as well as in the community. Working in this capacity provided an opportunity for me to work at a micro, mezzo and macro level of social work practice. At the micro level, I was actively engaged with clients and their families. At a mezzo level, I collaborated with community stakeholders and institutions. At a macro practice level clients of the Rehabilitation Services Program were recruited and involved in changes in mental health service delivery at the clinic. Client engagement creates opportunities for clients to have a voice and fosters empowerment by being active participants in systemic change.

This experience ignited my desire to seek employment opportunities in mental health that incorporates both the clinical and community aspects. I am very thankful to have experienced such a rich, fulfilling practicum and to be surrounded by knowledgeable staff that were willing to share their expertise.

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