CLINICAL SOCIAL WORK WITH CHILD AND YOUTH MENTAL HEALTH IN VERNON JUBILEE HOSPITAL

by

Ashley Judge

B.S.W., University of Victoria, 2017

PRACTICUM REPORT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

April, 2019

TABLE OF CONTENTS

Abstract

This report focuses on what I learned about the child and youth mental health (CYMH) system during my Master of Social Work (MSW) practicum at Vernon Jubilee Hospital (VJH) located in Vernon, British Columbia. It targets the development of child and youth mental illness, as it relates to a holistic model of health and demonstrates the significance of social and cultural contexts in the search to improve the health of Aboriginal communities and reduce the vulnerability to children and youth at risk of developing a mental illness. Services on the Women and Children's Health Services (WCHS) unit at VJH are highlighted, including the assessment, treatment planning, safety planning, referral and safe discharge of CYMH clients. Reviewing the literature provided the theoretical context for connecting culturally diverse frameworks to clinical competencies in delivering CYMH care. Meanwhile, shadowing, clinical work, and ongoing supervision provided skill progression for increasing cultural competence in social workers and mental health care providers.

Word List

A–C

Aboriginal (adj)
acknowledgement(s) after-effect(s)
Antabuse (trademark) anti–sexual violence (adj)
Appendix A
attention-seeking (adj)
BC Children's Hospital
behaviour
borderline personality disorder
cellphone(s)
chapter 1
community mental health services
counselling

D–F

descendant(s)
ecosocial
emergency department (ER)
focusing
follow-up(s) (n/adj)

G–I government-funded (adj)
health care (n/adj)
I Learn (modules)
Indigenous (adj)
in-patient (n/adj)
interagency (adj)
interrelationship(s)
intersectoral

J–L judgment(s)
judgmental
(adj) lifelong
(adj)

M–O

Meditech (software)
Mental Health Act mental health–related (adj) midpoint
modelled
multidisciplinary
non-profit
(n/adj)

P–R person-centred
(adj) PhD
policy-maker(s)
practice (n) practise (vb) principal (adj, main)
principles (n, tenets)
problem-solving
(n/adj) psycho-education (n) quality-of-life (adj)
readmission(s) record keeping (n/adj)
Rehabilitation (unit)
report (vs. paper)

S–V section 4.17
self-care (n/adj) self-esteem (n) set-up (n)
smartphone(s) socio-economic (adj)
sociopolitical (adj)
sub-goal(s)
takeaway(s) time frame(s) towards
versus

W–Z

waitlist(s) well-being world view(s)

List of Abbreviations

ADHD	attention-deficit hyperactivity disorder
BJJ	Brazilian jiu-jitsu
BPS	biopsychosocial
BPSS	biopsychosocial-spiritual
BSW	Bachelor of Social Work
CBT	cognitive-behavioural therapy
CYMH	child and youth mental health
DDMHS	Developmental Disabilities Mental Health Services
ER	emergency department
FASD	fetal alcohol spectrum disorder
IRSS	Indian residential school system
MCFD	Ministry of Children and Family Development
NOK	North Okanagan
ODD	oppositional defiant disorder
PCC	patient care coordinator
PIE	person-in-environment
PTSD	post-traumatic stress disorder
QRT	Quick Response Team
SANE	Sexual Assault Nurse Examiner
SCAN	suspected child abuse and neglect
SDOH	social determinants of health
VJH	Vernon Jubilee Hospital
WCHS	Women and Children's Health Services
WHO	World Health Organization

Acknowledgements

I would like to acknowledge and thank the North Okanagan Social Work Department at the Vernon Jubilee hospital (Alley Periton, Juanita Post, Kimberly Skerritt, Tonya Ciccone, Megan DeSimone, Kristeena Robinson, Courtney Dennis, Lindsay Walker, Trevor Carpenter and Bonnie Richardson) for their incredible warmth, openness and welcome, which fostered a wonderful atmosphere for learning. In the past three years, I learned an abundance regarding social work practice through my work with clients and from my supervisors, professors, practicum placements, colleagues and fellow students. To the people, I have met along the way that have pushed me, inspired me and made my journey possible, thank you for your continued support.

My time with the North Okanagan Social Work Department has been extremely valuable in developing my practice, and I am privileged to have spent my time working alongside people who have such passion and genuine commitment to their profession. Throughout my work experience I have seen their unwavering dedication to social justice, as they strive to meet the needs of the most marginalized and ill people in our society.

Additionally, I would like to impart a personal thank-you to my academic supervisor, Tammy Pearson, PhD. Tammy has been my clinical supervisor and academic guide. Her direction and support have helped me build upon and sharpen my skills and practice, and for this I am deeply thankful. I would also like to thank my committee members, Si Transken, PhD, and Juanita Post, for their time, effort and support in helping me complete my master's degree.

Lastly, I would like to thank my family, friends and co-workers for their constant support on this educational journey. I will always remember and be grateful for my time in Prince George and Vernon, as it has helped to shape me, as an individual and clinician which has provided me with a solid foundation for my practice.

Dedication

I want to extend my heartfelt gratitude to my mother Janice and deceased step-father "Papa Ken." Without my mother's patience, support and unconditional positive regard and my stepfather's meddling and welcomed guidance, I would not be where I am today. This report is dedicated to them and to all the children and youth who struggle with a mental illness and those who did not receive the quality of care they deserved in time and to the individuals who are yet to be reached. This report is also written in part of my personal effort to combat the stigma against mental illness, especially the stigma against borderline personality disorder.

Chapter 1: Introduction to the Practicum

According to the Canadian Mental Health Association (2014), "one in seven" of the children and youth in British Columbia experience mental health challenges that hinder their development. When left untreated, these same issues can follow children and youth into adulthood. The purpose of my practicum, which occurred from April 23 to August 3, 2018—was to learn how social work practice is applied with children and youth in a hospital setting. At the midpoint of my practicum, my focus narrowed to child and youth mental health (CYMH) services at my practicum site, Vernon Jubilee Hospital (VJH). Specifically, I focused my learning in the area of clinical social work and CYMH. My conceptual framework consists of strength-based and empowerment practice, anti-oppressive, structural, social determinants of health and person-in environment lenses. I self-locate, as a person with a mental illness, who is passionate about fighting the stigma surrounding mental illness and reducing barriers to appropriate treatment and supports. As a professional, I am continuously gaining more psycho-education on topics concerning the transformation of the treatment of the various mental illnesses that individuals encounter.

The obstacles I have conquered and the positive gains I have made in my life are a testament to the importance of incorporating strength-based and empowerment frameworks when supporting all individuals who are faced with a mental illness. Because of my own experiences with mental illness and trauma, I have developed a strong empathy for clients in vulnerable situations. My personal history is partly why I am drawn to clinical and medical social work. I wish to alleviate unnecessary pain and suffering that individuals with a mental illness endure.

Practicing from the framework allowed me to see the larger social issues and the impact individuals' encounter on a regular basis.

Personal Positioning

I am of Ukrainian, Irish, English and Norwegian descent. My personal and family history, professional experience, and my social work education has strongly influenced and developed my theoretical orientation, which provided me with the insight and empathy required for professional social work practice with children and youth who are faced with a mental illness. When I was an adolescent, my mental health challenges began to emerge. I was often very depressed, anxious and felt incredibly lonely, as if no one understood what I was going through. The maternal side of my family sought professional help for my situation however, it was not successful. My mother continued to take me to multiple psychiatrists and counsellors to gain knowledge about my mental health, but helpful direction was not provided at that period of time. In contrast, the paternal side of my family did not talk about mental illness and pretended that mental illnesses did not exist. The suppression of speaking about one's mental illness, coupled with my secretive eating disorder and self-mutilating behaviours, served to compound my feelings of hopelessness, shame and stigmatization. Having suffered with severe mental illnesses on and off for about 16 years, I gained the personal insight, motivation and sense of purpose to reduce the suffering in relation to untreated and misunderstood mental illnesses. Consequently, I went through many years of confusion and struggled trying to help myself. These life experiences have made me passionate about the goal of educating people about living with a mental illness and the support required when faced with a mental illness. Eventually, I received the proper diagnosis and treatment which made a tremendous difference in my life.

My personal history partly explains why I am drawn to clinical counselling in relation to mental health. The obstacles I have conquered and the positive gains I have made in my life are a testament to the importance of incorporating strength and empowerment frameworks when supporting clients.

In 2015, I was enrolled in the Bachelor of Social Work (BSW) program through the University of Victoria. Before and throughout my BSW studies, I was fascinated with learning more about mental health. I have been drawn to viewing health using the social determinants of health model. I have also been drawn to the biopsychosocial (BPS) system framework. These frameworks focus on the person in environment which includes, family, community, society (Ragesh, Hamza, & Kvn, 2015, p. 165-167; World Health Organization, 2007), which is influenced by intersectional needs and issues within the various systems. The World Health Organization (WHO) lists the critical social determinants of health, which are culturally and globally similar. Social and emotional well-being is considered to be a very important social determinant of health (WHO, 2012). Community social supports greatly impact on the quality of the emotional and mental health of children and youth. Child and youth mental health (CYMH) consists of the interaction and balance of social institutions and the adolescents who are acculturated into the current political and social environment. Subsequently, these social institutions exist within the same social system and influence how and if people can achieve a holistic life. Through multidisciplinary professional teams within medical facilities such as clinics and hospitals, many complicated needs can be assessed and met. Within our families, cities, workplaces and schools, we learn and teach to foster the psychological and social skill development of children and youth.

SDOH and holistic frameworks align with social work values and principles in how they evaluate all intersectional social factors in an individual's, organization's or community's environment and explain what areas are injured by social inequality. A holistic, biopsychosocialspiritual (BPSS) approach to health acknowledges how biological, psychological, sociological and spiritual areas affect one another and shape health. By approaching clients with a holistic, person-in-environment (PIE) perspective, I can more easily see and understand the structural issues that may impact them. Intersectional and anti-oppressive frameworks are invaluable for perceiving all the interacting social issues in patients' lives present with symptoms of a mental illness. In addition to such theoretical frameworks, my experiences as a youth with mental illness have also influenced my social work practice and made me appreciate the importance of empathy, patience and community supports.

My work experiences have also shaped my theoretical orientation. I currently hold two positions. My first position is a residential youth worker with the North Okanagan Youth and Family Services Society. The youth I work with have diverse backgrounds in regards to the situations that have led them to residential care. Frequently, I work with children and youth who have experienced trauma. In cases of CYMH issues, there is a pattern of an unstable home environment, maladaptive coping skills, behavioural challenges, and symptoms of mental illness. In a number of cases, there appears to be an apparent biological connection, with the youth displaying or developing similar characteristics to the mental illness exhibited by their parent. Witnessing this connection has intrigued me to better understand how the implementation of early preventative measures can lead to better outcomes for future generations of children and youth experiencing a mental illness.

Mental illness can be inherited, but also stems from a lack of achieving or maintaining access to the social determinants of health. Additionally, this finding has encouraged me to learn and develop the skills and knowledge of approaches social workers use to assist youth who have a mental illness or symptoms of a mental illness. These skills include being curious and accepting that the youth is the expert on their mental health challenges. Developing a safe therapeutic relationship with the youth. I use what Rogers termed "positive regard" (as cited in Miller, 2012) to emotionally support them and assess the circumstances that have led to their current situation. Through my practicum setting, I had the opportunity to understand how clinical social work skills can be used in an acute health care setting to assess patients, develop care plans, arrange a safe discharge, and achieve community collaboration to facilitate preventative and protective measures in the lives of youth with mental health challenges.

Practicum Placement

My practicum occurred within a few different units within the Vernon Jubilee Hospital (VJH) one of the regional hospitals under the umbrella of Interior Health. This 148-162 bed hospital is centrally located in the city of Vernon (pop. 40,000), in the Okanagan region of British Columbia's Southern Interior. The land on which VJH was built originally "belonged to the Interior Salish people" (Okanagan Nation Alliance, 2017, p. 2). In "1811 first contact between Indigenous people and white traders began, with the west trail along Okanagan Lake used to export furs from by the Pacific Fur Company, the Northwest Co and the Hudson's Bay Company successively" (Vernon City Counsel, 2016, p. 5). The influx of foreign settlers resulted in land being claimed, bought, and mined for gold (Vernon City Counsel, 2016, p. 6). With continued growth in population local government was established and more people were drawn to the

potential economic success of ranching, farming and developing fruit orchards (Vernon City Counsel, 2016, p. 5-6) later in "1859 Oblate missionaries arrived drawn by the Indigenous presence" (Vernon City Counsel, 2016, p. 5.). Two years later a "large Indian Reserve was constructed" (Vernon City Counsel, 2016, p. 5) fast forward to today and the end result is two reserves "a small one at the head of Okanagan Lake and on the west side of the lake a larger reserve" (p. 5). The land on which VJH is built is the traditional territory of the Syilx peoples. The story of how VJH came to be constructed has multiple variations, I will discuss them next.

From my research on the land upon which VJH was built I came across two different explanations for what spurred VJH origins of development and expansion. According to the Vernon Jubilee Hospital Foundation, a charitable society that supports health care in the North Okanagan the mayors wife Mrs. F Cameron lead a committee raising funds to construct a hospital in 1897 after a diphtheria outbreak (VJH Foundation).The alternative story I came upon focuses on the journey of Samuel Polson and his family originally from Scotland came over to Manitoba (Harder, 2015). Later in his life after becoming a preacher one among many of his other career paths he became involved in real estate and purchased land in the Okanagan including Polson Park and the land upon which VJH was constructed (Harder, 2015). Samuel's wife Elizabeth was mentioned as being an advocate for the hospital she was the president of the women's hospital auxiliary and in 1908 Samuel ended up donating 25 acres of land to the city of Vernon a portion of this land became VJH (Harder, 2015).

This day inside the entrance to Polson Tower at VJH an art piece titled Star Blanket of Life is displayed. This piece was painted by David Wilson an Aboriginal artist commissioned by the health authority with the Okanagan Nation Alliance to be displayed at VJH and presented during a prayer, song and drumming ceremony in 2012 (Froneman, 2015).

Additionally, two others of Wilson's paintings, representing the four seasons, commissioned in 2011 when the tower opened now serve as the donors' wall. In attendance at the ceremony for the unveiling of Star Blanket of Life were hospital and B.C. Interior Health personnel and members of the Okanagan Indian Band such as Chief Byron Louis and local elder Victor Antoine. The purpose of the ceremony was a statement towards reconciliation representing a commitment from both organizations to "work together to ensure more equitable and accessible health care services from the Syilx nation and other Aboriginal members" as stated by Richard Harding the health services administrator for the North Okanagan (Froneman, 2015). During this ceremony Richard also gave acknowledgment of the land displacement and health inequity experienced by the traditional Okanagan peoples by stating: "VJH is located in traditional Okanagan Nation territory and work still needs to be done to improve competent health care for Aboriginal peoples and foster an atmosphere that welcomes all people at the hospital" (Froneman, 2015).

Employed by Vernon Jubilee Hospital is the North Okanagan (NOK) Social Work Department. The North Okanagan (NOK) Social Work Department has social workers assigned to various units. My practicum learning occurred on the Quick Response Team (QRT), Women and Children's Health Services (WCHS), and Rehabilitation. Learning about clinical social work practice in a community and acute care hospital setting, as it relates to child and youth mental health (CYMH), was a worthwhile learning experience that I discuss in the succeeding chapters. For the purpose of this report, I mainly focus on my time completed in the Women and Children's Health Services unit, since this unit provided me with the most learning regarding the application of clinical social work skills with CYMH populations.

The first part of my practicum occurred with the Quick Response Team (QRT). This multidisciplinary team of health care professionals included part-time social workers who provided services to vulnerable people leaving the hospital or at risk of hospital admission (Interior Health, n.d.). The role of these social workers involved the completion of psychosocial assessments. Based on the psychosocial assessment, the social worker can take on a variety of roles, depending on the individual needs of clients. Some examples of roles are crisis intervention, resource counselling and referrals, system navigation and advocacy.

Emergency Response and Community Work

The role of social workers in the Emergency Department (ER) can vary depending on the presenting issues that the client is exhibiting. One of the main tasks of an ER social worker is connecting patients to the services they need at home and in the community, to avoid unnecessary admissions and readmissions (various authors, as cited in Auerbach & Mason, 2010). This valuable service aids in the reduction of excessive health insurance costs. In addition to reducing costs, connecting patients to community services can be viewed, as a preventative service. As a result, clients are informed about alternative ways they can care for their health and learn advocacy skills, resulting in client empowerment and reduced use of services.

Vernon Jubilee Hospital: Women and Children's Health Services Unit

The second part of my practicum took place in the Women and Children's Health Services (WCHS) unit. This particular unit provides maternity, obstetrics, pediatrics, and acute health care services for women's specific health issues. The pediatrics section of this ward is where clients with CYMH needs receive health care services. VJH has created an information brochure for

patients, families and caregivers titled "You Have Been Admitted to the Hospital… Child and Youth Mental Health Admissions" (Interior Health, n.d.; see Appendix E for a copy of the brochure). The purpose of this brochure is to inform clients, families, and caregivers of what to expect during admission and who is involved in the support and treatment process. Acute CYMH admission staff includes a team of professionals composed of adolescent and family psychiatrists, nurses, social workers, pediatricians, dietitians, care aids and the patient care coordinator (PCC). The latter oversees the entire WCHS unit. The PCC works with all unit staff and is responsible for daily operations of the unit, such as supporting staff, responding to grievances, supervising staff and consulting on cases. The social worker who is part of the unit team works closely with all members of the team to ensure safe and quality care for the children and youth admitted. During an admission the team collaborates in an effort to achieve "stabilization, assessments, treatment and support plans, safety contracts, referrals, and if necessary, team meetings in the process of providing acute health care services" (Interior Health, n.d.).

The pediatrics section of the WCHS unit provides free assessments, medication reviews, written care plans, visitation and safety contracts, and referrals to local and provincial CYMH services for patients, families and caregivers (Interior Health, n.d.). The WCHS unit at VJH has outlined the following admission and treatment plan in the aforementioned admissions brochure. A treatment plan may include the following elements:

I. Written care plan
II. Reviewing current medications
III. Changing medications
IV. Limited or low stimulation activities
V. Interviews and assessment
VI. Suicide assessment
VII. Safety contract

VIII. Visitation contract
IX. Passes (to leave the unit or hospital)
X. Team meeting
XI. Referral to: Local CYMH; Local counselling; Adolescent psychiatric unit; BC Children's Hospital in Vancouver. (Interior Health, n.d.)

Client Population, Mandate, and Services Provided

Interior Health is "mandated by the Health Authorities Act to plan, deliver, monitor, and report on publicly funded health services for the people that live within its boundaries. Interior Health's Vision, Mission, Values, and Guiding Principles inform how it delivers on its legislated mandate" (Interior Health Authority, 2018, p. 5). Interior Health's vision is "to set new standards of excellence in the delivery of health services in the Province of British Columbia" (Interior Health, 2018). Their mission, as stated on the Interior Health website is to "promote healthy lifestyles and provide needed health services in a timely, caring, and efficient manner, to the highest professional and quality standards" (Interior Health, 2018). Interior Health's guiding goals are as follows:

1. Improve health and wellness
2. Deliver high quality care
3. Ensure sustainable health care by improving innovation, productivity, and efficiency
4. Cultivate an engaged workforce and healthy workplace (Interior Health, 2018)

Vernon Jubilee Hospital is one of 16 hospitals under the branch of the Interior Health Authority. Vernon has a population of approximately 40, 000 people. VJH serves all members of society, all ages, abilities, backgrounds, genders and orientations. On the pediatrics section of the WCHS unit is where CYMH admissions are placed. Client services for CYMH patients are available in the local and closely surrounding areas of Salmon Arm, Lumby, Enderby and

Armstrong. Children and youth who are having severe concerns with their mental and emotional health are admitted to VJH after intake in the emergency department. The presenting mental and emotional health concerns I encountered during my practicum are as follows: depression, depressive symptoms, non-suicidal self-harm, fetal alcohol spectrum disorder (FASD), attention deficit hyperactivity disorder (ADHD), addiction to or abuse of alcohol, suicidal ideation, oppositional defiance disorder (ODD), borderline personality disorder (BPD), anxiety, intellectual and developmental disabilities, post-traumatic stress disorder (PTSD), and aggressive behaviours. The social worker's role is to assess the patient's mental health issues using a biopsychosocial (BPS) framework. This includes identifying barriers to accessing quality mental health supports in all areas of the client's life and making access easier and quicker. Interagency referrals are made automatically if local CYMH services have been involved.

Examples of reducing barriers can include having the patient talk to a psychiatrist, social worker, and pediatrician about mental health challenges and other problems; connecting and fasttracking the patient to local CYMH services and clinicians provided and funded by the Ministry of Children and Family Development; and having the patient receive psycho-education tailored to an individual patient's treatment and prevention. Understanding the process of admittance, agency structure, mandate, goals, client population, and the services provided helped in guiding my learning goals, which evolved during my practicum. Approximately at the midpoint in my practicum, I had a change in field placement supervisors. This change resulted in some redirection of goals, specifically to narrow my focus to CYMH services at VJH. The following were my original learning goals. The remainder of my report outlines my new expertise in acute clinical social work with CYMH patients.

Learning Goals

The overall objective of my practicum was to develop my skills and confidence with clinical social work practice, with a focus on studying and learning the services and tools social workers may use to support CYMH clients and their families. I wanted to practise using a variety of clinical social work assessment tools through a biopsychosocial-spiritual (BPSS) lens applied in a hospital setting. From this main objective, I identified the following goals and sub-goals that assisted me in achieving my objectives:

I. Continue to develop a professional identity as a social worker and recognize client and community issues from a structural perspective.
    a. Maintain professional boundaries and engage in ethical practice;
    b. Engage in reflexivity through a combination of journaling and debriefing with supervisors and mentors;
    c. Further develop my professional practice framework as I integrate my learning and experiences from my placement;
    d. Obtain clinical supervision and feedback and meet with my supervisors, as needed;
    e. Understand the structural issues that may impact the client population that I work with.

II. Gain familiarity with the practice environment and agency structure
    a. Review agency structure and policy;
    b. Complete the eight hours of I Learn modules before I begin training in the hospital, as required in the hospital social work role;

c. Observe and work collaboratively with co-workers, supervisors and professionals from other disciplines;
d. Participate in clinical supervision, team and interdisciplinary meetings;
e. Familiarize myself with clinical and hospital social worker roles and techniques used at VJH.

III. Develop clinical and medical social work skills

a. Review and gain familiarity with theories, frameworks, and how social work theory and practice are applied in the hospital setting;
b. Continue to develop my skills in the area of intake, assessment, treatment planning, discharge, community follow-up and termination;
c. Receive continuous supervision and feedback from my supervisors (Megan, Alley and Kimberly);
d. Practice clinical and hospital social work skills with patients, families and other health care professionals;
e. Develop record keeping and case management skills as applicable to working in a hospital;
f. Develop an understanding of how social workers in hospitals can work within the medical model to practise ethically and assist clients in an empowering, antioppressive, and person-centred manner;
g. Read and familiarize myself with the SANE manual and program, which stands for Sexual Assault Nurse Examiners, who are “registered nurses who have completed specialized education and clinical preparation in the medical forensic care of the patient who has experienced sexual assault or abuse” (Hanlon, 2018).

IV. Develop self-care strategies that will enhance my social and emotional well-being
    a. Continue to maintain my self-care strategies to maintain balance, which include exercising at the gym and training in Brazilian jiu-jitsu, getting adequate amounts of sleep, taking my medication, being social with friends and family, reading and practising deep breathing exercises. Part of my wellness plan will be gaining support and approval of my plan with my supervisors to ensure the prioritization of my wellness.
    b. Meet regularly with my supervisors to engage in clinical supervision and to debrief intense and triggering experiences
V. Develop an understanding of community agencies that are connected to my practicum organization and that are able to provide additional support to my clients as needed
    a. Review resources within and outside of the Vernon and Okanagan area
    b. Develop relationships with additional community agencies
    c. Have the ability to make referrals as needed
    d. Connect person-in-environment, anti-oppressive and structural frameworks to VJH's resourcing and networking

To establish the evaluation of my performance, I met regularly with my practicum supervisors for reflective discussions and supervision. This ensured I was delivering competent and ethical clinical social work that linked theory to practice. To ensure I was sufficiently prepared for practicing acute clinical social work, attending supervision meetings and accomplishing my learning goals, during my practicum I engaged in reflexive practice, defined as an individual's self-critical approach that encourages questions on how knowledge is generated and how relations of power interact throughout this process (DCruz, Gillingham, &

Melendez, 2006, p. 75). To employ reflexivity, I kept a creative art journal that reflected on my practice, as it connected to my learning goals.

Chapter 2: Literature Review

This section broadly discusses the literature relating to child and youth mental health (CYMH). CYMH is discussed from international, provincial, and cultural perspectives. Specifically identifying risk factors for CYMH development in an Aboriginal context. After presenting some relevant definitions from the World Health Organization, my literature review discusses the final report of B.C.'s Select Standing Committee on Children and Youth, *Child and Youth Mental Health in British Columbia: Concrete Actions for Systemic Change* (Ryan-Lloyd, Morrison, & van Leeeuwen, 2016), which outlines how CYMH services can be improved. I then extensively review the literature on CYMH and CYMH in an Aboriginal context. This allows a deeper understanding of the influence of intergenerational trauma on the mental health of children and youth, the way the biopsychosocial (BPS) framework is interpreted, and the importance of a culturally respectful therapeutic relationship. Presenting mental health issues at VJH, and a social worker's role in CYMH service provision are highlighted. The literature on hospital social work has been on roles involving reducing hospital admissions, single-sessions where the social worker intervenes by assessing and creating discharge plans for patients and their families within a limited time-frame through connecting them to hospital and community resources that best suits their health care needs (Auerbach, & Mason, 2010, p. 315). I then discuss non-suicidal self harm, depression and suicidal ideation, as specific examples of CYMH issues. In addition, I address social work assessments and services in hospital, and how these can be used in social work practice with children and youth with mental health challenges. I then discuss the development of CYMH and what mental health service providers can do to bring a more culturally sensitive approach and understanding of CYMH in an Aboriginal context and how to incorporate this into social work practice with survivors of intergenerational trauma.

Child and Youth Mental Health

The World Health Organization describes mental health as being critical to overall well-being and health as a balance of complete physical, mental and social wellness (WHO, 2013). Mental health is influenced by multiple factors in a person's life. The WHO (2012) states that happy and confident adolescents are likely to grow into happy and confident adults. Strong emotional and mental health leads to feelings of well-being, which strongly influences youth self-esteem, behaviour, and educational achievements, and social belonging (WHO, 2012). Strong, healthy foundations for children and youth such as these has been shown to improve CYMH outcomes as well as mental health as an adult. Directly linked to the family foundation, mental health is shaped by socio-economic factors (WHO, 2013). The social determinants of health are very closely linked to prevention, development, treatment, and status of mental illness. Each child and youth will grow up in a unique social context. Due to current social-political environments, some families face more difficulties and are more vulnerable in comparison to others. Factors that expose people to risk of poor mental health outcomes are poverty, child maltreatment (such as neglect) or abuse; early exposure to substances; belonging to minority groups or Indigenous populations; and non-heterosexual orientations (Ryan-Lloyd, Morrison, & van Leeuwen, 2016, p. 6). Health care funds targeted towards creating, growing and maintaining CYMH programs has been shrinking over the years.

In 2013, in British Columbia, the Select Standing Committee on Children and Youth undertook a project to study CYMH. The committee's final report acknowledged six high priority areas in CYMH. Barriers to CYMH services were classified into the following six areas. The first is insuring CYMH funding reaches the organizations directly providing services. The second is reducing wait times for accessing services (to within 30 days). Third, children and

youth should be offering input into the programs, with client satisfaction surveys being continuously developed and administered. The report outlined mental health programs developmentally appropriate for youth that need to be expanded. The fourth barrier documented was the need for more effective service delivery (5). A lack of child-and-youth-friendly services were identified with the committee recommending a preventative framework focused on maintaining and promoting mental wellness through initiatives that utilized client feedback and online services (6). This would involve early intervention, screening and prevention programs. According to the report, these programs need to be seen as higher priority to ensure their preservation through funding. Funding preventative programs is recommended to reduce the cost of mental health issues and cost throughout the remainder of a youth's life. The fifth barrier concerns clinical services. This idea promotes that each community that provides CYMH clinical service needs to be connected with other community services. For example, an initiative such as outreach teams could act, as the point of first contact instead of hospital emergency departments later on, when crisis intervention becomes the immediate problem. Unfortunately, once a patient is discharged, treatment plans and follow-up time frames need to be publicly funded and advertised. Increasing the number of transitional (in-patient and outpatient) services requires more health care workers such as psychiatric nurses, social workers, and mental health clinicians, child and adolescent psychiatrists, and on-call psychologists. The report further indicates a need for increased availability of clinical services to rural areas, which could be achieved through technologies such as telehealth and other online initiatives.

Lastly, as the sixth barrier, the report notes that the transition age of 18 is creating a huge gap in CYMH services. Specifically, when they turn 18 years of age, youth no longer qualify for the previous services they were receiving. This could send the message that youth have lost their

value as a mental health client. In response to this finding, the report offers suggestions for continuing mental health services into young adulthood. It also identifies vulnerable populations "that need special attention" (Ryan-Lloyd, Morrison, & van Leeuwen, 2016, p. 6). Listed vulnerable populations according to the report were "Aboriginal children and youth, sexual and gender minority youth, children in care, and special needs children and youth" (p. 6). School districts were implied to be responsible for mental health programs to support sexual and gender minority youth. Due to the increased risk of mental health issues, the committee recommended that "all children in care have access to mental wellness programs and early intervention programs" (p. 7). Further, the report recommended that "culturally appropriate services for Aboriginal children and youth be publicly funded" (p. v7).

CYMH in Norwegian, Hungarian and Aboriginal cultures.

Having explored the concept of CYMH at the international (WHO) and provincial levels, this section briefly compares a few alternative cultural perspectives to the Western understanding of child and youth mental illness. In Canadian culture mental health is usually not talked about unless there is a problem or unbalance. These problems tend to be labelled as illnesses or disorders of the individual. In cultures that lean towards the socialist spectrum, mental health is viewed as interdependent with and not separate (or separable) from social well-being. An issue of an individual, family or community is shared, and can be improved through the collaboration between individuals and groups, use of social policies, relationships, and the community working together towards the goal of wellness for all.

For instance, a study on post-traumatic growth (resilience) in Norwegian youth identified improvement in interpersonal relationships, feelings of maturity and wisdom, and a desire to help

and protect others (Glad, Jensen, Holt, & Ormhaug, 2013) these were linked to increasing resilience in these youth. Elsewhere, examples of the consequences of large disparities in socioeconomic resources and the social determinants of health (SDOH) can be seen from a study on mental well-being among Hungarian adolescents (Varga, Piko, & Fitzpatrick, 2014). This study demonstrated that promoting mental health at a young age had a positive effect on physical health later in life. In terms of socio-economic markers, the study found that youth with parents who worked manual jobs or were unemployed had lower scores of mental well-being (Varga et al., 2014). The study promotes awareness of these groups of adolescents being at a higher risk of having mental health challenges and that high schools in socio-economically disadvantaged regions are likely to have similar mental wellness outcomes. Results from the 2014 study by Varga and colleagues indicate where the mental health programs, funding and staff need to be in placed to prevent poor mental health outcomes and promote positive current and future mental and physical health outcomes. These findings are transferable to a Canadian context in illustrating how socio-economically disadvantaged and marginalized populations are at increased risk of developing mental health issues.

In Aboriginal cultures, mental health issues are not viewed as solely an individual's illness, but represent an imbalance in a person's life, relationships, or and even the sickness of an entire community and experiencing oppression. Health is understood in a holistic context, with cultural and spiritual health tied to mental and physical well-being (King, 2014). Due to cross-cultural differences in understanding mental health, extra consideration is needed in how mental health professionals, doctors, funders, and social policy-makers interact, speak about, and educate themselves. Continuing mental health professional development and disciplinary

competence require more focus on informing mental health professionals of the diverse cultural and theoretical ways to approach, understand and heal mental health issues.

Child and Youth Mental Health in an Aboriginal Context

Consecutively, to grasp CYMH within the context of Aboriginal communities and the intergenerational inheritance, it is imperative to understand the BPS influences on mental illness. Trauma can impact any area of life. Thira (2016), in a workshop booklet, gives an example of emotional and psychological trauma, defining it as the "day-to-day exposure of a profound emotional wound based on a horrific experience in the past" (p. 49). An instrumental source of mental illness and trauma for Aboriginal peoples is colonization (Roy, Noomohamed, Henderson, & Thurston, 2015). Colonization is not a historical term to be spoken of in the past tense but a reminder of the insidious and ongoing oppression Aboriginal people in Canada have been experiencing shortly after first contact between Aboriginals and settlers. One example of colonization in Canada is the Indian residential school system (IRSS). The intergenerational impacts of the IRSS can still be seen today in the higher rates of suicide, mental illness and trauma many Aboriginal communities and families are dealing with. For the purpose of this report, intergenerational trauma refers to the commonality between historical and present day racist social policies. Some examples are the IRSS, 1969 white paper and existing governmental policies that continue the destruction of Indigenous peoples and their culture through microaggressions carried out daily hidden in plain sight.

Intergenerational trauma is a term used to explain the long--lasting impact of the Indian residential schools and additional abusive policies on Aboriginal people and their culture. These long--lasting memories and effects live on through the processes of "historical trauma

transmission, collective trauma, transgendered grief, and historic grief" (Brave Heart & DeBruyn, 1998, p. 288). These are additional labels used by various Indigenous cultures and scholars to place a name on the damage from acculturation suffered by the First Nations peoples in the Americas. Intergenerational trauma affects not only those who attended Indian residential schools, places where racism, neglect and abuse were common. Intergenerational trauma also affects all Indigenous people in how families pass down their cultural knowledge and experiences through parenting with each subsequent generation. Ongoing repeated cycles of abuse, addiction, mental illness, suicide and trauma are imbedded into children who likely will expose their children to risk of inheriting their parent's trauma.

Excessively high suicide rates among Aboriginal people are one outcome of intergenerational trauma. According to Strickland, youth suicide has been linked to intergenerational trauma (as cited in Roy et al., 2015). For example, in a study conducted by Chounard and colleagues, Aboriginal youth were found to commit suicide six times more often than the national average of non-Aboriginal youth (as cited in Roy et al., 2015), with the "rates for Inuit youth eleven times higher and being among the highest rates in the world" (Government of Canada, 2018). Intergenerational trauma has also been associated with maladaptive coping such as substance abuse and violence (Roy et al., 2015). Substance abuse has in turn been affiliated with the development of post-traumatic stress disorder (PTSD) or complex trauma symptoms in family members of IRSS survivors (O'Neill, Fraser, Kitchenham, & McDonald, 2018). Other researchers have spotlighted how Canada's efforts of colonization and cultural discontinuity are linked to social issues of substance abuse and violence, which diminishes health and well-being and may spread the predominance of mental health issues (Rousseau, Guzder, & Kirmayer, 2014). Healing mental illness within an Aboriginal context involves not only the

personal emotional or psychological recovery, but also the wider society, communities, families and healing of the spirit. More government funding, more programs and more awareness are needed to begin to mend the harm caused by colonization (Ryan-Lloyd, Morrison, & van Leeuwen, 2016, p. vii). As long as caregivers continue to carry their trauma, then they will influence the mental well-being of their children, who often grow up to repeat a similar cycle of intergenerational trauma.

Understanding the Development of Child and Youth Mental Health

Mental illness in children and youth can present with many faces. The symptoms of depression can look different depending on the individual characteristics of the child or youth. Of course, the definition of depression in the *Diagnostic and Statistical Manual of Mental Disorders (DSM5)* will remain the same across the field of psychiatry and clinical social work. For example, the American Psychiatric Association (2013) describes depression as having common features such as the presence of sad, empty, or irritable mood, which can be accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function and care for themselves. Consistency in communication across disciplines is necessary. During my practicum I engaged with various children and youth with mental health issues. This section explores the frequent representations of poor mental health outcomes at Vernon Jubilee Hospital. From the first day of my practicum on the Women and Children's Health Services (WCHS) unit, I had the opportunity to shadow a complex case involving a female youth. For confidentiality reasons, I will refer to her as Mel. Mel had originally been admitted to the hospital due to an incident of dangerous behaviour at home. An ambulance was called and took her to the hospital. After admission, Mel was treated in the pediatrics section of the WCHS unit. Mel had the

following diagnoses: anxiety, attachment trauma, autism spectrum behaviours and suicidal ideation. During Mel's stay I had the opportunity to attend a CYMH planning and discharge meeting in reference to Mel's care. This meeting reaffirmed my knowledge regarding the likelihood of diverse symptoms of various mental illnesses coexisting in one person; I knew how common it is for a child or youth to have multiple mental health issues concurrently.

Mental illnesses that often present together are depression, non-suicidal self-harm and suicidal ideation. Throughout my practicum I witnessed numerous combinations of concurrent mental health issues. The explanation for what causes mental illness is complex. Depending on a person's cultural upbringing, the origin or problem of mental illness can vary. For example, the rates of non-suicidal self-harm vary across international studies. Nixon, Cloutier, and Jansson (2008) found lower rates of non-suicidal self-harm in Norwegian and Hungarian youth (8–10%), compared to Canadian youth (13.9–15%).

One current framework used to understand health outcomes is the biopsychosocial (BPS) approach. Another framework is the social determinants of health (SDOH). These two explanations consider a person's social context and attempt to identify social and structural barriers to holistic health. What is not specifically addressed in either of these theories is the role spirituality plays in enhancing health. According to the Canadian Institute for Health Information (2008), people with the diagnosis of depression make up only a tiny proportion of the deaths by suicide. As explained in chapter 1, a person's social environment (community) can have extremely strong impacts on every aspect of their health. Take, for example, living in a community where your parents were around to spend lots of time with you and gave you attention, teaching you many things and building up your self-esteem and confidence. Then imagine a community where your parents abused alcohol and could not consistently meet your

basic needs, such as enough quality food and a sense of safety in your home. The first example helps to establish a strong foundation for the child's and community's health. The second environment described can predispose children and communities to anxiety, lack of trust, modelling of maladaptive coping choices, emotional self-soothing and unhealthy interpersonal interactions. Further, it can cause these behaviours to be seen as normal.

When comparing mental health issues in individual children and youth, a more encapsulating view of causes is needed. For, after all, children learn behaviours that are modelled to them, and they are being taught the dialogue of pathologization (the terms used by the health care system) from a younger and younger age. Different cultural explanations and motivations for children and youth displaying symptoms and behaviours of psychological and emotional pain must be included in mental health assessments, or the risk of doing more harm, albeit unintentional, increases. Henriksen (2017) describes the required paradigm shift elegantly in a review of the book *Re-visioning Psychiatry: Cultural Phenomenology, Critical Neuroscience, and Global Mental Health*:

> Overall, the anthology advocates a shift away from today's predominantly biological paradigm in psychiatry towards an eclectic, interdisciplinary, and integrative approach to mental disorders, treatment, and research, emphasizing the need for a complex systems perspective that clearly recognizes the variety of interactions within and between biological, psychological, cultural, and social processes that all contribute to mental health problems and well-being. (p. 149)

In a world dominated by technology and social media, ignorance of other cultural beliefs and approaches to mental health can no longer be an excuse for maintaining a solely Western outlook. In British Columbia, self-harm is perceived by health care professionals through a few dominant theories. The first theory is attention-seeking behaviour. The child or youth is trying to get their caregivers' attention and has learned, albeit maladaptively, that engaging in self-

inflicted damage is rewarding them with concern from others. What is not always investigated is why the child or youth thinks they need to hurt themselves to deserve the attention. For youth to seek caregivers' attention is a natural and necessary social interaction needed for relational bonding and trust development. I encourage caregivers and mental health professionals to try to see beyond the disturbing behaviour and explore with the youth the root cause of their pain and unmet need.

As mentioned previously in chapter 1, my practicum goals revolved around developing clinical social work skills, with a focus on studying and learning the services and tools social workers can use to support CYMH clients and their families. Additional learning goals I had were expanding my professional identity, informing myself of agency structure, practising selfcare strategies, and gaining familiarity with allied community agencies. I also wanted to practise using a variety of clinical social work assessment tools through a biopsychosocial lens applied in a hospital setting. By linking my learning goals to the subjects in my literature review, I was able to my practice with social work theory. Merging theory and practice at my practicum location was also achieved through research and focused skill development in the area of CYMH.

It is very important for all health care professionals and social workers to grasp the connection between culture and health. It is even more relevant and critical to understand the ways in which intergenerational trauma from colonization lives on in the generations of Aboriginal descendants in the forms of poor mental health, trauma and addiction. With an understanding of how the process of decolonization works, social workers can spread this knowledge and teaching, bringing culturally informed practice into traditionally Western biomedical health care settings and services. Chapter 3 provides a summary of my learning

experiences, to further illustrate how culturally informed mental health practices can be taught and incorporated into my practicum setting at Vernon Jubilee Hospital.

Chapter 3: Familiarity with Programs and Agencies

This chapter will describe my experiences in the areas of learning about the SANE program, the agencies structure, and community agencies and resources. My main goal for my practicum was to develop clinical social work skills in the areas of child and youth mental health (CYMH). I wanted to gain a better understanding of what and how services were used in an acute in-patient health care setting. Additionally, I incorporated culturally informed practice to help me understand CYMH from an Aboriginal context using a decolonization lens. In this chapter, I share my learning and explain my skill development that I obtained during my time on the Women and Children's Health Services (WCHS) unit. I describe how my practicum experience allowed me to achieve my learning objectives. Additionally, I give a synopsis of how my understanding of structural and culturally informed social work has matured to enable me to recognize colonial structural oppression in current health care policies and practices.

Familiarizing Myself with the SANE Program

From conducting my literature review, and from shadowing and working alongside my supervisor, I discovered that there are Sexual Assault Nurse Examiner (SANE) programs across Canada. SANE practitioners are registered nurses who have completed specialized education and clinical preparation in medical forensic care of patients who have experienced sexual assault or abuse (Hanlon, 2018). I had the opportunity to learn what responsibilities my supervisor had as the sole manager, promoter and advocator of the SANE program at Vernon Jubilee Hospital (VJH). My supervisor worked in the hospital and community with the SANE nurses, coordinates the sexual assault services, and has the following roles and responsibilities: liaises between

agencies and the community in the area of sexual assault; presents public education sessions; counsels survivors and refers survivors for longer-term counselling and medical follow-up; performs ongoing evaluation and management of the program; oversees protocols and procedures; applies for and secures funding for the program to continue to operate in Vernon; and arranges the training and hiring of new SANE nurses. These critical tasks of the SANE program are conducted with little to no funding. My supervisor is truly an inspiring and essential social worker in the field and at VJH.

Further, across my literature review on the SANE program, I discovered that Canada does not have a national anti–sexual violence policy. In addition, according to Benoit, Shumka, Phillips, Kennedy, and Belle-Isle (2015), in an issue brief published by Status of Women Canada, in 2015 only five provinces (Ontario, New Brunswick, Nova Scotia, Manitoba and Quebec) had province-wide policies or action plans to address sexual violence through prevention efforts and enhanced supports and services for survivors. This report also states, citing a Government of Ontario action plan from 2011, that as many as "1 in 3 women in Canada will experience sexual assault at some point over the course of their lives" (Benoit et al., 2015, p. 3). Additionally, as reported by Dobrowolsky (2009), Sensoy and DiAngelo (2017) and Wilson-Raybould (2017), less than 5% of sexual assaults in Canada in 2014 were reported to the police. Unfortunately, less than half of the assaults reported in 2015 ended in criminal charges and less than half again (43%) of those charged with criminal sexual assault were convicted (Wilson-Raybould, 2017). Disgracefully, this is the lowest conviction rate for violent crimes in Canada (Wilson-Raybould, 2017). The reality and abundance of sexual assaults in Canadian society proves the crucial nature of programs such as SANE and other provincial health care services, like the Suspected Child Abuse and Neglect (SCAN) clinic at the Royal Inland Hospital

in Kamloops, British Columbia. Having these vital services in each community could reduce the after-effects of trauma that all too many women and children needlessly experience.

By adding an Aboriginal and disability lens to the reoccurrences of sexual assault, Statistics Canada (2017) found that the rate of sexual assault among Aboriginal people was about "three times higher than among non-Aboriginal people" (Conroy & Cotter, 2017), and "poorer mental health" was determined to be "a consequence of sexual assault" in a portion of the cases (Conroy & Cotter, 2017). Conjointly, the danger of sexual assault only increases when research findings reveal the likelihood of the victim being Aboriginal and having a disability. It was reported "that individuals with disabilities—particularly women and those with mental disabilities—are at greater risk of sexual violence" (Conroy & Cotter, 2017). Comprehending the connection between vulnerability to sexual assault, poor mental health outcomes, and being of Aboriginal descent is necessary for prevention and decolonization to expand. Conroy and Cotter (2017) state that the factors of being female and having a mental disability make individuals at greater risk of sexual violence, due to greater vulnerability and abuses of trust. Correspondingly, a person's social environment and culture could influence their response to sexual assault and trauma for benefit or harm.

From my literature review, I repeatedly found that social responses to sexual assault have been strongly linked to adverse mental health outcomes. For example, according to Richardson and Wade (2010), "for many victims, negative social responses are as painful and debilitating as the violence itself" (p. 140; see also McCombie, 1976). Stigmatizing social responses such as blaming, shaming, and difficulty in accessing sexual assault services can and do highly influence mental health outcomes for sexual assault survivors (Richardson & Wade, 2010). Again, promoting and funding programs such as SANE nurses who organize and present educational

sexual consent presentations in schools, health clinics, and other public institutions can reduce some of the exposure to stigma in families, peer groups, colleges and universities, and health care settings, thus reducing the severity of mental illness.

Familiarizing Myself with Agency Structure

This section provides an overview of what I learned about the agency structure of Interior Health at VJH. Understanding the agency's set-up assisted me in grasping the structural layout of the North Okanagan (NOK) Social Work Department and helped inform me of the agency's framework. The framework at VJH was modelled after the biomedical model of disease and illness. Mental health was viewed in terms of being mentally healthy or having some affliction that caused mental illness. Common afflictions documented were a biological inheritance, trauma induced, symptoms of fetal alcohol spectrum disorder (FASD), or a concurrent issue that accompanied addiction. To gain familiarity with my practicum environment and the agency's structure, I did the following: completed the NOK department of social work orientation package; reviewed Interior Health policy; completed I Learn training modules on a variety of subjects; and shadowed and worked collaboratively with other health care professionals, social workers and my supervisors. I also participated in NOK social work and interdisciplinary team meetings and familiarized myself with the clinical health care social worker roles and practices used at VJH.

Interior Health employs social workers in all sectors of care at VJH (Interior Health, 2018). During my practicum, I witnessed and experienced the role of a social worker at VJH. Throughout VJH, social workers complete assessments that reflect the understanding of the various barriers that influence the social determinants of health. As a practicum student, I worked

on addressing practical, emotional, social, and economic barriers that prevented patients from accessing the skilled care of both acute care and community health care professionals. In many cases, I helped patients and their families negotiate complex health and social systems. Another task I undertook was encouraging patients to build or rebuild supportive social networks to facilitate preventative and protective measures. Skill building was done to increase a patient's abilities to cope with stress, and to strengthen their autonomy and problem-solving skills. Services I provided included patient and family counselling, which could be for any stage of life or type of health problem. Counselling involved assisting with care coordination for complex client and family needs; mediating between clients and family members and Interior Health staff; providing caregiver support and referral; responding to concerns around neglect or abuse of vulnerable adults; and liaising with community and other government agencies during transitions in care. One such example was Ministry of Children and Family Development (MCFD) placements and children and youth admitted under the *Mental Health Act*.

One crucial role of social workers at VJH is reducing barriers to accessing mental health treatment. Through the fast-paced acute care environment of the WCHS unit, children, youth and families are connected with mental health care professionals far more quickly than they would be through accessing the outpatient community supports and services channels. From my perspective, the quick access to and support from health care professionals is important. However, also important would be having community programs and services with shorter waitlists to see psychiatrists, meet with mental health clinicians, and implement strategies for the client and their family. Such changes could reduce the harm done to CYMH patients by helping to reduce presentations to the emergency department, such as in cases of substance overdose, self-inflicted harm, suicidal ideation or suicide attempt.

Familiarizing Myself with Community Agencies and Resources

As my practicum progressed, I became aware of hidden community resources and connections. Nearing the end of my practicum, I had the chance to work with and refer numerous clients to a wide range of agencies in the process of supporting their health. From working within a multidisciplinary team on CYMH cases, I was able to see how interagency collaboration unfolds in acute health care. I also gained additional knowledge of where to find other communities' and provincial-wide services for neonatal abstinence syndrome newborns and mothers with substance use issues. I became familiar with various MCFD offices and the surrounding catchment areas. Some examples of the organizations I interacted with are as follows: BC Children's Hospital; North Okanagan Youth and Family Services Society; Vernon Women's Transition House and Specialized Victim Assistance Program; the Vernon Child and Youth Mental health office; Secwepmec Child and Family Services Agency—Kamloops; The Gathering Place (Aboriginal Child and Family Services—Vernon); Splatsin Stsmamlt Services (Child and Family Service Program); Lower Nicola Indian Band; and the Okanagan Indian Band and Okanagan Nation Alliance—Syilx. The relationships I developed with nurses, pediatricians, psychiatrists, social workers, clinicians, MCFD social workers and Aboriginal agencies allowed me to provide the support and services clients required in a timely fashion. During my literature review, I came across the Okanagan Nation Alliance—Syilx (2017) Wellness webpage, which lists specific programs designed and listed for Aboriginal CYMH. I had not heard of these programs before. I read about the different perspectives of "mental health" or holistic wellness programs and services, specifically those grounded in a Syilx-centred framework in which culture and

relationships and community were emphasized. These programs were designed and funded by the communities that self-governed themselves.

Developing a Professional Social Work Identity

One of the primary aspects of social work is developing a professional social work identity. Through developing my professional identity, I have recognized how my personal and professional values align. My personal practice model and theoretical guidance and perspectives have been influenced by the following main frameworks: biopsychosocial (BPS); strength-based and culturally informed. The theories and concepts that most closely follow my beliefs and values are those of social constructivism and social responsibility. I am drawn to theories that explain how the social and environmental context of a community determines the overall wellness of the people and families within it. (These theories are discussed further in this section). O'Neill (2017) states that a major part of moulding a culturally congruent practice is a professional's cultural awareness. My cultural awareness of my family history of mental illness, growing up as a child of divorce, and living in a small town that stigmatized divorce and single parenting has contributed in moulding my practice, as a professional. In regard to ensuring culturally congruent practice, without knowing or being aware of my own cultural road map and heritage, I would not be able to continue to uncover and unlearn the cultural biases and schemas of understanding the world I was raised in and the one I live in today.

One way to increase cultural awareness is using the BPS and SDOH frameworks. Throughout my practicum, I developed a deeper understanding of the value in utilizing a SDOH and BPS approach. Both approaches take into account structural inequalities and environmental influences. Both also can be used as part of the social work assessment process, planning and

intervention. The WHO Commission on Social Determinants of Health's (2007) "Conceptual Framework for Action on the Social Determinants of Health" informs my practice, explaining how health inequities are influenced by the social, economic and political structural power imbalances between social classes. Theories that support frameworks such as SDOH, BPS and ecosocial (Canadian Council on Social Determinants of Health, 2015) highlight the influence policy development and decisions have on health outcomes. Social determinants are structural obstacles requiring reformation. Through these frameworks' health equity and well-being stem from possessing adequate social cohesion and social capital (Canadian Council on Social Determinants of Health, 2015). The social determinants of health inform my professional social work identity with the explanation of how the barriers to health can be reduced and eventually eliminated. For example, the action framework focuses on intersectoral action, social participation, and empowerment at the global, public policy, community and individual levels. My social work practice identifies with the social epidemiology theories of how society operates from or responds to psychosocial influences. Therefore, my practice approaches health as being tied to people's political and economic resources.

Further, ecosocial and systems theories can be useful social justice frameworks to assess, plan and intervene as a social worker at multiple levels. These frameworks fit well with my values in that they use a holistic and intersectoral approach. They recognize the impacts of social exclusion, the role and potential strengths of individuals and communities, and the importance of upstream action at multiple structural levels. They clearly identify how interactions between determinants result in health inequity and show how to intervene and prevent harm through health promotion initiatives. The SDOH, BPS and ecosocial systems approaches share the belief that the characteristics of a community are created by the social interactions between and within

members of a community or culture. This idea is derived from the theory of social constructivism (Blum, 1994).

Social constructivism explains how underlying and unquestioned sets of values, ways of socially interacting, and knowledges and teaching are promoted throughout generations. Our communities are the environments in which we learn what ethics and morals are right or wrong and good or bad. Cultural and social values intergenerationally passed down characterize what social responsibility entails. Relationships that are developed then mirror these values, which in turn shape our personal and our community's health and wellness. Consequently, social responsibility is constructed through our contributions to our communities. And the more positive and healthy actions we participate in, the more holistic wellness of the entire community and culture is enhanced as a result (Bellefeuille & Charlesworth, 2003). Everyone has abilities to offer, some with more resources than others. The more people who put in effort in the many ways such as time, energy and passion—encompassing physical, spiritual, emotional, political and economic effort—the more they demonstrate social responsibility. This then has a ripple and compounding effect on the health of families and entire communities. In addition, a sense of belonging and care (or their opposite, harmful stereotypes and perspectives) can be cultivated through these behavioural cycles. I believe in the power of community social responsibility to heal and enhance the health and wellness of collective groups.

The health and wellness of a community and all the individuals and social groups within it is influenced by the environments and relationships present within it. To enhance community wellness approaches can be implemented through common goals that define the nature of a community. The interrelationship between the social environment and health of people and their community is contingent on the types and quality of interactions with the various social

determinants of health. For example, the use of smartphones can result in fewer face-to-face interactions between friends, couples, co-workers, and between parent and child. Globalization has had both helpful and harmful effects on relationships and the health of non-hegemonic cultural and social groups, due to the consequences of the globalization movement being mainly controlled by capitalist, sociopolitical and economic values. Judgments of what constitutes health and wellness plus which treatment methods are important and publicly funded are decided for all of society, but this capitalist framework is not valued by all members of society.

As a professional, it is critical and necessary for me to examine all relationships as to their social environments, structural levels, and the types of attitudes, values and beliefs they operate from. Being aware of the social and environmental contexts relationships operate in will help uncover the strengths of and barriers to the health and wellness of communities. As a practising social worker, I bring with me into each encounter my own individual "cultural heritage" (O'Neill, 2017; Roysircar, 2004), which characterizes and influences me towards certain theories, frameworks and approaches I choose and use. These "choices" I make are derived from the current dominant Canadian, Western European, Caucasian, male--determined values, beliefs and attitudes. Meanwhile, messages from the government in control are constantly broadcast throughout my social environment and replicated and reinforced through the interactions I have with others who share the same cultural beliefs.

Without professionals having awareness of subjectivity, their own assumptions, values and biases will prevent them from understanding the worldviews of culturally different clients (Roysircar, 2004). As a result, further harm can occur due to lack of awareness of pre-existing cultural schemas that become the lens through which clients are assessed and assisted, potentially resulting in inaccurate and inappropriate assessments (Kress, Eriksen, Rayle, & Ford, 2005;

O'Neill, 2017). In my practice, I am continuingly developing and incorporating more knowledge and experiences of multicultural perspectives and diverse customs to better facilitate culturally sensitive, competent, and informed social work practice (Kress et al., 2005).

Culturally informed practice is paramount in the health care field. Structural inequalities related to race and culture can be hidden until a decolonization approach and conversations are started. Through culturally informed perspectives, social control and oppression through manmade social institutions can be more clearly seen, and the cause of ill health can be traced to colonizing practices. Determined causes of poor mental health will vary depending on your cultural framework, social upbringing, and situation or environment. Thira (2016) describes the first three waves of colonization in his workshop manual in a section titled "The Community Is the Medicine." Thira (2016) further states that a fourth wave colonization is being accomplished through using the "mental health industry." The fourth wave is the one I will be focusing on. The fourth wave consists of social services and is currently operating. Similar to the first three waves is the way culture is still being separated from daily living, school, work, family, spiritual practices and health. This is being done through systems such as public schools, hospitals, universities, and health care centres. In British Columbia, all the government funded, and public health services and programs exist within the same framework of health, the Western bio medical model. Practices linked to this model contribute to the continued cultural destruction of the Aboriginal peoples. The colonizing tool used this time is in a different form: social and health care services. For example, the understanding of mental health from a Western and an Aboriginal perspective is incompatible (O'Neill, 2017, p. 171). From an Aboriginal cultural perspective, mental health challenges are viewed as holistically connected to a person's or community's environment. Relationship conflict whether that be between individuals, the land, community,

nation and environment are caused by damage to relationships' resulting in the presenting mental health issues (O'Neil, 2017, p. 177). So, when mental wellness strategies are suggested that go against the values, beliefs and do not address the social justice violation, a positive outcome is not necessarily assured (Roy, 2014, p. 11).

Yes, therapeutic approaches can help to address mental health issues. For instance, cognitive-behavioral therapy (CBT) will reduce some emotional and psychological discomfort, but the "soul wound remains" (Brave Heart & DeBruyn, 1998). So, to only treat part of a health problem will only improve that part. To fully heal and treat mental health challenges competently, Western medical models of health need to incorporate Aboriginal views and practices for health care. To deliver safe and quality mental health care services to Aboriginal patients and communities, health must be understood as interconnected and inseparable from all parts of life, such as the physical, emotional, social, spiritual, cultural and psychological (Roy, 2014, p. 11-12).

Developing Clinical Social Work Skills

I developed my clinical social work skills in the area of documentation from charting on cases using the software program Meditech, as well as reviewing my supervisor's documentation. I was also given a handout titled "Social Work Reference Guide and Meditech Social Work Consultation Report" (Interior Health. (n.d.). The main takeaways from this document are the categories of consent, purpose of assessment and current situation. Also listed or discussed are client and family concerns, context and situation, family strengths and collateral information. As well, as additional community and professional supports—a social worker must assess any potential barriers known or predicted related to service delivery. The social worker documents

specifics about the identified areas of concern, such as the social worker's clinical impression, desired outcomes for the client, the interventions and strategies, and the plan. The plan encompasses the intervention that addresses the client's situations and connects the client's to specific services. Documentation must be written in a competent manner—free of judgmental language and culturally sensitive. Social workers must document in a clear concise manner that includes, the facts and professional recommendations. Furthermore, the case notes need to be written in language that is logical to all readers despite one's educational background and avoid words that could be taken in an unfavourable way.

Referring to the British Columbia College of Social Workers' (2009) "Code of Ethics and Standards of Practice," which includes principles of practice for the social work record, one of my supervisors provided the following advice. She said to ask yourself, "What does everybody who reads my notes need to know? What can and should be left out?" She recommended that documentation needs to be detailed enough that if another social worker takes over your case, they will be able to effectively support your client and know what happened and what the next steps are. Section 4.11 in the social work record guidelines (BCCSW, 2009; Standards of Practice: General) states that particulars of the social work process to be placed in a record are the history obtained by the social worker, including an assessment, diagnosis, formulation and plan. Then treatment and other interventions, for example, if you are teaching or advocating appropriate details, need to be included. Record maintenance guidelines section 4.17 requires the following: social workers are to keep client records stored securely for no less than seven years from the date of the last entry. If your client is a minor, records should be kept no less than seven years past the age of majority of the client.

Tasks at the WCHS Unit and Assessment Tools

As mentioned, the second part of my practicum was on the Women and Children's Health Services (WCHS) unit at Vernon Jubilee Hospital and constitutes the focus of this report. During my practicum, various social work assessment tools were used in the field. According to Ragesh, Hamza, and Kvn (2015), they indicated that assessments conducted in a mental health setting require an adaptive and open--minded approach. The literature associated with social work assessments and treatment approaches guided my practice with clients in a curious and respectful way, which was grounded in aims of social justice, which gave clients the power to guide their health care. Dean and Poorvu (2008) stated that values and interests of social work require broad approaches regarding assessments and formulations. Furthermore, these approaches depend on the ability of social workers to harmonize social justice, ecological, systemic, biological, cultural, spiritual and psychological perspectives. For example, the biopsychosocial (BPS) framework is only one of the perspectives available and used for assessment, goal formulation and intervention planning (Corcoran & Walsh, 2010). Social workers may employ multiple frameworks at one time, such as adding resilience and person-in-environment perspectives to a single case (Corcoran & Walsh, 2010).

Besides observing and conducting client assessments, responsibilities in my practicum involved treatment planning, safety planning, and ensuring a safe discharge. These various components of case management improved my skills and provided me with insider knowledge of access and availability of personal, family, and community resources from both clients and health care professionals (see list in earlier section, "Familiarity with Community Agencies and Resources"). Being able to manage a small case load allowed me to advance my skills in the areas of intake, assessment, treatment planning, discharge, community follow-up, and

termination. According to Ragesh and colleagues (2015), the social work process in psychiatric settings consists of: "1. Clinical Evaluation (to understand the psychopathology of the client and making provisional psychiatric diagnosis involving consultation with a psychiatrist); 2. Psychosocial Assessment; 3. Analysis and Formulation; 4. Psychosocial Diagnosis and 5. Psychosocial Intervention Plans" (p.166). As I observed several of these processes with the CYMH clients, families, and other health care professionals, I discovered that the steps are not as precise as the above outline, but rather each individual case can be ambiguous and require the knowledge of multiple frameworks to adapt to specific needs.

Assessments can range from informal interviews and conversations to the use of psychiatric standardized and scored tests and scaling to quantify data. The purpose of using evidence-informed assessment instruments in clinical social work is to accurately and effectively diagnose and treat mental illnesses in children and youth from diverse cultural, environmental, social and behavioral backgrounds (Corcoran, and Walsh, 2010). Assessments often fit into a standardized framework or theory, such as the person-in-environment (PIE) or BPS theories. The Interior Health library at the hospital, included a number of websites related to social work assessments. One website, SocialWorkersToolbox.com (n.d.), had more than 15 different categories, ranging from screening tools to suicide prevention apps, psycho-education for clients, and assessments for children and adults. These resources ranged in their focus, from young children under five to seniors at palliative stages of life. The American Psychiatric Association website, which uses the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, has an assessment tool section that reviews interviews, questionnaires for caregivers and clients, as well as culturally diverse assessment tools for different languages, and culturally sensitive instruments. I also found the following tools useful during the course of my practicum. In

particular, the screening tools listed online by the SAMHSA-HRSA Center for Integrated Health Solutions (n.d.), Beck's Depression Inventory (Beck, Steer, and Brown, 1996), and the Social Work Assessment Tool (SWAT) from the National Hospice and Palliative Care Organization (2008).

Enhancing Self-Care Strategies

Self-care in the social work profession is incredibly important to ethical and competent social work practice. Burnout and stress from vicarious trauma impact the social worker, their family, and the clients they serve. My goal of enhancing my self-care strategies was motivated by multiple factors. I wanted to be able to provide an authentic and strong healing practice delivered through the social work relationship. I also knew that to be successful in supporting patients with mental health challenges, I would need to maintain my own balance. To model a healthy, well-balanced mental state for patients, I had to be diligent in noticing personal signs of tension, low energy and negativity. Throughout my practicum, I relied on different self-care strategies and found that one strategy may not be effective 100% of the time. Recognizing this taught me to explore multiple ways to care for myself—so I in turn, as a student social worker can do the work of caring for others.

Throughout my practicum, I set aside time to write in my journal in the evening after work (see sample entries later in the next section). During these times I wrote and critically reflected on what had happened that day. I wrote about complicated cases, ethical dilemmas, and social, political and health issues that involved Aboriginal governance associations. I wrote about new and important learning and about anything that troubled me that day. For troubling encounters during my practicum, I reached out to trusted professional confidantes, such as my

faculty supervisor and my agency supervisor. The journaling was part of my self-care routine and a visual way for me to assess if I was struggling with professional boundaries or required an increase in my self-care efforts. This was done to ensure no harm came to the client population, staff, the agency, or myself. Additional self-care measures I continued to engage in were: practising Brazilian jiu-jitsu (BJJ); exercising (cardio and weights); investing time in positive relationships by keeping in touch with previous co-workers and supervisors; spending time with my family and friends; and incorporating comedic relief into my day. In addition to the supervision I participated in and received, I engaged in a reflexive phone conference with my academic and agency supervisors' midway through the practicum, reviewing my learning goals and ensuring I was meeting my objectives. This practicum report and the presentation of the information are the final evaluation piece of my practicum, confirming that I reached my targeted learning goals.

Journal Entries

Monday, June 25, notes from the midterm. A couple of goals to work on. Intakes and portraying confidence and design an assessment routine in my head in a clinical way with a BPS framework. The second goal is to research and learn about different social work assessments and tools used within the hospital.

Friday, June 29: Had the opportunity to shadow/work at Gateby [adult day care centre] for the day. It is now called short stay. I enjoyed myself and felt confident!

Monday, July 23. I was put in charge of my own CYMH case today. I was able to witness the interactions between the youth and youth psychiatrist. This case was like others I have shadowed in the low intelligence quotient, suicidal ideation, self-harm, and depressive symptoms. I learned

the mother and daughter were both diagnosed with FASD. I am feeling raw emotions when I interact and contemplate how the occurrence of FASD can be reduced. CYMH and MCFD staff did not have answers for long-term prevention and intervention of FASD in children, families, or communities. From this case I learned about Developmental Disabilities

Mental Health Services (DDMHS). I previously did not know this existed. This is an office in Kelowna. In Vernon we have a DDMHS worker who works out of the local health unit. I keep contemplating the etiology of addiction and substance abuse, and the etiology of mental illness. Mental health issues usually begin to present in adolescence and then can continue into adulthood. I question whether addictive behaviours are a response to untreated CYMH issues? Or a combination of biological, psychosocial, and cultural determinants impacting the body and mind through prolonged exposure to stress, trauma, and inequitable health conditions of individuals, families, communities, social groups? Enacted and enforced through policies written by members of society and government with the power to create social change and justice but, cannot relate to the problems of marginalized minorities continuing the discrimination and oppression of diverse cultures and societal values through socio-economic control. Canada's current socioeconomic model of capitalism and individualistic values are one of many options of political and cultural systems available to choose from. There are alternative viewpoints which could be more sustainable and improve the health and well-being of the entire society instead of the few dominant social and economic powers who benefit from a capitalist framework.

Friday, July 27: Today I am contemplating methadone. In the nursery we have been continuing to see newborns so sick from NAS withdrawal that they require detox with the support of nurses and doctors for as long as two to three months. I'm sure there could be a better and less harmful way to help both mother and baby. Maybe there is a safer drug or medication that has less risk of

side effects for developing babies in utero. From my literature review and a practicum presentation I attended I know there are pharmaceuticals that can reduce cravings and are less dangerous to developing fetuses. I wonder why methadone has not been replaced or discontinued from best-practice recommendations in health care? Is it the cost of these alternative medications? If so, why would our health care system reduce quality and safety of people's health to save money?

Monday, July 30: Today we received two referrals involving First Nations patients and families. The woman I was supporting has had a negative, harmful, and racist experience in the past by hospital staff and a volunteer at VJH. My goal is to tread lightly and encourage her sovereignty when I meet with her and her family again.

Tuesday, July 31: Last Day of practicum. The CYMH case I was in charge of today turned out to be a youth I have worked with in the community in the past. I orchestrated the team meeting of professionals involved with the youth. I also facilitated the collaboration of multiple health care professionals and family members in the process of assisting the youth's well-being. I am frustrated and have been contemplating why the youth is struggling again. I recognize from personal knowledge that mental illness can be a life-long journey with cycles of change and maintenance lasts for a period then episodes happen. Unfortunately, the episodes can involve rage and physical violence, making safety of both the youth and foster family of utmost importance. I believe my frustration stems from thinking the health professionals involved with this youth's care have missed a crucial determinant that could be the trigger to these aggressive reactions. Has a factor involving the social, biological, psychological, spiritual, cultural or aspect of growth and development been overlooked with this youth? Or I wonder if this is a case of trying to fit an individual's needs into a rigid cookie cutter model of a foster home?

Reflections on the Cycle of Addiction

From my time spent on the WCHS unit with the CYMH cases, I have become more aware through my reflective practicum journal of how parents and caregivers seem to be at a loss on how to help improve the mental wellness of their children and youth. I have been contemplating the biomedical model of disease. Mental health medical professionals, such as doctors and psychiatrists, have expectations placed upon them to know exactly what to recommend. I wonder when the shift occurred from families, neighbours and local communities being able to support each other through emotional and psychological hard times versus the increasing social isolation. In particular, women (and especially Aboriginal women) seem to be at risk of mental health issues during pregnancy. An Australian study cited by various academics found that for 15% of women, the experience of pregnancy and motherhood will be affected by mental illness, with higher rates for Aboriginal and Torres Strait Islander and other vulnerable communities (as cited in Makregiorgos, Joubert, & Epstein, 2013).

During my practicum, I worked with multiple cases that involved fetal alcohol spectrum disorder (FASD). Symptoms often present in the mother having substance abuse problems, as well as involvement of the Ministry of Children and Family Development (MCFD) with concerns for child welfare. Sadly, the cycle of addiction can continue into the next generation. For example, two of the youth I was working with had parents with FASD, and the youth themselves received the diagnosis as well. Here was an example of the intergenerational inheritance of developmental disabilities and predisposition to mental health issues due to the side effects and symptoms of FASD. Multiple negative indicators identified as social determinants of health (SDOH)—including lack of family and relationship, emotional and

psychological challenges, inability to foresee consequences, being born into poverty, and potentially abusive environments—create tragic outcomes, with the past repeating itself over and over. Responsibility is usually placed on the individual (mother, family, or whichever social justice organization receives funding to try to break the cycle). For true change to occur and last, government leaders and citizens need to realize that stigma, shame and blame will not cure the problem or help the people with FASD. Healing will be more possible when governments and communities understand the impact and damage of people being denied the same positive social determinants of health as others in society. Prevention requires accountability. People need help and often do better with social support. If social policies went farther than addressing the surface problem, additional trauma could be avoided. Taking a child from a family with FASD does not fix the issue. Often more children are born with the same issues from the same families. The root of the issues is systemic.

If social justice work is to be done, then questions need to be asked and answered: Why are some of our neighbours drinking alcohol until they become painfully sick and develop chronic diseases? What is the cause of this? Is it linked to the social determinants of health? Having enough economic resources influences how effective and easily accessible mental health services are. Addiction, mental illness and other social issues need to be considered a problem for all members of the community and each ministry and level of government. Relegating social issues to only specific provincial ministries creates barriers by restricting communication between ministries with overlapping clients. In the effort to maintain client confidentiality delays occur in accessing multiple community resources at one time. It is time for some changes to be made in our strategies for addressing social issues, especially mental illness in families and children and youth.

Chapter 4: Implications for Practice and Recommendations

Cook, Morrow, and Battersby (2017), documented that a lack of cultural competency in mental health services and providers compound the issues of inequity. The authors present some very forward-thinking ideas on how to reduce inequity between mental health consumers and service providers and programs (Cook et al., 2017). In fact, they conducted a study on the quality and success of mental health service providers and services. They interviewed clients who accessed mental health services and identified there was a lack of cultural competency in relation to the services they accessed and the professionals that provided the mental health services. It was suggested that the clients self-direct their care and treatment, in order to design their own services and add their own ideas, perspectives and insights. Cook, Morrow, and Battersby (2017) concluded that input and control from service consumers could alter social policies on mental health funding and accessibility, ultimately making services more equal and fairer. Alterations in social policy may make a difference in practice—when service providers have knowledge of colonial oppression and racism and respect for the differences between the collective and individualistic treatment solutions.

Some examples of self-directed care offered by Cook et al., (2017) were distributing funds directly to isolated communities, so local members could choose to spend the funds on what would be most helpful. For example, depending on the unique needs of the people in an area, cultural, spiritual, financial resources and insufficiencies would shape how the money was utilized. They suggested the use of cellphones for more accessible communication, especially in situations of crisis counselling and support. Combatting stigma about mental illness was another important aspect of reducing inequity supported by the study. It was found that stigma associated

with mental health services was reduced when the self-directed care model was used. One of the self-directed care suggestions was for clients to access resources from mental health role models. Role models can be anyone who has or had mental health experiences and can share their wisdom through teachings, books, presentations, and other creative mediums. The study also found that with increased cultural competence among the services and the service providers, current programs could be modified to better fit the needs of individuals and specific communities, improving the equity between mental health services despite differences in location and abundance of resources.

According to Vennapoosa (2012) the healthcare industry is becoming more challenged as cultural diversity continually increases in the population and cultural differences can impact how individuals utilize health and social services. I witnessed how on at least two occasions false assumptions based on stereotypes of Aboriginal women having addictions issues were made by healthcare staff on two units of VJH. One involved the suspicion of staff being worried about parental fitness due to the client having a mental health diagnosis and the other treated a client as if they were the patient's presenting physical health issue of alcoholism, because she repeatedly presented to the hospital. Assumptions were made by some staff that the patient was choosing to destroy her health and liver by continuing to drink. The later woman was open and allowed me to collaborate with her and create a personalized harm reduction plan upon discharge regarding her drinking and steps for improving her overall health. When supporting these two women I took on the stance that they were the experts on their life and health, and I took the time to get to know what was happening in their lives using biopsychosocial assessments to better gain a holistic perspective of their life.

Examples of Aboriginal cultural competency within a hospital health care setting could include constructing an Indigenous healing room where “ceremonies specific to the client’s Nation” (Mann, & Adam, 2016, p. 61) can be performed. Ceremonies for spiritual cleansing and healing can take place in the form of praying, singing, dancing, drumming and any other Nation specific practices can be carried out with a traditional medicine person or elder involved if possible. Encouraging the practices of spiritual and physical healing rituals such as preparing or using “underground dugouts for sweat purification and cleansing” is another cultural practice multiple nations engaged in (Mann, & Adam, 2016, p. 63). These dugouts often had “chezel (steamed rocks) to provide heat and steam for the rituals” (Mann, & Adam, 2016, p. 63). Constructing a place on site where rituals such as these can be practiced would show respect for alternative cultural methods of healing. Ritual healing supplies could also be stocked and kept on site such as “cedar, spruce, and balsam branches which are burned and then the smoke is used to cleanse the spirit” in need of healing (Mann, & Adam, 2016, p. 63). Additional “plant-based drinks, poultices, and creams could be made by medicine people, used” (Mann, & Adam, 2016, p.58) and stored. It is through the shared experience and knowledge exchange of these cultural health traditions where diversity between cultures is openly encouraged and respected as well as can be modelled for new employees, patients, and the community. Trauma is understood differently when viewed from a First Nations medicine perspective. For example, “rituals are understood to serve the purpose to restore balance and heal trauma, sickness, and spiritual oppression (negative medicine)” (Mann, & Adam, 2016, p. 59). Trauma and sickness are understood to create imbalances in a person’s life. These imbalances can lead to a “person losing their spirit” which can present through any of these symptoms: people having a “lost look in their eyes, being extremely tired, struggling with addiction or mental health challenges, and a change

in who the person was before the traumatic event" (Mann, & Adam, 2016, p. 59). Cultural competency can also be promoted by requesting elders and band knowledge holders to speak and share stories of the powers and the traditional purpose and role of medicine people. For example, how medicine people are gifted with the ability to heal and restore both "spiritual and physical ailments" (Mann, & Adam, 2016, p. 58). It is critical for health care providers, directors, and managers to promote awareness, educational knowledge and skill training in cultural competency for all levels of staff due to their position serving as role models in the healthcare industry.

On the women and children's floor all healthcare staff could be required to complete a specified number of cultural competency hours in which they can take indigenous courses or attend workshops offered and taught by indigenous teachers. For example, 'Indian Hospitals' historically were used as an ethnic cleansing tool by segregating Indigenous people from their families and the dominant white European culture. Tuberculosis was used as a cover to send and contain Indigenous men, women and children for treatment and to reduce the spread of infection. Unknown to these survivors of the Indian Hospitals was the non-consented to surgeries done to Aboriginal girls to make them infertile and incapable of having children. This act was committed by healthcare staff with the intention to prevent and in effect kill future generations of Indigenous people. Knowing this truth about the Indian Hospitals I am now suspicious of certain motives and practices in healthcare. From my experience working with Indigenous women during my practicum and a recent cultural competency training offered through my work place organization Carrier Sekani Family Services I am less likely to automatically mislabel or jump to conclusions thinking an Indigenous patient is being resistant to treatment. I now recognize the appropriateness of their response to present day hospitals and health care facilities. I critically reflect and question where the cultural gaps in understanding Indigenous patient and health care

provider viewpoints are. Regarding the ratio of Aboriginal employees staffed at VJH I did not count or record this data. I did observe that all the employees I interacted with spoke English. I was introduced to Diana Moar the Aboriginal patient liaison worker at VJH and a few of the clients I worked with were also working with Diana. The number of indigenous healers, social workers and advocates I have included in my report is eighteen. Eighteen out of fifty-nine sources, that's thirty percent. I was a little shocked at the number thinking I had found many journals and articles with Indigenous authors and allies. Interesting how many sources that write about mental health do so without full awareness, cross cultural knowledge and skills to understand client's specific cultural context and worldview of their health. I too am colluding in this claim, I hope to help more than hinder in my journey of becoming an Ally with the Indigenous people I work with and write about. Reflecting on the number of Indigenous sources and my afterthoughts on the history/herstory of the land on which my practicum was I can better understand how racist colonial micro-aggressions are still an issue and so deeply ingrained. I was not aware of other hospital staff as having First Nations heritage as this was not discussed in my presence. I was asked twice during my practicum if I had Aboriginal heritage once by my field supervisor and then by my editor. Outsiders from designated Aboriginal child protection agencies such as Secwepemc (Kamloops) identified themselves as belonging to the Secwepemc band. I did not record how many staff in the agency from top to bottom were of Indigenous heritage. Paying more attention to the staffing make-up and what types of positions are occupied with diverse ethnic and cultural backgrounds is one goal I have for my developing practice and cultural competency.

Social work in a hospital setting involves working with interdisciplinary professionals and collaborating on health promotion, illness prevention, and early intervention to prevent

mental health issues (Newfoundland and Labrador Association of Social Workers, 2018). Some of the tasks and roles social workers perform in the hospital are counselling, psychotherapy, community development, promoting and delivering health and social programs, and being involved in relevant sociopolitical processes to improve social and health services. The role of a health care social worker can vary depending on the unique needs of the client. A common role that I facilitated, at the VJH was to assist clients to fulfill basic needs such as food, shelter and safety. Social and mental health well being is linked and are contingent on having one's basic needs met. In the absence of meeting one's general basic needs, social, mental and overall wellness can be jeopardized. Treating one's mental health issue with a singular lens, through medication or individual therapy will result in crucial solutions being missed.

The application of family systems, person-in-environment, and the examination of social determinants of health could improve the mental health care system. I strongly suggest policies on social issues such as CYMH be reviewed and altered if necessary, to ensure families are included and supported in the service and treatment plans (see forms in Appendices A to D). Children and youth are dependent on their family unit. Parents play a vital role in the process of accessing timely and effective treatment. If multiple barriers to care exist—the high cost associated for counselling or a residential program, this only compounds the frustration of families. In addition, the time children and youth wait on excessively long waitlists to see adolescent psychiatrists or clinicians' increases the family's stress and frustration. Additional social programs are required to address the reoccurrence of children and youth mental health issues. Admissions and discharges from the hospital can be drawn-out, due to the limited resources for children and families— perhaps, with collaboration, the MCFD, the Ministry of

Health, and the Ministry of Mental Health and Addictions can all contribute money and work together on prevention of illness and promotion of mental health in communities.

In hospitals, social workers are in the role of primary health care workers. To reiterate, health from my perspective as a social worker encompasses more than the physical and biological characteristics in a person's life, but also includes a person's family, social groups and communities they interact with. Social justice and health care social work are aligned in their goals. Hospital social workers work with people to resolve, prevent and lessen the impact of psychosocial, physical, spiritual, emotional and other mental health–related issues. The World Health Organization (WHO) (2012) defines health as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. I propose that the WHO could also incorporate the complete cultural and spiritual well-being to the definition of health. In my experience, a lack of cultural competency, knowledge and respect in health care workers often ends up harming people's health on multiple levels and contributes to mental illness in society.

Reflecting on my practicum in the Women and Children's Health Services unit at Vernon Jubilee Hospital, I know primary health care and social work in health care settings involves health promotion, prevention and early intervention, treatment and follow-up. However, I found there was not a lot of follow-up in the field. Yes, as social workers we connected clients to community programs, but when asked by my field supervisor the question "Whatever came of this person or this case?" often I had to respond, "I'm not sure, because I am not dealing with that case anymore." I believe the follow-up is lacking and could be improved. Follow-up contact could also serve as preventive measures for having readmissions for the same health issues. Often at VJH we admitted children with mental health issues who had been in previously, a year or two ago, for the same problem or a very similar issue. I was left wondering: Is this going to happen

in another year or two? And how can we create a system that offers a long-lasting and complete treatment and plan for these patients? Social workers in health care settings do utilize the person-in-environment (PIE) approach. PIE is empowering and derived from a strength-based perspective. It can be used with individuals, families, groups and communities. Working with the PIE theory aligns with the social determinants of health. Therefore, social workers can use their knowledge and these frameworks to link the physical, social, emotional, psychological, economic, spiritual, biological, cultural and socio-economic impacts on the health of people and communities.

The World Health Organization, as cited by the Newfoundland and Labrador Association of Social Workers (2018), outlines the five key principles of primary health care, which are as follows: One, involve the public. Unfortunately, there is untapped feedback from public participation; their insight into their health and what support works best is invaluable. Two, accessibility to services needs to be promoted in health care. All people living in an area, even if they live in a rural area or are homeless, deserve equitable access to health care resources. Three, appropriate technology is another key part of primary health care. The most up-to-date, effective, efficient and safest medical equipment increases quality of life. Unfortunately, often only the large metropolitan cities (such as Vancouver, in B.C.) can afford the newest health care technology. Smaller towns do not always have access to this equipment. Yet travelling to another location and then paying to stay overnight, plus taking time off work become additional barriers to care. Four, social work and health care relies on interdisciplinary collaboration. Doctors, nurses and other medical specialists have advanced knowledge in treating many biophysical illnesses. But personal knowledge from the patient of their health condition can also help inform the treatment decisions, based on what has worked or not worked for this person in the past. And five, the last principle, is health promotion, important because it helps to prevent the spread of

diseases, unnecessary death and overdoses. Health promotion strives to keep people safer and healthier. To be effective, health promotion must not get overly caught up with preventative methods but also continue to fund promotional health activities and programs. This can be accomplished through using public media tools and engaging with and within schools where children, youth and families congregate.

My recommendation for social work practice is to combine Western therapeutic approaches with Indigenous holistic practices. Health encompasses the whole person and needs to be connecting spiritual well-being with the physical, social and the psychological. There is a very strong correlation between poor mental health and trauma (Roy et al., 2015, p. 63). See also O'Neill et al., 2018). Preventing mental illness begins with healthy families. Addiction and mental illness in parents and caregivers increase the vulnerability of their children developing similar mental health and addiction challenges. Mothers with FASD are also at high risk of drinking during pregnancy because of the effects that FASD has on their impulse control and interference with understanding the future consequences of their actions. Pharmaceuticals to treat alcohol and drug addictions have been around since the 1960's. More recently the effectiveness of these medications has been documented. Johnson, Rosenthal, Capece, Wiegand, Mao, Beyers, and colleagues (2008) undertook a study on quality-of-life improvements with the treatment of Topiramate with alcohol-dependent individuals. Their findings outlined the health benefits and improvements of overall quality of life for individuals who are alcohol dependent. Findings concluded that the pharmaceutical Topiramate had an overall outcome of decreasing obsessional thoughts and compulsions with using alcohol (Johnson et al., 2008). With these findings on drugs such as Topiramate dating back to approximately the 1970s (Harries, 2018; Maryanoff, 2016), especially considering the safety associated with them and the clinical effectiveness, it

seems strange that anti-alcoholic medicines are not more widely known or prescribed. Topiramate is but one pharmaceutical shown to improve the health of patients taking it, in comparison to undergoing detox or taking Antabuse. The latter is a commonly prescribed medicine for those with alcohol use disorder; it functions by making a person violently ill when they drink alcohol. Medications such as Topiramate need to be publicly funded and more widely promoted to become accessible and make a larger impact.

A community and its members' quality of health and wellness is dependent upon the relationships that exist between the physical, social, emotional, spiritual and political aspects of their lives, as well as economic availability or scarcity of resources. Unequal distribution of these resources leads to power imbalances, especially in circumstances where individualism is prioritized over the social and collective responsibility of the community. Holistic community health and wellness is dependent on core cultural and social values such as social responsibility, which are reinforced through the interactions we have in relationships within and across communities. Attitudes, values and beliefs are learned through the relationships we develop, sustain and create in our communities. For example, protective factors in suicide prevention suggest using positive and caring role models that teach empathetic and respectful relationships with a sense of belonging. By supporting the self-esteem of adults in communities, healthy adjustments will occur and be intergenerationally circulated, creating a self--replicating wellness enhancement recipe for mental health.

Conclusion

My practicum in the Women and Children's Health Services (WCHS) unit at Vernon Jubilee Hospital has contributed immensely to my development as a clinical social worker. Reflecting, I can now see how crucial direct field training and experiences contributed to my broader understanding of social work practice. I have grown more familiar with child and youth mental health, CYMH in an Aboriginal context, intergenerational trauma, and clinical social work practice within an acute care in-patient hospital setting. The enlightenment I have gained from researching the literature on these topics has strengthened and shifted my practice. During my practicum, I focused my learning goals on expanding my professional identity as a social worker, informing myself of the agency structure, developing clinical social work skills, practising selfcare strategies, and gaining familiarity with allied community agencies. Arising from these learning goals, I have recognized the enormous need to integrate Western approaches with diverse cultural approaches to health, particularly in regard to the mental well-being of children and youth. My future social work practice goals include developing a culturally competent practice, continuing my education, and incorporating my learning into practice. Soon, I would like to research how culturally competent practice with CYMH clients can be utilized within and beyond in-patient settings. For the same reason that social workers design individual care plans, I have a goal for my professional practice—I will continue to inform and adapt my knowledge to work respectfully with diverse cultures, but also I desire to influence policy to expedite the overall healing and positive gains for children and youth who struggle with mental health issues—by the way of increasing the availability of services. Moreover, future research studies measuring the impact of incorporating culturally diverse approaches into a variety of CYMH service settings is an area of interest.

References

American Psychiatric Association. (2018). Assessment Tools [Website]. Retrieved from https://www.apa.org/pi/about/publications/caregivers/practicesettings/assessment/tools/index.aspx

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

Auerbach, C., & Mason, S. (2010). The value of the presence of social work in emergency departments. *Social Work in Health Care*, *49*(4), 314–326.

Beck, A. T., Steer, A. R., & Brown, G.K. (1996). Beck Depression Inventory®-II (BDI®-II). [Website]. Retrieved from https://www.pearsonclinical.com/psychology/products/100000159/beck-depressioninventoryii-bdi-ii.html#tab-scoring

Bellefeuille, G., & Charlesworth, J. (2003). The next great human adventure: A community wellness approach to social policy. *Social Development Issues: Alternative Approaches to Global Human Needs, 26*(2/3), 90–108.

Benoit, C., Shumka, L., Phillips, R., Kennedy, M. C., & Belle-Isle, L. (2015). *Issue brief: Sexual violence against women in Canada*. Ottawa: Status of Women Canada.

Blum, L. (1994). *Moral perception and particularity.* Oxford, UK: Cambridge University Press.

Brave Heart, M. Y., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research, 8*(2), 56–78.

British Columbia College of Social Workers. (2009). Code of ethics and standards of practice. Retrieved from http://www.bccollegeofsocialworkers.ca/registrants/code-of-ethics-andstandards-of-practice

Canadian Council on Social Determinants of Health. (2015). *A review of frameworks on the determinants of health*. Ottawa: CCSDH. Retrieved from http://ccsdh.ca/images/uploads/Frameworks_Report_English.pdf

Canadian Institute for Health Information (Ed.). (2008). *Mentally healthy communities: A collection of papers*. Ottawa: Canadian Institute for Health Information.

Canadian Mental Health Association. (2014). Mental illnesses in children and youth. Retrieved from https://cmha.bc.ca/documents/mental-illnesses-in-children-and-youth-2

Caputi, M. A. (1978). Social work in health care: Past and future. *Health & Social Work*, *3*(1), 8–29.

Vernon City Counsel. (2016). The City of Vernon: Heritage register.

Conroy, S., & Cotter, A. (2017). Self-reported sexual assault in Canada, 2014. Ottawa: Statistics Canada. Retrieved from https://www150.statcan.gc.ca/n1/pub/85-002x/2017001/article/14842-eng.htm

Cook, J. A., Morrow, M., & Battersby, L. (2017). Intersectional policy analysis of self-directed mental health care in Canada. *Psychiatric Rehabilitation Journal, 40*(2), 244–251. doi:10.1037/prj0000266

Corcoran, J., & Walsh, J. (2010). *Clinical assessment and diagnosis in social work practice*. Boston, MA: Pearson Education.

DCruz, H., Gillingham, P., & Melendez, S. (2006). Reflexivity, its meanings and relevance for social work: A critical review of the literature. *British Journal of Social Work, 37*(1), 73–

90. Retrieved from https://doi.org/10.1093/bjsw/bcl001

Dean, G. R., & Poorvu, N. (2008). Assessment and formulation: A contemporary social work perspective. *Families in Society: The Journal of Contemporary Social Services, 89,* 596–604. doi:10.1606/1044-3894.3822.

Dobrowolsky, A. (Ed.). (2009). *Women and public policy in Canada: Neo-liberalism and after?* Toronto: Oxford University Press.

Froneman, K. (2015). Artist unveils star blanket of life at VJH. Vernon Morning Star. Retrieved from https://www.vernonmorningstar.com/life/artist-unveils-star-blanket-of-life-at-vjh/

Glad, K. A., Jensen, T. K., Holt, T., & Ormhaug, S. M. (2013). Exploring self-perceived growth in a clinical sample of severely traumatized youth. *Child Abuse & Neglect*, *37*(5), 331–342. doi:10.1016/j.chiabu.2013.02.007

Government of Canada. (2018). Suicide prevention [Webpage]. https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuithealth/health-promotion/suicide-prevention.html

Hanlon, M. (2018). Saint John SANE program. Retrieved from http://www.forensicnurses.org

Harder, J. (2015). Retrieved from http://historynstuff.blogspot.com/2015/04/a-bio-sketch-ofsamuel-polson-preacher.html

Harries, J. (2018). *Alcohol use disorder (AUD) Information.* Presentation to mental health care service providers from South Okanagan AUD project Lead Jeff Harries MD. Vernon Jubilee Hospital, BC.

Henriksen, M. G. (2017). Re-visioning psychiatry: Cultural phenomenology, critical neuroscience, and global mental health [Review]. *Journal of Phenomenological Psychology*, *48*(1), 149–154. doi:10.1163/15691624-12341324

Interior Health Authority. (2018). 2017/19-2019/20 Service Plan. [PDF]. Retrieved from https://www.interiorhealth.ca/AboutUs/Accountability/Documents/Service%20Plan%202017-18_2019-20.pdf

Interior Health. (n.d.). Social work report reference guide and meditech social work consultation report. [Handout]. Interior Health Authority.

Interior Health. (n.d.). You have been admitted to the hospital… Child and youth mental health admissions. Information for patients, families and caregivers [Brochure]. Interior Health Authority.

Interior Health. (2018). Strategic direction [Webpage]. Interior Health Authority. https://www.interiorhealth.ca/AboutUs/StrategicDirection/Pages/default.aspx

Johnson, B., Rosenthal, N., Capece, J., Wiegand, F., Mao, L. Beyers, K.,… Swif, R. (2008). Improvement of physical health and quality of life of alcohol-dependent individuals with Topiramate treatment: US multisite randomized controlled trial. *Archives of Internal Medicine, 168*(11),1188–1199. doi:10.1001/archinte.168.11.1188

King, J. (2014). Honouring the voices, perspectives and knowledges of First Peoples through research, critical analyses, stories, standpoints and media reviews. *First Peoples Child and Family Review, 9*(1), 3-4.

Kress, K., Eriksen, K., Rayle, A., & Ford, S. (2005). The DSM-IV-TR and culture: Considerations for counsellors. *Journal of Counselling & Development, 8* (1), 97–104.

Makregiorgos, H., Joubert, L., & Epstein, I. (2013). Maternal mental health: Pathways of care for women experiencing mental health issues during pregnancy. *Social Work in Health Care*, *52*(2–3), 258–279.

Mann, M., & Adam, W. (2016). *Nowh Guna' our way: Carrier culture, knowledge + traditions.*

Prince George, BC: Carrier Sekani Family Services.

Maryanoff, B. E. (2016). Phenotypic assessment and the discovery of Topiramate. *ACS Medicinal Chemistry Letters, 7*(7), 662–665. http://doi.org/10.1021/acsmedchemlett.6b00176

McCombie, S. L. (1976). Characteristics of rape victims seen in crisis intervention. *Smith College Studies in Social Work*, *46*(2), 137–158.

Miller, L. (2012). *Counselling skills for social work*. London: Sage Publications.

National Hospice and Palliative Care Organization. (2008). Social work assessment tool (SWAT). Retrieved from https://www.nhpco.org

Newfoundland and Labrador Association of Social Workers. (2018). Social work and primary health care [Webpage on Canadian Association of Social Workers site]. https://www.casw-acts.ca/en/social-work-primary-health-care

Nixon, M. K., Cloutier, P., & Jansson, S. M. (2008). Nonsuicidal self-harm in youth: A population-based survey. *Canadian Medical Association Journal*, *178*(3), 306–312. doi:10.1503/cmaj.061693

Okanagan Nation Alliance—Syilx. (2017). Wellness [Webpage]. https://www.syilx.org/wellness

Okanagan Nation Alliance. (2017). Syilx-The Indigenous peoples of this land.

O'Neill, L. (2017). An ally in Northern community health: Respectful engagement in healing relationships. In S. L. Stewart, R. Moodley, & A. Hyatt (Eds.), *Indigenous cultures and mental health counselling: Four directions for integration with counselling psychology* (pp. 171–181). New York, NY: Routledge/Taylor & Francis Group.

O'Neill, L., Fraser, T., Kitchenham, A., & McDonald, V. (2018). Hidden burdens: A review of intergenerational, historical and complex trauma, implications for indigenous families.

Journal of Child Adolescent Trauma, 11(2), 173–186. Retrieved from https://doiorg.prxy.lib.unbc.ca/10.1007/s40653-016-0117-9

Ragesh, G., Hamza, A., & Kvn, S. (2015). Guidelines for social work assessment in mental health settings. *International Journal of Research and Scientific Innovation, 2*(10), 165–168.

Richardson, C., & Wade, A. (2010). Islands of safety: Restoring dignity in violence-prevention work with Indigenous families. *First Peoples Child and Family Review*, *5*(1), 137–145.

Rousseau, C., Guzder, J., & Kirmayer, L. J. (2014). *Cultural consultation: Encountering the other in mental health care*. New York: Springer.

Roy, A. (2014). Intergenerational Trauma and Aboriginal Women: Implications for Mental Health during Pregnancy. *First Peoples Child and Family Review, 9*(1), 7-21.

Roy, A., Noomohamed, R., Henderson, R., & Thurston, W. (2015). Promising healing practices for interventions addressing intergenerational trauma among Aboriginal youth: A scoping review. *First Peoples Child and Family Review, 10*(2), 62-81.

Roysircar, G. (2004). Cultural self-awareness assessment: Practice examples from psychology training. *Professional Psychology: Research and Practice, 35*(6), 658–666.

Ryan-Lloyd, K., Morrison, H., & van Leeuwen, A. (2016). *Final report: Child and youth mental health in British Columbia: Concrete actions for systemic change*. Victoria, BC: Select Standing Committee on Children and Youth.

SAMHSA-HRSA Center for Integrated Health Solutions. (n.d.). Screening tools [Webpage]. http://www.integration.samhsa.gov/clinical-practice/screening-tools

Sensoy, O., & DiAngelo, R. (2017). *Is everyone really equal? An introduction to key concepts in social justice education*. New York: Teachers College Press.

SocialWorkersToolbox.com. (n.d.). [Website]. http://www.socialworkerstoolbox.com

Thira, D. (2016). *Trauma response and healing* [Workshop booklet]. Thira Consulting.

Varga, S., Piko, B. F., & Fitzpatrick, K. M. (2014). Socioeconomic inequalities in mental wellbeing among Hungarian adolescents: A cross-sectional study. *International Journal for Equity in Health*, *13*(1), 274–292. doi:10.1186/s12939-014-0100-8

Vennapoosa, C. (2012). *Examples of cross-cultural competence.* Retrieved from http://www.exforsys.com/career-center/cross-culture-competence/examples-of-crosscultural-competence.html

Vernon Jubilee Hospital Foundation. History – Vernon Jubilee Hospital: The Cottage Hospital. n.d. Retrieved from https://vjhfoundation.org/who-we-are/history/

Wilson-Raybould, J. (2017). *Finding solutions: Improving the reporting, charging and prosecution of sexual assaults against adults*. Ottawa: Department of Justice Canada. Retrieved from https://www.canada.ca/en/departmentjustice/news/2017/03/finding_solutionsimprovingthereportingchargingandprosecutionofse.html?wbdisable=true

World Health Organization (WHO). (2012). *Adolescent mental health: Mapping actions of nongovernmental organizations and other international development organizations*. Geneva: WHO Press.

World Health Organization. (2013). *Comprehensive mental health action plan 2013–2020*. Retrieved from http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf?ua=1

World Health Organization. Commission on Social Determinants of Health. (2007, April).

A conceptual framework for action on the social determinants of health [Draft].

Retrieved from

https://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

Appendix A: Learning Contract

Student: Ashley Judge

Practicum Supervisor: Kristeena Robinson

Academic Supervisor: Tammy Pearson

Agency: Interior Health Vernon Jubilee Hospital

Length of Placement: From: 23/04/18 To: 15/08/18

Hours of Work: 560

Learning Objectives

List what you hope to achieve given the opportunities available within the organization and your needs and interests. The learning objectives must be clearly stated. For each learning objective, specify

iii. how you will achieve it (tasks or activities to be completed) iv.
what will be the evidence of achievement

Learning Goals

The overall objective of my practicum is to develop my skills and confidence with clinical and medical social work, with a focus on understanding the need for having social workers in a hospital. I have identified the following goals and sub-goals that will assist me in achieving my objectives:

I. Continue to develop a professional identity as a social worker and recognize client and community issues from a structural perspective.
    a. Maintain professional boundaries and engage in ethical practice
    b. Engage in reflexivity through a combination of journaling and debriefing with supervisors and mentors

c. Further develop my professional practice framework as I integrate my learning and experiences from my placement
d. Obtain clinical supervision and feedback and meet with my supervisors as needed
e. Understand the structural issues that may impact the client population that I work with

II. Gain familiarity with the practice environment and agency structure
    a. Review agency structure and policy
    b. Complete the eight hours of I Learn modules before I begin training in the hospital, as required in the hospital social work role
    c. Observe and work collaboratively with co-workers, supervisors and professionals from other disciplines
    d. Participate in clinical supervision, team and interdisciplinary meetings
    e. Familiarize myself with clinical and hospital social worker roles and techniques used at VJH

III. Develop clinical and medical social work skills
    a. Review and gain familiarity with theories, frameworks, and how social work theory and practice are applied in the hospital setting
    b. Continue to develop my skills in the area of intake, assessment, treatment planning, discharge, community follow-up and termination
    c. Receive continuous supervision and feedback from my supervisors (Megan, Alley and Kimberly)
    d. Practise clinical and hospital social work skills with patients, families and other health care professionals

e. Develop record keeping and case management skills as applicable to working in a hospital
f. Develop an understanding of how social workers in hospitals can work within the medical model to practise ethically and assist clients in an empowering, antioppressive, and person-centred manner
g. Read and familiarize myself with the SANE manual and program, which stands for Sexual Assault Nurse Examiners, who are "registered nurses who have completed specialized education and clinical preparation in the medical forensic care of the patient who has experienced sexual assault or abuse" (Hanlon, 2018)

IV. Develop self-care strategies that will enhance my social and emotional well-being
    a. Continue to maintain my self-care strategies to maintain balance, which include exercising at the gym and training in Brazilian jiu-jitsu, getting adequate amounts of sleep, taking my medication, being social with friends and family, reading and practising deep breathing exercises. Part of my wellness plan will be gaining support and approval of my plan with my supervisors to ensure the prioritization of my wellness.
    b. Meet regularly with my supervisors to engage in clinical supervision and to debrief intense and triggering experiences

V. Develop an understanding of community agencies that are connected to my practicum organization and that are able to provide additional support to my clients as needed.
    a. Review resources within and outside of the Vernon and Okanagan area
    b. Develop relationships with additional community agencies
    c. Have the ability to make referrals as needed

d. Connect person-in-environment, anti-oppressive and structural frameworks to VJH's resourcing and networking

Proposed Timeline of Completion and Evaluation

The Master of Social Work program at the University of Northern British Columbia requires that students complete a practicum that consists of 560 hours. The proposed start date for my practicum will be April 23, 2018 and I anticipate working at the practicum site on a full-time basis from Monday to Friday, alternating between having Wednesdays off and weekends depending on my field supervisors' schedules. Based on this time frame, I hope to complete my practicum by August 15, 2018. In order to evaluate my performance, I will meet regularly with my practicum supervisors for supervision, which will ensure that I am delivering competent and ethical clinical and hospital social work practice that connects theory to practice.

In order to ensure that I am sufficiently prepared for supervision and working towards my learning goals, I will engage in reflexive practice during my practicum, which is defined as "an individual's self-critical approach that questions how knowledge is generated and, further, how relations of power operate in this process" (DCruz, Gillingham, & Melendez, 2006, p. 75). In order to engage in reflexivity, I will keep a creative art journal that reflects on my practice as it connects to my learning objectives. For example, at the end of each practicum day, I will set aside an hour or so to journal (write, paint, color, create with craft materials) to critically reflect on what happened, any important learning, or anything that troubled me that day. For troubling aspects, I may encounter in practicum, I will reach out to a trusted professional confidant, such as my faculty supervisor, Tammy Pearson, or my agency supervisor, Kristeena Robinson. The journaling will be part of my self-care routine and a visual way for me to see if I am struggling with professional boundaries or requiring further self-care due to my experiences of mental

illness and trauma. This will be to ensure no harm is done to the client population, staff, the agency, or myself while engaging in this practicum. Additional self-care measures I will continue to engage in are training in Brazilian jiu-jitsu (BJJ); exercising (cardio and weights); keeping in touch with previous co-workers and supervisors; talking and spending time with my mother and close friends; watching comedy (stand-up & movies). In addition to supervision and reflexivity, I will schedule a phone conference with my academic supervisors' mid-way through the practicum in order to review my learning goals to ensure that I am meeting my objectives. My supervisor will also complete a final evaluation of my performance to confirm that I have reached my targeted learning goals.

Additional Learning Objectives:

- Research assessment tools used by social workers in hospitals and acute health care settings using the hospital library a one resource.
- Work on trust and rapport building and initial intake meetings with more confidence.
- Take on cases start to finish.
- Ensure I practise a healthy sleep schedule.
- Journal in the moment about the thoughts of other professionals in rounds and how this might affect the client.

Signatures

Student: _____ Date: _____

Practicum Supervisor: _____ Date: _____

Academic Supervisor: _____ Date: _____

Appendix B: CYMH Safety Plan

Interior Health

YOUTH MHSU SAFETY PLAN
ACUTE SERVICES

Content used with permission of BC Children's and Women's Hospital

Calm, Cool, and Collected! Tell us what helps YOU stay cool & feel SAFE

Help us understand how we can help you calm down BEFORE a crisis occurs. Please list things that will help us know when you are feeling stressed or upset. This form is used to help staff work together with you to create a safe environment. You can add to the plan at any time. Please feel free to ask questions (there is no such thing as a stupid question). We are here to help.

What of the following are difficulties or problems for you?

- ☐ Losing control
- ☐ Violent or aggressive behaviour
- ☐ Other
- ☐ Drug or alcohol abuse
- ☐ Feeling suicidal
- ☐ Suicide attempts
- ☐ Hurting yourself (self-harm)
- ☐ Feeling unsafe
- ☐ Running away

What of the following (triggers) make you feel angry, upset, or unsafe?

- ☐ Not being listened to
- ☐ Darkness
- ☐ Loud noises / bright lights
- ☐ Feeling lonely
- ☐ Being alone
- ☐ Lack of privacy
- ☐ People yelling
- ☐ Arguments
- ☐ Being touched
- ☐ Being stared at
- ☐ Not having control
- ☐ Being teased / picked on / bullied
- ☐ Uniforms (police / security)
- ☐ Someone lying about my behavior
- ☐ Other
- ☐ Contact with person who is upsetting
- ☐ Particular time of ☐ day ☐ night

Please describe your warning signs. For example, what you and / or other people may notice when you begin to feel upset or angry? (This information will be helpful so that together we can create new ways of coping with anger and stress)

Changes in your body:	☐ Sweating	☐ Racing heart	☐ Clenching fists	☐ Wringing hands	☐ Being rude
	☐ Breathing hard	☐ Clenching teeth	☐ Red faced	☐ Can't sit still	
Changes in what you say or how you say it:	☐ Loud voice	☐ Swearing	☐ Singing		
	☐ Yelling	☐ Crying	☐ Laughing loudly		
Changes in what you do:	☐ Isolating	☐ Not taking care of self	☐ Sleeping less	☐ Hurting others or things	
	☐ Avoiding people	☐ Throwing objects	☐ Eating less	☐ Eating more	

Injuring self (how?)

Other

What are some things that help you feel safe / protected or help calm you down? This information is helpful so that staff members are aware of the things that help you feel better when you are having a hard time. We may not be able to offer all the choices that you have picked, but we would like to work with you to figure out what we can do while you are here.

- ☐ Exercise
- ☐ Reading or other quiet activity (journal, drawing)
- ☐ Watching TV / video games
- ☐ Other
- ☐ Being around other people
- ☐ Talking with staff / peers
- ☐ Relaxation (deep breathing; yoga; music)
- ☐ Calling a friend or family
- ☐ Listening to music
- ☐ Taking a hot or cold shower / bath
- ☐ Hugging a stuffed animal
- ☐ Doing an activity (cards, games)

Is there anything else that would make your stay easier and more comfortable? Please tell us.

Staff signature _____ Date _____

Appendix C: Referral Form

CYMH referral form; Vernon Jubilee Hospital referrals.

Date: (YYYY/MM/DD)	Child/**Youth's Last Name**:	Child/Youth's **First and Middle** Name:

Name of person referring:	Date of Birth (YYYY/MM/DD)	Personal Health Number (PHN)
Child/Youth's Gender Identity: Male ☐ Female ☐ Other ☐ _____	Age ( )	

Child/youth's Address(es):	City:	Postal Code:

Is the Child/Youth of Aboriginal origin? Yes ☐ No ☐	☐ First Nations ☐ Inuit ☐ Nisga'a ☐ Metis ☐ Other	Ethno/Cultural Background: Language(s) spoken at home:

Parent(s)/Legal Guardian(s) Name:

Indicate Guardian's Relationship to child/youth:

Mother: ☐ Father: ☐ Relative (specify): ☐ _____ Other (specify): ☐_____

Home Phone Number(s):

Cell Number(s):

Family Doctor : **Psychiatrist:** **School Name:** Grade: Contact Person and position:	Medications:	Diagnoses:

Discharge Date:

Is youth family aware of referral?

Child or youth has had previous counselling or mental health services Yes ☐ No ☐
If yes, when and with whom?

Presenting issues:

Do you have any safety concerns today? Yes ☐ No ☐

Appendix D: List of Mental Health Act Forms

Committal forms CYMH - Checklist

Form #	Form Name	Completed By:	Date Completed	Initial
	FORMS THAT MUST BE COMPLETED ON ALL YOUTH			
4	Medical Certificate – Involuntary Admission	Psychiatrist/GP		
4	Medical Certificate – Involuntary Admission	Psychiatrist/GP		
5	Consent for Treatment	Psychiatrist/GP		
13	Notification to Involuntary Patient Rights under MH Act	SW/RN		
15	Nomination of a Near Relative	SW/RN		
16	Notification to Near Relative – Admission of Involuntary Patient	SW/RN		
17	Notification to Near Relative - Discharge of Involuntary Patient	Psychiatrist		
	Form 17 – Mail a copy to the Near Relative	Ward Clerk?		
	Renewal Forms			
	FIRST RENEWAL AND RIGHTS		**Date Due:**	**Date Done:**
6	Medical Report on Examination of Involuntary Patient (Renewal Certificate)	Psychiatrist		
13	Notification to Involuntary Patient Rights under MH Act	SW/RN		
	SECOND RENEWAL AND RIGHTS		**Date Due:**	**Date Done:**
6	Medical Report on Examination of Involuntary Patient (Renewal Certificate)	Psychiatrist		
13	Notification to Involuntary Patient Rights under MH Act	SW/RN		
	Extended Leave (DISCHARGE from VJH)			
20	Leave Authorization (Extended Leave)	Psychiatrist		
17	Notification to Near Relative - Discharge of Involuntary Patient	Psychiatrist		
	Forms 17 and 20 – originals to VJH PSYCH	Ward Clerk?		
	Forms 17 and 20 - Copies made for chart	Ward Clerk?		
	Fax copy to CYMH Vernon – 250-549-5458	Ward Clerk?		
	Form 17 – Mail a copy to the Near Relative	Ward Clerk?		
	Review Panel			
7	Application for Review Panel Hearing	Patient/Relative		
18	Notification to Near Relative (Request or Order for a Review Panel Hearing)	Review Panel Chairperson		
	Second Opinion Forms			
11	Request for Second Medical Opinion	Patient		
12	Medical Report	Second Psychiatrist		

Reference: http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

Websites for Youth:

www.ok2bblue.com

www.mindyourmind.ca

ON LINE RESOURCES:

www.keltymentalhealth.ca
www.heretohelp.ca
www.bckidsmentalhealth.org
www.kidshealth.org
www.mentalhealth.com
www.camh.net
www.depression-screening.org
www.thesupportnetwork.com
http://psychologyinfo.com/depression/teens.htm

"There may be more to learn by climbing the same mountain a hundred times, than by climbing a hundred different mountains..."

~Richard Nelson

CONTACT NUMBERS:

Child & Youth Mental Health
250-549-5404

Pediatric Unit at VJH 250-558-1213

Pediatric Clinic 250-558-5506

KELTY Mental Health Resource Center
1-800-665-1822

Adult Mental Health 250-549-5737

Crisis Line 1-888-353-2273

Community Response Team
250-260-7893

North Okanagan Youth and Family Services 250-545-3572

Family Resource Center
250-545-3390

Mental Illness Family Support Center
250-260-3233

VERNON JUBILEE HOSPITAL

YOU HAVE BEEN ADMITTED TO THE HOSPITAL...

Child and Youth Mental Health Admissions

Information for Patients, Families and Caregivers

THE ADMISSION:

You have been admitted to hospital for stabilization as a result of some concerns for your mental and emotional health. This admission has occurred with the goal of stabilization and to create a treatment plan to support you once you are discharged from the hospital. You will meet with a psychiatrist who will work out specific goals for your treatment and support plan.

Your treatment here may include:

- Written Care Plan
- Reviewing your current medications
- Changing your medications
- Limited or Low Stimulation Activities
- Interviews and Assessments
- Suicide Assessment
- Safety Contract
- Visitation Contract
- Passes
- Team Meeting
- Possible referrals to:
  - Local Child and Youth Mental Health
  - Local Counselling
  - Adolescent Psychiatric Unit
  - Referral to BCCH Vancouver

THE TEAM:

In order to support you and your child with this admission there is a team of professionals available to you to help with the questions and concerns that can arise for you. You and/or your family may meet with some or all of the following team members during this admission:

- Psychiatrist
- Nurses
- Child and Youth Mental Health Counsellor
- Social Worker
- Patient Care Coordinator
- Pediatrician
- Family Physician
- Dietitian
- Family Psychiatrist
- Care Aides

A schedule will be set up individually with each team members for weekly appointment times.

Only when we are no longer afraid do we begin to live. ~D. Thompson

TEAM MEETINGS:

Depending upon the length of time that you are here, there may be weekly team meetings of the people involved with you or your child. If your stay here is short term, this may only be a meeting for discharge planning. The team discusses the progress towards the goal of being medically stable and possible options for treatment and support. If you are here for a longer period of time, the team will meet with you and your family/support and your treatment care plan will be updated and a copy will be given to you. You and your family/support person are invited to attend the second half of the meeting to present questions and get updates from the team.
You will be provided a sheet to write out your questions for the team if you do not want to attend in person.

Mapping Intergenerational Trauma and Mental Health Impacts on Community

Table 1: Trauma Braid

Instinct	Flight	Freeze	Fight
Trauma	Anxiety	Depression	Rage
Colonization	"Addiction"	Suicide	Violence

Source: Thira, 2016, p. 6.