# CLINICAL SOCIAL WORK WITH INDIGENOUS CHILDREN AND YOUTH

by

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**Abstract**

In this report I discuss my practicum experience at Carrier Sekani Family Services and my work with the Child and Youth Mental Health Team during the summer of 2021. I review the agency I worked with, including an overview of the services they offer and its mission. My personal positioning and theoretical orientation are outlined, with a specific focus on how social location impacts my work, social constructivism, and strength-based framework. A literature review is provided in which four topics related to my practicum are reviewed: child and youth mental health, Indigenous child and youth mental health, the importance of providing services to children and youth, and practice considerations. I discuss my practicum learning experience and focus on the theme of holistic practice. Finally, I review how my practicum experience will impact my future practice and how my learning will benefit me and my future clients.

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Thank you to local artist Carla Joseph of Hummingbear Cree-ations for granting me permission to include her beautiful artwork, *We are Found,* in this report.

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**Dedication**

To the Indigenous children of Turtle Island, past and present. May the world honour you, stand with you, and see you for the gifts you are.


*We are Found* by Carla Joseph (2021)

# Chapter 1: Introduction

This report outlines my learning from my practicum experience with Carrier Sekani Family Services in the Child and Youth Health and Wellness Counselling Program. The practicum occurred between May and August 2021 in Prince George, BC. The practicum focused on clinical social work practice with Indigenous children and youth. This report discusses the agency with which I was placed and the learning goals I developed for my practicum experience. This report also reviews my theoretical framework and personal positioning. A literature review focuses on child and youth mental health, Indigenous child and youth mental health, the importance of providing services to children and youth, and practice considerations for working with this population. Lastly, I discuss the learning I gathered from my practicum experience and its implication for my practice.

## Placement Agency

The Carrier and Sekani people are located in north-central British Columbia (Brown, 2002). Their territory spans over 76,000 square kilometers, and there are approximately 22 First Nations communities who identify as Carrier or Sekani on the terrority (Carrier Sekani Family Services, 2015). There are 10,000 individuals represented by the Carrier Sekani First Nation (Carrier Sekani Family Services, 2015). Like many Indigenous communities, the Carrier and Sekani peoples have experienced hardship due to colonization, such as discrimination, loss of human rights, oppression, abuse, mistreatment, forced assimilation, and land displacement, all of which will be discussed in detail in the literature review (Blackstock & Trocmé, 2005; Kirmayer et al., 2009; McCormick, 2009). Although there has been much devastation, the immense strength and resiliency of the Carrier and Sekani peoples are evident in their continued efforts to tackle the negative impacts of colonization (Brown, 2002).

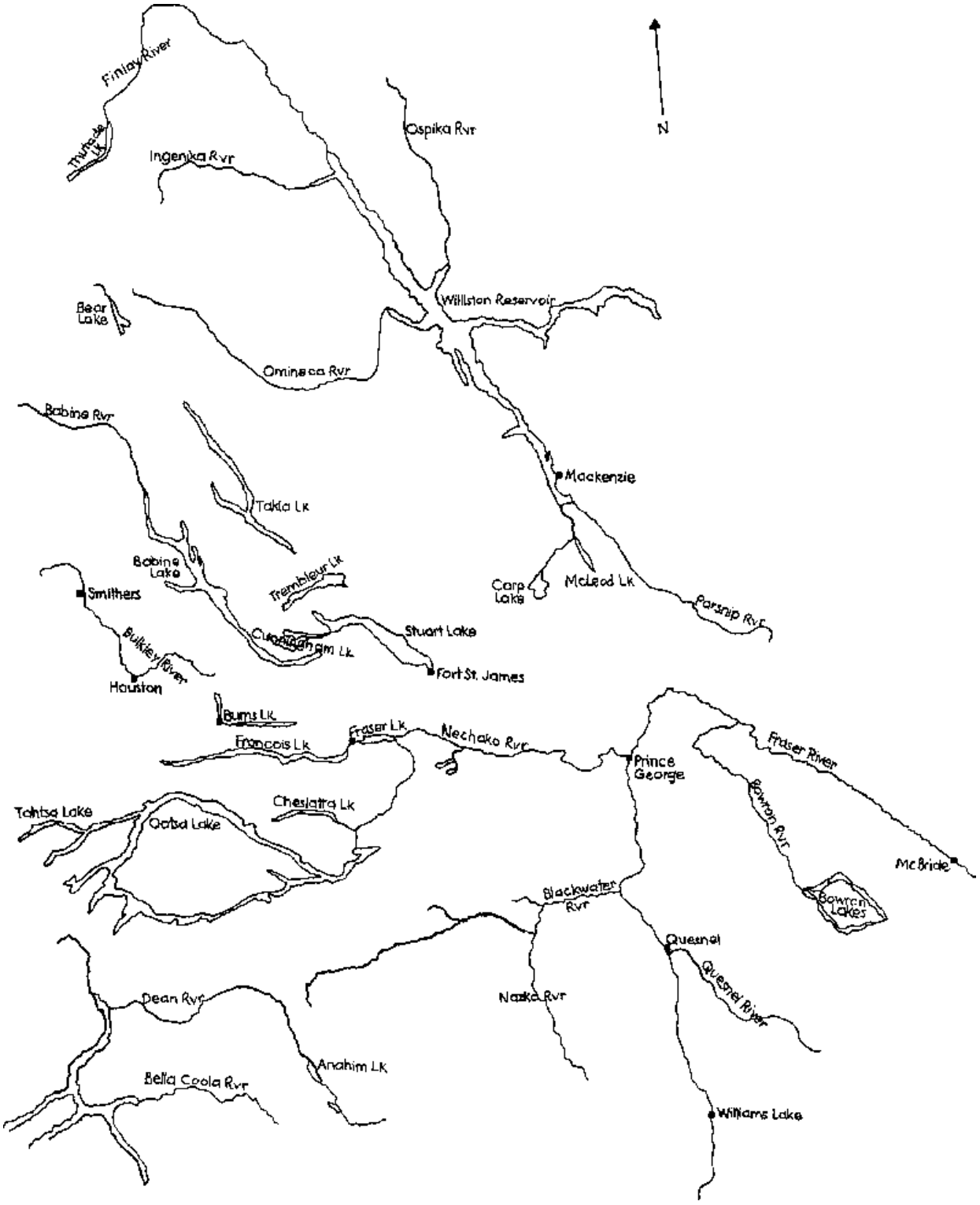


Figure 1: Carrier Region of British Columbia (Brown, 2002, p. 26)

Carrier Sekani Family Services, originally known as Northern Native Family Services, was created in 1990 (Carrier Sekani Family Services, 2015). Elders and leaders of the Carrier Sekani Tribal Council recognized that there were numerous issues in Carrier and Sekani communities resulting from the adverse effects of colonization that made support services needed. The organization has grown substantially in the last three decades and has expanded its services. The organization has and continues to create programs that met the Carrier and Sekani people's unique needs to provide healing and empowerment. The organization has and continues to build programs and services that are rooted in Carrier and Sekani knowledge, values, and culture.

**Services Provided**

Carrier Sekani Family Services offers a wide range of services and has three primary offices located in Prince George, Vanderhoof, and Burns Lake (Carrier Sekani Family Services, 2020). These offices also arrange services for surrounding rural and remote communities (Carrier Sekani Family Services, 2020). Carrier Sekani Family Services offerings include Aboriginal Patient Liaison Program, Addictions Recovery Program, Aboriginal Supported Child Development, Best Beginnings Outreach Program, Bridging to Employment, Canadian Prenatal Nutrition Program, Community Linkages Program, Early Years Centre, Family Empowerment Supported Visit Program, Family Preservation and Maternal Child Health, Family Support Program, First Nations Health Benefits and Patient Travel Program, Foster Family Resources, Guardianship and Voluntary Delegated Child Welfare Services, Health and Wellness Counselling Program, Home Care, Intensive Family Therapeutic Services, LGBTQ2+ Health and Wellness, Mediation and Family Justice Services, Mobile Diabetes Program, Primary Care,

Safe House Dzee Bayugh, Vanderhoof Indigenous Head Start, Wrap Around Parental Guidance and Support Program, and Youth Services (Carrier Sekani Family Services, 2021a).

My practicum was completed with the Health and Wellness Counselling Program in Prince George, and I worked with the Child and Youth Mental Health Team. This team provides counseling services to children and youth who are experiencing "difficult situations and emotions" (Carrier Sekani Family Services, 2020, paragraph 1). The program focuses on providing services and supports that are unique to clients' needs and do so through culturally relevant mental health consultations, assessments, and interventions (Carrier Sekani Family Services, 2020).

**Carrier Sekani Family Services Mission**

Culture is the core of the programming at Carrier Sekani Family Services, and the programming aims to provide holistic wellness through the Carrier Life Cycle Model (Carrier Sekani Family Services, 2021b). The Carrier Sekani Family Services mission statement is as follows: "With the guidance of our Elders, Carrier Sekani Family Services is committed to the healing and empowerment of First Nations Families by taking direct responsibility for: health, social, and legal services for First Nations people residing in Carrier and Sekani territory" (Carrier Sekani Family Services, 2021b, paragraph 3). Carrier Sekani Family Services asserts that it provides services that meet high standards and are culturally relevant to serve the Carrier and Sekani peoples of Northern British Columbia to "create wellness together" (Carrier Sekani Family Services, 2021b, paragraph 1).

**Learning Goals**

Practical learning experience is an essential part of becoming a skilled and competent clinical social worker. As part of my practical learning, I planned my practicum to focus on

clinical work with children, youth, and their families to enhance my clinical social work skills. The following goals structured my learning journey during my practicum. My first goal was to continue to develop my professional identity as a clinical social worker. Second, I sought to gain familiarity with the practice environment and agency structure. I planned to continue to develop my clinical social work skills and knowledge of clinical social work, particularly with Indigenous populations. Last, I wanted to increase my knowledge of various counseling techniques used specifically with the child and youth populations. These goals guided my learning during my practicum experience.

The aim to develop my professional identity as a clinical social worker guided me to ensure I adhered to professional guidelines while also continuing to develop my own identity as a social worker. This was cultivated by engaging in reflexivity in dedicated periods of reflection, personal journaling, and planned time for reflective conversations with supervisors and mentors. Further, I maintained my professional self-care regimen, including taking scheduled breaks, having firm boundaries with respect to workplace hours, and maintaining a manageable workload. Last, I maintained ethical standards of practice using the Canadian Association of Social Workers (2005) Ethical Guidelines and Standards of Practice Guidelines when providing services to clients.

Growing my familiarity with the practice environment and my placement agency's structure helped me understand the nature and forms of community mental health services in a Delegated Aboriginal Agency. I reviewed the agency's mandates, policies, and practice manuals. I also observed and worked collaboratively with mentors, supervisors, and other professionals.

Continuing to develop my clinical social work skills was one central focus of this practicum. I was able to review theories, frameworks, and knowledge used in clinical social

work practice at the agency. I was also able to engage in workplace tasks such as intakes and clinical interventions to practice skills. Individual and group clinical supervision guided my practice and allowed me opportunities to review and enhance my application of skills.

Improving my clinical skills and knowledge of clinical social work with Indigenous populations, in order to provide the most effective and useful services, was an important aspect of my practicum learning. I sought to gain knowledge and understanding of the Carrier and Sekani peoples by focusing on their history and culture by acquiring and reviewing historical documents. Providing culturally safe services was a central pillar of this learning goal which was defined as "recognizes, respects and nurtures the unique cultural identity of Indigenous peoples and safely meets their needs, expectations, and rights" (Whanau Kawa Whakaruruhau, 1991, p. 7).

Lastly, I hoped to increase my knowledge of counseling techniques when working with Indigenous children and youth, both from a Western lens and an Indigenous lens. To achieve this goal, I was fortune to be able to participate in numerous trainings and events that focused on counselling techniques for this population. I was also able to complete personal research that assisted me to engage productively with this goal.

# Chapter 2: Personal Positioning & Theoretical Orientation

## Personal Position

Personal positioning is a valuable tool that enables helping professionals to engage in critical self-reflection to improve their work (Probst, 2015). Using this tool, clinical social workers can recognize and reflect on how their personal experiences shape their values, assumptions, and beliefs. It is understood within the profession of social work that the self is a critical part of our work as social workers because the self can never be removed entirely from practice (Lynch, 2000; Probst, 2015). Hence, personal positioning creates opportunities to challenge ourselves and improve our clinical practice.

Some positions I hold include being a clinical social worker who identifies as a Caucasian and cis-gendered woman who is heterosexual, able-bodied, and Christian. I am also a feminist, a mental health advocate, a child and youth counselor, happily married, and currently live a comfortable middle-class life. I currently live in Northern British Columbia. However, I am from a tiny rural community in Newfoundland, characterised by a strong Christian and conservative worldview, which is where I lived most of my life. Though my family was very low-income and struggled significantly economically, particularly during my childhood, I was raised in a loving and safe home that I will forever be grateful for. I was born in Canada in the 1990s. My ancestors are of Northern European descent and emigrated from England in the 1800s during what is commonly known as The Great Migration of Canada.

These positions impact how I see the world and live my life. Further, I humbly acknowledge that my upbringing, culture, and worldviews play a role in my work. When working with Indigenous peoples or any individuals from a different culture from my own, I have come to understand the importance of acknowledging my personal positions and taking

time, as Baskin (2016) suggests, to reflect on how my respective positioning will be present in my work. My culture and worldview often differ from those of clients I work with. Consequently, to work successfully and support Indigenous clients, I must be comfortable with acknowledging my positions with clients, taking time to understand why these elements may be of interest to (or be problematic for) clients, and being open to having candid conversations about how this may influence our therapeutic work.

My interest in clinical social work and mental health was sparked by my own experiences with mental health in my family. When I was a child, many of my relatives struggled with mental illness and addiction. However, these issues were never explicitly discussed or addressed. It was not until adulthood that I became fully aware of the reality and nature of the struggles my relatives lived with, the tremendous efforts made by my relatives to conceal their struggles, and their avoidance of professional help and treatment. My culture significantly impacted my family's actions; mental illness and addiction were viewed as personal failures and were considered shameful.

While my interest in the field was grounded in a desire to understand how mental illness and addictions impacted my family, my focus has evolved into a passion for the field. I have come to believe in the importance of openly addressing mental health concerns and speaking about mental health openly. Further, I believe everyone has the right to access supportive and high-quality mental health and addiction services. I have particular empathy for children and youth who are experiencing mental health struggles or are indirectly impacted by mental health and addiction. I consider my work a privilege and hope to spend my career in the mental health field. I plan to continue to develop my knowledge and expertise to effectively support children, youth, and families who have similar experiences as my own.

**Theoretical Orientation**

In thinking about the overarching theoretical framework through which I interpret my professional practice, I identify most closely with social constructivism. In the broadest sense, this framework is built upon the idea that human beings can be understood through relationships (Witkin, 2012). The beliefs and values that are integral to social constructivism, and that guide my practice, are as follows: practitioners seek to understand their world, there are multiple perspectives from which to understand reality, and it is through work with others that reality is constructed by means of interactions and lived personal experiences (Creswell & Poth, 2017). Additionally, within this framework the relationship between the client and the practitioner takes precedence in any intervention (Witkin, 2012).

Practitioners who adhere to this framework often exercise a pragmatic approach to their work (Witkin, 2012). Social constructivism is an adaptable framework that focuses on how one can best serve clients in each unique case. Care providers focus on selecting specific approaches that address the social landscape of the client's life, they consider existing issues that confront the client, and they acknowledge context of life stage and time within the client's life. This framework is in contrast to other frameworks that are more rigid in their approach and selecting interventions when working with clients. Witkin (2012) states that the social constructivism framework operates as an "ever-evolving, co-constructed character of the relationship, not particular methods or techniques, guides the practitioners' actions" (p. 3).

Further, my direct clinical practice is heavily influenced by a strength-based framework. This framework originated in the 1980s and has been considered an overarching framework in social work practice for decades (Howe, 2009; Saleebey, 2011). The strength-based framework

is broadly defined as an approach that focuses on a client's natural strengths and emphasizes the client's self-determination while they work toward self-actualization (Cummins et al., 2012).

The defining features of strength-based framework include a focus on the value of resilience and resourcefulness that clients have within themselves by virtue of being human (Howe, 2009). Recognizing that all clients have inherent strengths and then focusing on those qualities, rather than the client's limitations, is most productive for promoting healing (Howe, 2009). Social workers must help empower clients to move toward their goals by using a strengths-driven perspective—recognizing that therapeutic relationships that are collaborative in nature serve clients best (Howe, 2009). When using this framework, clinicians must ensure clients take the lead in their own therapeutic work so they can create sustainable change through problem-solving experiences that foster personal growth and learning (Howe, 2009).

A key aspect of using a strength-based framework in clinical practice is recognition that the strength-based framework does not encourage clinical social workers to dismiss problems (Saleebey, 2011). The framework recognizes that exploring issues and problems identified by clients is essential to conducting successful therapeutic work (Saleebey, 2011). While tackling problems that clients bring to us, the strength-based framework encourages clinical social workers to first acknowledge client's inherent strengths and capabilities that will help them manage their issues (Saleebey, 2001).

Additionally, this framework is characterized by a pragmatic approach: it recognizes that clinical social work practice includes multiple interventions, modalities, and therapies. Rapp et al. (2008) provide guiding principles to identify whether an intervention can be applied effectively in a strength-based framework. These principles include the idea that intervention must assess the client's strengths, capabilities, and resources. The goal of practice is to assist the

client in using the knowledge of their strengths to address issues. Intervention focuses on the client's self-determination in their therapeutic work. The clinical social worker is primarily a supporter; ultimately, the decision-making responsibility lies with the client, and it is the role of the clinical social worker to help the client cultivate that ability. Finally, interventions should focus on relationship-building because relationships are a source of support, hope, and empathy for the client.

Both social constructivism and the strength-based framework guide my practice. Social constructivism is the overarching framework that helps me understand the world and how to approach work with clients. At the same time, the strength-based framework provides more specific guidance that directs my clinical practice. Both approaches have similar underpinning values: focusing on the client and acknowledging them as the expert in their own life while the clinical social worker maintains a supportive role. These frameworks complement each other and enhance my practice.

# Chapter 3: Literature Review

Children and youth are a community's most cherished gifts, and they must be supported to grow and thrive. This literature review explores child and youth mental health in Canada and why this population is crucial to address in conversations about mental health. Indigenous child and youth mental health in Canada is also explored in connection with colonialism and its impacts on the mental health of contemporary Indigenous children. Finally, practice considerations relevant to clinical social work with Indigenous peoples will be reviewed.

## Child and Youth Mental Health in Canada

It is important to first review definitions and understandings of mental health. In traditional Carrier society, the concept of mental illness did not exist (Dobson & Schmidt, 2015). Carrier oral history does reflect that individuals did develop struggles related to wellness, and the causes of these struggles were related to being out of balance, the loss of spirit, or bad medicine (Mann & Adam, 2016). Currently, mental illness is recognized by Carrier peoples, but it is acknowledged that this concept was introduced through colonization (Dobson & Schmidt, 2015). The mind, body, spirit, and self are understood as interdependent in the Carrier worldview (Dobson & Schmidt, 2015; Mann & Adam, 2016). Consequently, Carrier peoples view "the whole person, family, community, natural environment, ancestors, and the spirit world are involved in maintaining mental health and treating mental illness" (Dobson & Schmidt, 2015, p. 33). The World Health Organization (2018) provides another definition of mental health, which is "a state of wellbeing in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make contributions to his or her community" (paragraph 2).

Conceptualizations and definitions of mental health vary across cultures, geographical regions, and generations. Nevertheless, common among various definitions and understandings, a shared theme is that mental health is an integral part of wellness throughout a person's life. The development of mental wellness starts as soon as a person is born and continues to fluctuate throughout the lifetime as a fluid state (Kostouros & Thompson, 2018). Positive long-term mental health is associated with increased positive life outcomes for children and youth, such as positive social relationships, increased self-confidence, increased overall happiness, higher likelihood of finishing high school, and, eventually, increased income potential (Bulter & Pang, 2014). When a child's or youth's mental health is suboptimal for extended periods of time, this condition is associated with less desirable outcomes such as lower life-satisfaction rates, a greater risk of physical health problems, reduced likelihood of finishing high school, and decreased income potential (Bulter & Pang, 2014).

Mental health issues are the leading health problem for children and youth (Waddel et al., 2005). It is estimated that in Canada 1.2 million children and youth are affected by mental illness (Mental Health Commission of Canada, 2019). Seventy percent of mental health problems arise during childhood and adolescence (Mental Health Commission of Canada, 2019). However, less than 20 percent of the children and youth impacted by mental health struggles receive the supports and services they need (Mental Health Commission of Canada, 2019). The vast number of children and youth who experience mental health struggles is a significant cause for concern in Canada and remains an important issue to be aware of and attend to.

**Indigenous Child and Youth Mental Health**

In 2016, Indigenous children represented 7% of Canada's child population (Statistics Canada, 2017). Among children and youth experiencing mental health struggles in Canada,

Indigenous children and youth experience a higher occurrence of mental health struggles than their non-Indigenous counterparts (Atkinson, 2017; Kirmayer et al., 2009). Indigenous children are also at significantly higher risk of mental health issues, in both quantity and severity, than their non-Indigenous counterparts (Adelson, 2005; Ning & Wilson, 2012; Young, 2003).

In discussing the mental health of Indigenous children and youth in Canada, it is impossible to understand the landscape of the issue without discussing intergenerational trauma. Indigenous peoples have had a unique experience among ethnic groups in Canada. Through colonization, Indigenous peoples have endured remarkable hardship, loss, and pain (Blackstock & Trocmé, 2005). For example, Indigenous people have experienced losses of land and culture and human rights; the break-up of families caused by the residential school system; and discrimination, racism, oppression, abuse, and mistreatment (Blackstock & Trocmé, 2005; Kirmayer et al., 2009; McCormick, 2009). Colonization in Canada attempted to dismantle Indigenous culture, displace Indigenous people from the lands they occupied, and assimilate Indigenous peoples entirely into Western culture (Woroniak & Camfield, 2013). Canada as we know it would not exist without stolen access to Indigenous peoples' lands and resources, and the unjust actions taken against Indigenous peoples as part of the colonization process (Woroniak & Camfield, 2013). The trauma and ongoing problems that colonization engendered continue to have significant impacts on Indigenous families today, including the most recent generation of Indigenous children and youth (Brady, 2015; Quinn, 2007).

Few Indigenous children today have had the opportunity to learn their culture or to be part of a strong, healthy family, or, for that matter, a strong community system, and these deficits are due to the impacts of colonization (Menzies, 2010). Understanding intergenerational trauma helps us understand why Indigenous children and youth experience more mental health struggles

than their non-Indigenous counterparts (Menzies, 2010). In addition, such knowledge assists our understanding of how to provide support to Indigenous children and youth struggling with mental health challenges (Menzies, 2010).

**The Importance of Providing Services to Children and Youth**

The onset of mental illness in Canada typically occurs before the age of 25 (Malla et al., 2018). Most mental health difficulties start to become apparent in childhood and early adolescence (Ellis et al., 2014). A period of opportunity exists during childhood and adolescence—between the ages of 4 and 17—to promote mental health and provide critical interventions that might prevent the onset of mental illness or could potentially reduce the severity of mental illness if it occurs (McGorry et al., 2007). For example, Malla et al. (2018) reported that when children and youth have access to assessment, diagnosis, intervention, and support services by the age of 12, there is a significant increase in positive outcomes associated with mental health. Research indicates the Canadian government should make Indigenous child and youth mental health a priority in the development of health care services and policy (Malla et al., 2018). Given the unique experiences of Indigenous children and youth associated with colonization and other risk factors such as high rates of poverty, geographical challenges, and restricted access to health care services among Indigenous populations, the importance of providing timely strength-based high-quality mental health supports and services for Indigenous children and youth in Canada should clearly be a national priority (Walker et al., 2018).

A thorough understanding of Indigenous history, colonization, and intergenerational trauma can help clinical social workers better understand the immense difficulties confronting Indigenous children, youth, and their caretakers (Cook et al., 2005; Fox et al., 2015). However, it is also vital to recognize Indigenous peoples' resilience and strength when asked to provide

support. Despite challenging and tragic circumstances, Indigenous peoples continue to push forward, fight for their rights, maintain as much of their culture as possible, and rebuild their communities (Blackstock, 2009). Blackstock (2009) quotes many Indigenous elders who state, in essence, "we did not get here alone, and we are not leaving alone" (p. 34). Non-Indigenous professionals in the mental health field need to consider our roles as supporters and allies of Indigenous peoples and look to Indigenous leaders, Elders, and knowledge holders to guide how we can best support Indigenous children and youth (Blackstock, 2009).

**Practice Considerations for Clinical Social Work with Indigenous Peoples**

Clinical social work practice plays an important role in providing mental health support to Indigenous peoples and can be broadly defined as "the application of social work principles to the broad scope of mental health treatment" (Groshong, 2009, p. 7). Practice in this area of social work focuses on building therapeutic relationships as the foundation upon which supporting clients is grounded (Groshong, 2009). Clinical social work practice identifies clients in both their environmental contexts and as individuals; this occurs in conjunction with the use of robust ethical frameworks to guide practice (Groshong, 2009).

In conversations about clinical social work, it is essential to acknowledge that mental health services have not been, historically, a context in which Indigenous voices or needs have been valued and validated as they ought to have been (Lavallee & Poole, 2010). Literature also demonstrates that many Indigenous people have had negative experiences when accessing mental health support, especially from non-Indigenous professionals (Nuttgens & Campbell, 2010). Further, Indigenous peoples have, in some cases, avoided seeking support because services have not provided in a culturally safe and respectful manner (Dion Stout et al. 2001; Nuttgens & Campbell, 2010). Hence, for any clinical social worker—especially those who are

non-Indigenous, such as myself—it is vital to consider how clinical social work can be improved to more effectively support Indigenous clients and ensure ethically sound services are provided. Such an objective starts with reflection on one's personal practice.

Cultural safety is a helpful concept when working with Indigenous peoples. The notion was created in New Zealand by Indigenous nursing leaders, and it functions as a critical lens through which to analyze how helping professions—specifically professionals who are non-Indigenous—provide services for Indigenous peoples (Ramsden, 2000). The purpose of this lens is to aid professionals' critical evaluation of their practice and improve it (Ramsden, 2000). Cultural safety is meant to improve services and support for Indigenous peoples and other clients with cultural backgrounds that differ from the helping professional (Ramsden, 2000).

Cultural safety has been adopted as a tool around the world and particularly in Canada. It is a versatile approach that is applicable across many professions, environments, and geographic regions (Brascoupé & Walters, 2009). Current literature is available to guide how clinical social workers can implement the concept in their work; it focuses primarily on guiding non-Indigenous helping professionals in using the cultural safety lens when supporting Indigenous people.

A significant part of applying cultural safety to practice includes reflexivity in practice. Reflexivity has long been recognized as a useful tool in social work contexts for improving practice and helping practitioners provide ethical support to clients (Probst, 2015). When using reflexivity within a cultural safety lens, there are two elements to consider. The first is that the clinical social worker must take the time to identify and acknowledge their assumptions, beliefs, and values (Syme & Browne, 2002). In the context of clinical work, the worker should focus on their own understanding of mental health, particularly the definitions and origins of their

understandings (Syme & Brown, 2006). The goal is to help the worker recognize that their understanding of mental health is based on their unique experience and is not an ultimate, objective truth (Syme & Browne, 2006). Second, the clinical social worker must come to understand how each individual client views mental health, what is important to them in their relationship with their mental health, and how the clinical social worker can support the client's needs (Syme & Browne, 2006). The goal is to use reflexivity to address cultural differences that may be present between the clinical social worker and the client (Ball, 2008; Syme & Browne, 2006).

Another significant aspect of applying cultural safety to practice includes addressing internalized racism and bias among clinical social workers (Gray & Hetherington, 2016; Ramsden, 2000). This process can be very labour-intensive and emotionally challenging (Gray & Hetherington, 2016). However, it is a critical therapeutic component that helps workers avoid unintentionally continuing oppression in their practice. Further, this process is particularly important for non-Indigenous clinical social workers who work with Indigenous populations. In this process, social workers take time to analyze themselves, their work, and their practice environment for oppressive or harmful practices that continue structural racism (Ramsden, 2000). Consciously and consistently addressing internalized racism and bias can begin to challenge and change oppressive practices and attitudes and dismantle harmful ideas that might otherwise be perpetuated (Ramsden, 2000).

A second valuable consideration in clinical social work with Indigenous people is Two-Eyed Seeing. Elder Dr. Albert Marshall introduced Two-Eyed Seeing approach in 2004 (Reid et al., 2020). Two-Eyed Seeing (*Etuaptmumk* in MiKmaq) "embraces learning to see from one eye with the strengths of Indigenous knowledge and ways of knowing, and from the other eye with

the strengths of mainstream knowledge and ways of knowing, and to use both these eyes together for the benefit of all" (Reid et al., 2020, p. 1). This approach offers valuable knowledge to clinical social workers, particularly when working in environments with multiple cultural backgrounds and experiences.

The Two-Eyed Seeing approach offers an alternative to traditional clinical social work practice. In Canada, many mainstream approaches to mental health in clinical social work practice and training are rooted in Western culture (Stewart et al., 2016). While Western approaches have value and can help support Indigenous peoples, it is recognized by the social work profession that using only Western approaches in clinical social work is very limiting. Indigenous peoples had employed their knowledge and understanding of how to maintain wellness for generations before contact with European settlers; that knowledge and historical practice can offer social work professionals much insight into Indigenous approaches to mental health (Baskin, 2016, McCormick, 2009). Indigenous approaches to mental health have also been incorporated into practice such as land-based healing programs and have generated many positive outcomes (Baskin, 2016). Utilizing the strengths and benefits of both Indigenous and Western approaches when working in mental health, as the Two-Eyed Seeing approach suggests, creates more effective supports and better outcomes when working with both Indigenous and non-Indigenous clients (Baskin, 2016; McCormick, 2009).

A third valuable consideration for clinical social work with Indigenous children and youth—in particular—is trauma-informed practice. As discussed, many Indigenous children and youth have experienced trauma in some form because of colonialism's values, practices, and impacts. Hence, it is essential to incorporate trauma-informed practice in therapeutic work with this population. Trauma-informed practice is a strength-based lens that is used to understand and

recognize how trauma impacts clients and to then create therapeutic environments that are safe and supportive for those who have experienced trauma (Poole et al., 2017). An essential aspect of trauma-informed practice is understanding that trauma impacts people in unique and complex ways, and can impose adverse impacts on individuals' functioning in daily life (Poole et al., 2017).

There are four guiding principles in trauma-informed practice. The first is that the practitioner must be aware of the nature of trauma (Poole et al., 2017). This principle implies that the practitioner knows what trauma is, the commonness of trauma experiences, how trauma can impact a person's brain and daily functioning ability, and the relationship between trauma and physical and mental health concerns. Further, the practitioner acknowledges that trauma creates survival instincts that were critical during those periods when trauma events occurred, and that that knowledge should be honored (Zingaro, 2012).

The second guiding principle in trauma-informed practice is the importance of creating an environment that cultivates safety and trust (Poole et al., 2017). By its very nature, trauma creates an environment in which a client was once deprived of safety, a condition that often trains the brain to be hypervigilant to threats in the environment to maximize protection and safety (Steele & Malchiodi, 2012). Hence, to support a client, practitioners must first start by creating physical, emotional, spiritual, and cultural safety in the environments where we serve clients who have experienced trauma. The practitioner should be aware of how they present themself and ensure they do their best to prevent causing distress accidentally (Crisis and Trauma Resource Institute, 2019). For example, ensuring there is always a clear path to an exit, asking the client clearly and directly about their preferences regarding seating or lighting, being

mindful of tone and volume when speaking, and being aware of facial expression (Crisis and Trauma Resource Institute, 2019).

Third, cultivating collaboration and connection while providing services is a guiding principle of trauma-informed practice (Poole et al., 2017). Trauma-informed practice is a strength-based framework. Hence, clients are always recognized as the experts in their respective healing journeys. Within trauma-informed practice services, the practitioner works collaboratively with children, youth, and their families. It is important that clients feel connected and secure within the therapeutic relationship to create a safe space for healing in which the client's choices are prioritized.

The fourth guiding principle of trauma-informed practice is competency in professional practice (Poole et al., 2017). This guideline is accomplished by ensuring the use of evidence-based interventions in practice. When working with clients who have experienced trauma, practitioners must take great care to ensure they do not cause additional harm to the client, such as retraumatizing. Hence, practitioners must ensure they have the knowledge and skills to serve clients effectively and safely when doing trauma work. In addition, practitioners must adhere to professional guidelines of practicing within their individual scope.

Allyship is a fourth valuable consideration for clinical social work when working with Indigenous peoples. Allyship refers to the relationship that is built when non-Indigenous people support Indigenous people in their efforts to claim their rights (Baskin, 2016). How to be an ally as a non-Indigenous clinical social worker—in particular, identifying the actions, thoughts, and values that define an ally, is complex. However, striving to be an ally as a person and as a professional is important in the pursuit of social justice and in efforts to improve society as a whole (Baskin, 2016).

In examining allyship, it is vital to acknowledge the roles that of privilege, power, and social location play. Non-Indigenous people must be willing to explore and acknowledge their position in relation to colonization and oppression—that is, specifically, how they have benefited from colonization within Canada (Baskin, 2016). This process is often emotionally distressing, but it is a vital step in the process of becoming an ally. This process needs to be ongoing. Critically, it is a process that must be conducted authentically (Baskin, 2016). It should not be undertaken with the aim to either avoid feelings of guilt or to gain praise from peers or clients (Baskin, 2016). Clinical social workers must reflect on and acknowledge the power and privileges they benefit from in their personal and professional lives.

Baskin (2016) suggests that non-Indigenous people should adopt several objectives as they strive to be allies to Indigenous people. First, they should adopt a learning stance: Allies must grow their knowledge of Indigenous cultures, history, and current issues. As they do so, it is important to recognize that this process is the sole responsibility of the learner, who must actively seek out knowledge; it is not the responsibility of Indigenous peoples to educate others. Second, allies should always be mindful that the aim is to be supportive. Allies recognize that Indigenous peoples are experts of their experiences, and the role of allies is to support Indigenous agendas in ways that Indigenous peoples see fit. Third, allies must recognize that action is required to sustain allyship. Being an ally is not a passive role, and allies must take concrete actions to support Indigenous people and their work in addressing colonization, racism, and oppression.

A final consideration for clinical practice is telehealth practice. At the time of writing this report, the Coronavirus (COVID-19) continues to cause a global pandemic (Government of Canada, 2020). In Canada, governments and health officials continue to guide the public in

navigating day-to-day life while living with the threat of COVID-19. Like many other care professions, the landscape of mental health services has been greatly impacted by COVID-19. Many mental health professionals are utilizing telehealth, which is defined as "any health-related service that is provided remotely via technology-assisted media such as the telephone, computer, or internet" (Campos, 2009, p. 27). While this method of providing services is not new and has been practiced for decades, it has only become broadly prevalent among Canada's mental health professionals due to the pandemic's imposition of limits on in-person services.

Similar to in-person services, telehealth mental health services provide assessments, referrals, intervention, treatment, and crisis management services (Grady et al., 2011). Although this means of service delivery is not necessarily equivalent to in-person services and can provide unique challenges, telehealth providers strive to deliver comparable high-quality services. There is also a growing body of literature that focuses on the benefits of telehealth services. Advantages include, for example, the ability to provide services to more clients across long distances, provision of services to clients in remote and rural areas, greater flexibility in delivery of services to clients-particularly with some populations, such as youth, may feel more comfortable using a telehealth service in contrast to in-person service (Biggerstaff & Short, 2017; Campos, 2009; Edwards et al., 2015; Grady et al., 2011; Myers et al., 2017).

Research has demonstrated that telehealth technology can be used successfully to support a wide variety of mental health and addiction issues (Mahmoud & Vogt, 2019: Myers, 2019; Swinton et al., 2009). Zhou et al. (2020) found that telehealth is also beneficial in efforts to combat ongoing distress and social isolation due to the ongoing COVID-19 pandemic. Further, this approach creates a framework in which clients can continue to receive mental health support in the safety of their homes during the pandemic.

Of course, it must be acknowledged that there are also pitfalls in telehealth, as there are with any health delivery service. By nature, telehealth alters the dynamic of mental health services, particularly the counseling process, because it is a dramatic change from conventional in-person services (Nickelson, 1998; Weinzimmer, 2021). For example, providing meaningful human connection through physical presence cannot be replicated in telehealth services. There are also concerns about maintaining patient privacy and confidentiality while using telehealth services (Doshi et al., 2020). If a client is using telehealth from their home, the clinical social worker cannot control the environment and guarantee confidentiality as they could do in an office setting. For example, another person in the home may overhear the session, or the client may not have a private room from which to access service in a home setting. Another deficit common to telehealth is access to technology and the ability to use technology effectively (Weinzimmer, 2021). For example, clients may not have the ability to access the electronic devices they need or may not have the knowhow to use electronic devices to engage with service via telehealth. A final difficulty that arises across most health and support services is that clients often prefer in-person services and frequently decline telehealth services when they are offered (Woo & Dowding, 2018). It is recognized that this finding would likely be influenced by the current COVID-19 crisis and may be diminished. However, it is still important to recognize that research indicates many clients often prefer in-person services when it is an option.

Given the commonality of telehealth services currently, ethical considerations associated with telehealth services in clinical social work will be reviewed briefly. The British Columbia College of Social Workers (2015) has outlined standards of practice for social workers who provide telehealth services. First, the college recommended that social workers are competent in the use of electronic devices and software used to provide services, and that they are compliant

with the ethical standards of using technology for services. Second, social workers must take additional measures to obtain informed consent such as assessing a client's capacity to provide consent, taking reasonable steps to verify the client's identity, and providing the client with additional policies pertinent to engaging in telehealth services. Third, social workers must take additional steps to ensure privacy and confidentiality are maintained in telehealth services, such as using safeguards when sharing information electronically, discussing the risks of using telehealth services, and informing clients of additional policies related to engaging in telehealth services. Lastly, as with all social work services, when using telehealth the social worker must maintain professional boundaries and avoid dual relationships and conflicts of interests. When using telehealth services, it is imperative to discuss expectations regarding the use of telehealth, and the social worker's availability to the client when using this service. For example, what type of communication can be transmitted via what type of technology and when the worker will respond to communications. While telehealth is not a new service, as noted earlier, it was not used widely in clinical social work practice prior to the pandemic. Hence, familiarity with current ethical standards for the use of technology for telehealth services is vital for clinical social workers.

# Chapter 4: Learning Experience from Practicum

During my practicum at Carrier Sekani Family Services, I had many opportunities to learn about clinical social work practice, and these have helped me achieve my learning goals. This chapter will summarize the learning that pertains to my goals. Specifically, learning about my professional identity, the practice environment, the people served by the agency, and clinical social work practice. A significant portion of my practicum focussed on learning clinical skills while working with Indigenous peoples and the child and youth population; this learning will be discussed as relevant to specific learning experiences.

## Professional Identity as a Clinical Social Worker

As part of my goal to develop my identity as a social worker, I wanted to maintain my professional self-care regime and maintain professional boundaries. I believe I was successful in this effort. I was able to take scheduled breaks, take screen breaks, maintain workplace boundaries, maintain ethical standards, and keep work at work. As someone who worked in the child and youth mental health field before my practicum, I felt I understood self-care and aimed to maintain the habits and practices I had used in my self-care regime. However, in receiving clinical supervision, I realized my understanding of professional self-care was limited.

As part of an individual supervision session, a discussion about balance and self-care within professional practice became a central topic. In my professional role, I had always thought about self-care in terms of how I could ensure I got enough rest and had time to recharge while not at work so that I could better face the challenges that come with clinical social work practice. I learned, however, that I have neglected being intentional during my workday and thus ensure I could effectively serve clients. We discussed balance it in terms of balance within the workday instead of the traditional way I had thought about it as work-life balance. I was asked various

questions about my practice experience: Do you know when you work best? Do you know when you write best? Are you planning tasks based on when you can do them best? Are you booking your lower-needs and higher-needs clients in strategic ways when possible? Are you intentional in thinking about using your time best while also maintaining your wellness during the workweek and workday?

I realized many of the answers to those questions was "No". It had not occurred to me to think about balancing self-care within work hours and not merely work-life balance. Of course, I do not discount the value of work-life balance and do not plan to abandon my exiting practices. However, what this learning has made apparent is the opportunity to enhance my self-care plan. For example, I know I have more energy during the middle of the workweek than on Mondays and Fridays; hence, it would likely be best to book higher-needs clients during the mid-week days whenever possible. I also know I tend to write best directly after appointments: working on documentation helps me process, organize what took place, and make a flexible plan for the next session. Ideally, I should always leave time between sessions to ensure I can complete this task instead of booking client appointments back to back to fit in as many appointments as possible. Going forward, I will be asking myself the questions raised in clinical supervision and use them to guide me in being intentional in creating balance in my workday.

***Allyship and Professional Identity***

During my practicum, I had the opportunity to attend webinars on cultural safety hosted by the Indigenous Cultural Safety Collaborative Learning Series. During one of the webinars, Dr. Karina Walters shared an analogy that an Elder had shared with her. The story, which I paraphrase here, is if you ever put crabs in a bucket you will notice they behave strangely: the crabs try to get out, but in the process they pull each other down in their attempt to escape,

making it impossible for any of them to get out successfully. One might ponder, why would the crabs not just work together to get out of the bucket? However, a more interesting question might be, why are the crabs in the bucket in the first place? Crabs on the coastline, on rocks, and in the sea do not pull each other down; they live well together (K. Walters, personal communication, June 4, 2021).

Dr. Walters talked about how this analogy is a metaphor for issues caused by colonization that arise among Indigenous peoples. She referred, specifically, to how colonization has caused so much harm in Indigenous communities such as high rates of violence, crime, and child apprehension. Dr. Walters posited that as helping professionals we can sometimes get so caught up in trying to help people "in the bucket" that we forget about the bucket itself. This analogy was powerful for me and made me think immediately about what allyship means for a helping professional in direct practice.

I have struggled with the term "ally" in a professional context. I have struggled particularly with learning how to engage in allyship in my role as a clinical social worker who works primarily in direct practice with children and youth. I have pondered what actions I can take within my role that would provide allyship. Being an ally is an active role, and I have often framed allyship as an advocate role in a political context. However, Dr. Walters' story and knowledge gave me a valuable insight: as a clinical social worker, as I see it, much of my role will always be about "being in the bucket" with clients so I can provide direct services. However, I can deliver direct service and still be constantly aware of the existence of the bucket we are standing in—that is, colonization and its effects. I support clients and families in their understanding of and experiences with colonization's effects in their lives: specifically, by being informed about how colonization is ever-present in the lives of Indigenous peoples, by being

sensitive to the approaches I use in my work with Indigenous clients, and reflecting consistently on my practice to ensure it is culturally safe. Further, I can assess the policies and procedures of the organizations I work with to ensure cultural safety is prioritized and use my voice to advocate for changes when needed. While striving for allyship may look different than the conventional version of allyship I had imagined, it is nonetheless allyship and an essential part of my role when working with Indigenous peoples. A critical part of my professional identity is striving to be anti-oppressive in my work. Hence, allyship must always be a part of my practice as a clinical social work.

***Personal and Professional Identity***

During my practicum, 215 bodies of Indigenous children were found buried at the site of the former Kamloops Indian Residential School in British Columbia. More Indigenous child remains were found at other residential school sites across Canada in the weeks that followed. The number of remains found at former residential school sites continues to increase as I have written this report. While it has been well known that large numbers of Indigenous children died at residential schools, confirmation of this knowledge is a tragic and heart-wrenching reminder of the harms done to Indigenous peoples by settlers in this country.

I am a descendant of European colonizers. News of the discoveries is a reminder of the shame and injustice that coincides with that fact, because settlers have traumatized Indigenous children and families for decades. My social location as a non-Indigenous clinical social worker who works with Indigenous peoples is complex. This is a component of identity that I carry into every aspect of my work and continually evaluate in daily practice. As the news unfolded, I found myself reflecting on my motivations to take part in social work. I believe my primary motivation for working with Indigenous peoples is that I feel compelled to contribute to this

work. Indigenous peoples have endured horrendous hardships and abuse because of the actions of my ancestors, regardless of whether there are direct familial connections. In my work, I see the impacts and continuation of these harms every day. I am hopeful that I can be a part of the generation of Northern European descendants that will genuinely recognize and take ownership of the wrongdoings that Indigenous peoples have endured. I am hopeful that I can serve and support Indigenous peoples fighting to move forward in reconciliation to make meaningful, positive change. As a social worker and a Canadian citizen, I am responsible for doing my part and taking action to actively be involved in the reconciliation process. This responsibility will always remain foundational in my identity as a clinical social worker.

**Practice Environment**

I completed my practicum at the Prince George Carrier Sekani Families Services office with the Child and Youth Mental Health Team as a part of the Mental Health Wellness counseling program. Although I was based in Prince George, the majority of the practicum was completed at home via telehealth technology. Although I had done some telehealth work before my practicum, this was the first time I had been completely immersed in a telehealth environment. Consequently, a lot of my practicum focused on learning how to manage working from home. Managing confidentially and maintaining workplace boundaries while working from home were two significant challenges and areas of learning.

In managing confidentiality, my biggest struggle was physical space. Due to COVID-19, my husband was also working from home in our tiny one-bedroom apartment. I set up a small office space in my bedroom so that I could shut a door between our workspaces. Unfortunately, due to the size of the apartment, it was impossible to block out noise completely. To solve this issue, we both got noise-canceling headphones to minimize background noise and prevent each

other from overhearing our respective work conversations. I also coordinated my appointments, whenever possible, with periods when my husband was likely to have few phone calls or meetings. When this was not possible, I had the option of booking space at the office or explaining my situation to whomever I was meeting, and I did my best to ensure they knew their confidentiality was protected. Because my "office" space was a shared living space, I was also very mindful of anything I wrote down. Put another way, I did not write down any personal information. Any scratch notes I did take to aid my memory were then converted to electronic records and the paper copy was destroyed immediately after a conversation or meeting. Hence, throughout the practicum, I was especially mindful that my workspace did not reveal confidential information.

Another struggle I managed while working from home was that of workplace boundaries. While working from home I had access to the technology I needed to do practicum tasks all the time; it was sometimes challenging to keep practicum work to scheduled times only, especially learning tasks that were interesting to me. On the other hand, because I was in my home, it was also easy to get distracted by things at home, such as chores I needed to complete or hearing my cat misbehaving in another room. To establish boundaries, I set alarms and timers to remind myself to maintain regular work hours and complete workplace tasks within those hours. I also planned my days, even on days when I did not have appointments or meetings, so that my time was organized. These steps helped ensure I always had practicum tasks and daily goals to focus on so that I did not become distracted by my environment. I also eliminated distractions by moving distracting household objects out of my immediate view and shutting the "office" door as a visual reminder that I was engaged in practicum time. These strategies helped me mirror an

in-person work environment so that I was mentally at my practicum during appropriate hours, and, during off-hours, I was at home.

**The People Served**

During my practicum at Carrier Sekani Family Services, it was crucial that I learn about the population the agency serves. Due to the COVID-19 pandemic, this learning was conducted through independent research and reading. Although I recognized that my personal research could not capture the richness or complexity of any group's history or culture, my research did provide me with a lot of valuable knowledge that contributed to my learning. My research consisted of reviewing the Member Nations serviced by the agency, their locations, and information about the communities. Carrier Sekani Family services provides services to 11 Member Nations (Mann & Adam, 2017). These nations include: Saik'uz First Nation, Nadleh Whut'en, Stellat'en First Nation, Burns Lake Band, Wet'suwet'en, Lake Babine Nation, Nee Tahi Buhn, Skin Tyee Band, Cheslatta Carrier Nation, Takla Lake First Nation, and Yekooche First Nation. In the following paragraphs I will briefly review each nation.

Saik'uz First Nation is located 9 kilometers southwest of Vanderhoof. Saik'uz is also known as Stoney Creek for the creek that runs through the community (Mann & Adam, 2017). The name Saik'uz means "sandy bottom," which also refers to the creek. Many people who live in the community are descendants of the communities of Chinlac, Clucluz Lake, and Tatluk Lake. Saik'uz First Nation has more than 1,000 members and, in 2015, it was estimated that approximately 450 members lived in the community (Saik'uz First Nation, 2019). Saik'uz First Nation members form two clans, the Nulkiwhot'en (Lasilyu or Frog) and the Ta'chek Whut'en clan (grouse), and follow the Bah'lats system of clans.

Nadleh Whut'en means “the place where the salmon return every year” (Mann & Adam, 2017, p. 13). This community is located at the eastern section of Fraser Lake in north-central BC. In 2015, there were approximately 540 band members (Aboriginal Affairs and Northern Development Canada, 2015b). The Nadleh Whut'en comprise five clans: Lhtseh yoo (Frog) clan, Dumdehm yoo (Bear), Luk sil yoo (Caribou), Ulstah mus yoo (Owl, Grouse), and Tsah yoo (Beaver), and follow the Bah'lats system of clans. It should also be noted that the Lejac residential school site, which operated from 1922 to 1978, is located on Nadleh Whut'en terrority on the south side of Fraser Lake.

Stellat'en First Nation means “people of Stella.” Stella is a point of land at Fraser Lake (Mann & Adam, 2017). The members of this nation live primarily in the community of Stellako (Stellat'en First Nation, 2021). This community is located 160 kilometres from Prince George between the Stellaquo and Endako rivers. In 2015, there were more than 500 band members (Aboriginal Affairs and Northern Development Canada, 2015c). The Stellat'en First nation clans include: Luksilyoo (Caribou/Little Man), Tsa yoo (Beaver), Lhtsumus (grouse), and Lhtsehyoo (frog/crane).

The Burns Lake Band is located in the community of Burns Lake (Mann & Adam, 2017). In 2011, there were approximately 130 members (Carrier Sekani Tribal Council, 2011). Burns Lake Band is also known as Ts il Kax Kah, which means “Creek that runs through the area” and is a Carrier-derived name.

Wet'suwet'en is located on the Bulkley River (Mann & Adam, 2017). The name Wet'suwet'en means “People of Wa Dzun Kwuh River (Bulkley River)” (Mann & Adam, 2017, p. 16). In 2015, there was 234 members of the Wet'suwet'en (Aboriginal Affairs and Northern Development Canada, 2015h).

The Lake Babine Nation is one of the largest bands in northern British Colombia, with 2400 members recorded in 2015 (Aboriginal Affairs and Northern Development Canada, 2015a; Mann & Adam, 2017). The name Babine refers to “big or drooping lip,” as French fur traders noticed that high-ranking Babine women wore labrets in their lips at the time of early contact. Five communities represented by Lake Babine Nation, including Fort Babine, Old Fort, Tachet, Donald’s Landing, and Woyenne. Old Fort is a seasonal community where families go to gather berries, and fish and hunt. Donald’s Landing is also a seasonal community that is occupied only during the summer. The other communities are occupied year-round and have municipal services, the largest of which is Woyenne. The Babine terrority is known for an abundance of rich food resources, particularly salmon. The Lake Babine Nation clans include Caribou, Bear, Frog, and Beaver, and they follow the Bah'lats system of clans.

The Nee Tahi Buhn Indian Band has five reserves that are located on Francois Lake and Urcha Lake. In 2015, 140 members constituted the band (Aboriginal Affairs and Northern Development Canada, 2015f; Mann & Adam, 2017). The name Nee Tahi Buhn means “It fills at one end and empties at the other,” and is the Indigenous name of Francois Lake. The Nee Tahi Buhn Indian Band clans include Gilseyhu (Big Frog), Laksilyu (Small Frog), Gitdumden (Wolf, Bear), Laksamashu (Fireweed), and Tsayu (Beaver). The Nee Tahi Buhn Indian band follows the Bah’lats system of clans.

The Skin Tyee Band is located near Francois Lake, which is the second longest natural lake in British Columbia (Mann & Adam, 2017). The band has six reserves that are located on the Skins Lake and the Uncha Lake area. In 2015, there were approximately 187 members of the band (Aboriginal Affairs and Northern Development Canada, 2015g). The name Skin originated with a member of the band who traded with the Hudson Bay store in Old Fort during initial

contact; settlers referred to him as “Skin” because he was an excellent trapper who brought in the most furs for trade.

The Cheslatta Carrier Nation is located near the Nechako River (Mann & Adam, 2017). The nation name Cheslatta means “people who go upon the water” (Mann & Adam, 2017, p. 20). In 2015, there were approximately 330 band members. Preserving traditional language has been very important to this nation. As Mann & Adam (2016) explain “The Cheslatta language is a dialect of Nedgut'en of Dene, which is part of the Athabasca language family” (p. 20). In 2015, there were 8 fluent speakers and over 100 people learning to speak the language.

Takla Lake First Nations identifies as Sekani and Carrier, because this nation is considered to have Dene, Carrier, Bear Lake, Gitzsan, and Yse Kay Nay heritage (Mann & Adam, 2017). This Nation was taught the Bah'lats systems because of marriages between their people and the Gitxsan people. There are four clans in Takla Lake: Lux Gibuu (Wolf/Bear clan) , Jilh Ts'e Yu (Frog clan), Likh Ts'a Mis Yu (Beaver clan), and Gil Lan T’en (Caribou clan). In 2015, there was 700–800 band members and the majority were living on the reserve with others in various communities (Aboriginal Affairs and Northern Development Canada, 2015d).

Yekooche First Nation has approximately 230 members (Aboriginal Affairs and Northern Development Canada, 2015e; Mann & Adam, 2017). The name of the community in Carrier translates the location of the community, as “Ye Koo”, which is Cunningham Lake. The “-che” component of the nation name refers to the end of Nankut Creek.

When discussing the Indigenous peoples of this land, it is always important to acknowledge that colonization had significant and horrific impacts on their lives. Great numbers of Carrier and Sekani Nations people died due to exposure to foreign diseases carried by European settlers. The devastation during colonization included the loss of entire villages within

Carrier territory (Mann & Adam, 2017). The Lejac Residential school was attended primarily by children on Carrier territory due to its central location, near Fraser Lake. However, some Sekani and Gitxsan children also attended. The school operated from 1922 to 1976. The school's land was transferred to the Nadleh Indian Band, who destroyed the school building and created a memorial site on the property. Carrier peoples also experienced the Sixties Scoop, racist segregation in hospitals, government discrimination, and oppression, and inevitably, the horrific, long-term impacts of these wrongful actions and practices.

As stated in my goals, during this practicum I hoped to learn more about the culture of the people served by Carrier Sekani Family Services. Culture can be defined in many ways, but I most like the definition that "culture is an umbrella term which encompasses the social behavior and norms found in human societies, as well as the knowledge, beliefs, arts, laws, customs, capabilities, and habits of the individuals in these groups" (Tylor, 1871, p. 124). Culture is a moving, living, and ever-changing force among humans; consequently, recognizing culture as an umbrella term that encompasses many aspects of people's lives seems most fitting. Culture is a social concept that teaches us how the world should be understood and how we ought to operate within it (Mann & Adam, 2017). In learning about Carrier culture, it was clear to me that I would never come to fully understand Carrier culture in my short time at practicum. Indeed, I do not think I could fully understand the complexities of Carrier culture if I were to spend a lifetime at Carrier Sekani Family Services. I chose to narrow my focus and learn what I could about Carrier worldviews and values, the Bah'lats system, and the Carrier Life Cycle Model.

There are many traditional Carrier views of the world, some of which are described below (Mann & Adam, 2017). The northern interior of British Columbia is a homeland in which every physical feature—lakes and mountains, for example— is valued and named. The physical

environment is also home to many plants and animals that are respected. The land has sustained Carrier peoples for thousands of years and requires protection. In Carrier society, everyone within a given clan is related. The sharing of wealth is considered very important because what one gives will eventually come back in some form. The Bah'lats system plays a key role in determining the sharing of wealth among clans.

The potlatch system is called Bah'lats in Carrier tradition (Mann & Adam, 2017). It began as a means to manage conflict by bringing people together, according to Stellat'en oral history (Mann & Adam, 2017). These meetings evolved into a formal governing system that is now the core of political, economic, social, spiritual, and legal institutions for Carrier people. Moreover, "it represents a holistic, evolving approach to relationships within the Nation and with other Nations and always required decision-making protocols for conduct, as well as countless other aspects" (Mann & Adam, 2017, p. 87). All Bah'lats are conducted in an open environment in which clan members witness what occurs during the meeting. There are many different reasons for a Bah'lats, and many different events are conducted at these meetings such as witnessing the assigning of Chief names or conducting ceremonies. Most Member Nations still hold Bah'lats regularly, though others do not. As Mann & Adam (2016) note, "for most people, there is an understanding that the Bah'lats is the 'proper' way to deal with life events and inter-clan relationships" (p. 88).

Bah'lats are large meetings, and, as such, require a significant amount of coordination (Mann & Adam, 2017). These meetings are often planned a year in advance by the hosting clan and take a considerable amount of preparation and represent considerable expense. Some Bah'lats are attended only by invited community members, while other meetings are open to any community member to attend. The hosting clan also ensures that protocols for the meeting are

followed, which vary for each Member Nation. When attending a Bah'lat, respect, responsibility, obligation, compassion, balance, wisdom, caring, sharing, and love govern individual conduct at the meeting. All individuals are witnesses to what occurs at the Bah'lats and are expected to take great care to remember the details of what takes place. Hereditary Chiefs are responsible for recounting oral histories at Bah'lats when relevant. These events often involve feasts, prayer, performances, songs, dance, stories, gifts, and formal business.

The Life Cycle Model, which also forms the core of Carrier Sekani Services programming, is an approach that acknowledges that a lifetime has multiple stages and that each stage has its own needs for wellbeing and distinct determinants of holistic health (Mann & Adam, 2017). Within the interconnected worldview, it is understood that each individual's health and wellness impacts the health and wellness of everyone in the community. During each life stage, four principles are acknowledged: "We are all bound together by blood, land, and spirit[;] life is a continuum beginning and ending with the Creator[;] healing occurs for the whole person and impacts all people in that person's life[;] and lastly, historical impacts affect who we are today as Indigenous people" (Mann & Adam, 2017, p. 69).

In the Life Cycle Model, numerous states of life are recognized and, throughout each, the balance of mental, emotional, spiritual, and physical health is sought to maintain wellness (Mann & Adam, 2017). Each life stage is valued because everyone acknowledges that each life stage has wisdom to share. Some life stages include pregnancy, the birth of a baby, Ny nee Nyhudel Tsut (getting your mind back), menstruation, marriage, nearing death, and after death. There are various cultural practices among each Member Nation that are associated with life-cycle events. The Life Cycle Model "utilizes a restorative approach to healing which ensures that everyone has

a place and role in society and those gifts of the Creator are used and shared with the community" (Mann & Adam, 2017, p. 69).

**Clinical Social Work Learning**

During my practicum, I had the opportunity to attend a Case-Based Learning group that Compass Mental Health led in partnership with Carrier Sekani Family Services. The purpose of these meetings was to have multiple disciplines from across Carrier Sekani Family Services come together to perform case consultations and support clients with complex mental health needs. While participating in the group, a theme began to emerge: holistic care. Specifically, the focus was on effectively working collaboratively within a circle of care to provide holistic service for clients. While this way of practicing may seem to be an obvious approach to social work, in my experience, across multiple workplaces and in several provinces, it has not been the norm. This sparked my interest in understanding holistic care and it became a central theme of learning in my practicum experience.

In the Western worldview, aspects of the world are often dealt with as parts, in contrast to considering them as part of a whole. Generally, aspects of life, knowledge, understanding, and perception are broken down to enhance understanding. This approach to understanding the world in health and support services is often evident. For example, physical and mental health are organized into separate disciplines, which are then subdivided further into specializations of practice. Throughout my work with Indigenous peoples, I have learned about a contrasting way of understanding the world from a holistic worldview. Unlike the Western worldview, holistic worldviews recognize aspects of the world in the context of relationships (Baskins, 2015). For example, a person's wellness is considered in light of the spiritual, emotional, physical, and psychological aspects of their life, and these aspects are seen in the context of relationships with

family, community, nature, and creator (Baskin, 2015). There is much wisdom in a holistic health approach, especially when one considers how mental health and wellness can be promoted, understood, and supported in our society.

In previous work contexts, I attempted to incorporate a holistic approach to providing services. For example, I sought to consider the varied aspects of a client's life, to assess how those aspects intersected with mental health, and to help clients get support in other life areas to support wellness. Most often, I supported clients in this way through referral services. However, I wanted to ensure I stayed in my lane, so to speak: I was the mental health clinician, and that was the area of my expertise. Others would have knowledge better suited to assist clients in other areas. For example, if a client had physical health issues, I referred them to a doctor knowledgeable in that field and left care to that doctor to support the client's particular issue. mental health, I did not actively support those different aspects. I did not see that as my responsibility.

As I read *Braiding Sweetgrass* by Robin Wall Kimmerer (2013), during practicum, it occurred to me with particular clarity that I had not let the wisdom of holistic worldviews, particularly in practice, become a part of my approach and work process. This book recounts the author's honouring of Indigenous knowledge while becoming a trained botanist using the Western approach to science. Kimmerer writes about how worldview, values, and cultural understandings shape how we understand the world. I recognized and welcomed her approach. What interested me especially was Kimmerer's account of trying to simultaneously navigate Western and Indigenous understandings of the world. For example, she discusses how plants are conceptualized in the Western thought as parts to be explained and understood for their functional purposes only, while from an Indigenous worldview, she had come to understand

plants as whole beings that offer gifts and lessons. Kimmerer observed that the university valued Western understandings but did not value Indigenous understandings. For example, Kimmerer notes how university academics asserted that her non-scientific questions—which were underpinned by Indigenous knowledge—did not belong in academia or professional work.

While reading *Braiding Sweetgrass*, I realized that I had unintentionally neglected to make space for the practical application of Indigenous knowledge in my practice. While I understood the value of holistic service and valued the idea, I was not fully embracing the practical application of these ideas in my work. I have been primarily trained in Western ideologies of mental health and clinical social work. I had held to the idea that focussing only on mental health was my role, and I should not provide help or suggestions that were not in keeping with the traditional conception of clinical social work. For example, by referring a client for other services without working and collaborating, myself, with those services to best serve the client, I was not incorporating my knowledge of holistic care. While referring services will continue to be a vital part of my role, I observed a better way to provide service while attending the learning group. I therefore took steps to learn how to apply holistic views of health and apply them practically with clients. Which ultimately served the overarching purpose I pursued a practicum with an Indigenous organization—to learn a better way to serve Indigenous peoples by blending Indigenous and Western knowledge in a respectful and meaningful way.

The evaluation of my practice continued while visiting the community of Saik'uz with a colleague. Throughout the trip, we discussed her work in the community. Most interesting to me was her commentary about how clinical work happened in the community without designated office space. She noted that she often met clients at their schools or home, or she took clients into

nature on walks, playing in the park, or in picnic areas. I was most curious about work in public settings, often referred to as "walk and talk" counseling.

I was immediately filled with questions. How does confidentially apply in public settings? Specifically, what about working with children who need parental consent? How can we ensure children understand the risk to privacy and confidentially in public? How would a clinician manage a crisis in a public outdoor setting? How do you manage general safety in a public outdoor setting? While many of these questions arose from curiosity, I am sure many questions were also fueled by my ideas about how clinical work "should look" and my anxiety about changing traditional practice settings. My previous counseling work had taken place in an office with safeguards and controllable clinical settings, especially work with children when I was responsible for their safety during our sessions. The added layer of complexity of needing to build and keep trust with Indigenous parents as a white clinical social worker engaging with their children was a genuine concern. Keeping children safe and providing high-quality services—particularly in light of the long history of white social workers causing harm to Indigenous families and their children—is a responsibility I take very seriously.

While I thought about these questions, my colleague mused about how clinical social work "is only as limited as we make it" (K. Gable, personal communication, May 17, 2021). This is true because there is no single, uniform way to do clinical social work. Being in nature can be very therapeutic for clients. Both Indigenous knowledge and Western research have communicated the benefits of connection with nature for wellness and mental health (Baskin, 2016). This experience was another moment when I realized I was allowing my preconceptions about clinical work and fear of challenging how I was educated limit how I conduct clinical work.

The experiences I have discussed thus far reveal that during the practicum I had many occasions when I was challenged to evaluate why I conducted work in the way I did, and to examine and question the ways in which I constrain my work practices. These events led me to explore how I could enhance my practice in ways that added richness to my work with clients. In work with Indigenous children and youth, I thought about how I could improve how I engage with the client, their caregivers, and other members of the care team to support clients with a more holistic approach. I will discuss this in the following pages.

The change in how I thought about client care and social work began with the example of walk-and-talk services. I realized it was more helpful to discuss how my colleague manages potential issues associated with clinical work in an outdoor public setting instead of just focusing on potential issues with different approaches and methods. For example, we discussed having a conversation with a child about confidentially in terms they would understand. We focused on what it would be like to meet outside and whether they would be comfortable being seen in public with a counselor. We talked about the potential privacy risks and how protecting confidentially during services outside would occur so that the client could make an informed decision. Before conducting counseling in a public setting, the counsellor would need to ensure there is sufficient time during sessions to make plans with the child to establish expectations, boundaries, and safety. Last, it would be wise to ensure a colleague or manager was available who could assist if a crisis were to occur. Our conversation focused on how doing clinical work in non-conventional settings could be done in ways that adhered to ethical guidelines and maintained standards of practice.

In counseling with children and youth, it is understood that parents and caregivers play a vital role in children's lives. In clinical social work, the importance of involving caregivers in

mental health services is discussed at length in the literature (Brady, 2015; Landreth, 2012; Siegel & Bryson, 2012; Vanfleet et al., 2010). However, in my previous work experience, involving caregivers in meaningful therapeutic ways had been difficult to achieve and I realized this had been a deficit in my practice. I began to search for resources and therapy models that offered guidelines and practice interventions that involved caregivers in meaningful ways.

I considered why involving caregivers in the counselling process had been difficult in previous practice. The detail that stood out the most for me when I struggled to involve caregivers was time. First, my lack of time. The child and youth mental health field makes many demands, and often there are not enough resources to meet the demand for services. Hence, I often found myself working at a pace that did not leave me with enough time to actively involve caregivers beyond the necessary check-ins and progress meetings. The second issue was caregivers' lack of time to participate in service. In my practice, I often worked with families who were struggling in a multitude of ways; caregivers were focused on meeting survival needs such as shelter, food, heat, income, and, or, trying to manage in a high-stress environment. In short, they had more pressing needs and concerns than returning my calls.

Upon reflection in clinical supervision, I believe that struggling to provide support to caregivers is another example of struggling to find balance in my practice. Of course, I cannot control a family's ability to engage; however, I can control making time in my practice to attempt to engage with caregivers. One means to do so is to adjust my expectations. I realized I had been focused on the quantity of services I provided instead of quality of service. For example, I saw as many clients as possible rather than maintaining a manageable caseload. I have come to realize that my practice, in future, will require me to create more boundaries so that I can provide higher quality services. I can do this, for example, by maintaining a manageable

workload by saying no to extra work tasks or client files. It will be important that I book time throughout the week to connect with caregivers by providing caregiver support sessions as I have done during practicum. While doing this would be difficult, since it might feel like I was serving fewer clients (while waitlists continue to grow) to have time to provide direct caregiver support. It is a necessary change.

During practicum, I had the opportunity to complete trauma-focused cognitive behavioural therapy training, which promotes involvement of caregivers in my practice. The trauma-focused cognitive behavioural therapy model is an evidence-based treatment model designed to support the child or youth who has experienced a traumatic event and supports the caregiver to help with their child's healing (Cohen et al., 2016). The model's components include psychoeducation, parenting skills, relaxation techniques, affect identification and regulation, cognitive coping, trauma narration and processing, in-vivo mastery, conjoint child-parent sessions, and last, enhancing safety and future development. The training provided concrete and practical guidelines to support caregivers when using the model and for involving caregivers in the therapeutic process. Specifically, mention was made of how to prepare parents for joint sessions so that sessions can be as therapeutically productive as possible. While we cannot perfectly predict or fully prepare for a given session, practical guidelines that help prepare caregivers for joint sessions is very valuable. For example, arranging preparation sessions that outline what to expect, providing information to help caregivers manage their emotions before the joint session, how they can prepare for the joint session, how to manage if the session is distressing for them, and what the goals of the sessions are—this preparation would help tremendously to ensure the joint session is maximally therapeutic.

Another important aspect of involving caregivers in child and youth mental health is helping them support their child. During the practicum, I completed a learning webinar series called "*Rolling with ADHD,"* produced by Compass Mental Health, about supporting children with attention deficit hyperactivity disorder (ADHD). The webinars explored how ADHD impacts children, the importance of diagnosis and treatments, medications, and non-pharmacological interventions. When discussing non-pharmacological intervention, the speaker stated that the first thing they offer to caregivers is an education group about ADHD. The presenter recommended that clinicians look for caregiver education that educates on what ADHD is, how it will impact their child, how to support their child, advocating for their child, and managing ADHD in the family. The speaker stated that studies have shown that interventions that provide caregiver education are just as effective as medication for children with ADHD. For me, this finding highlighted that there are practical interventions I can provide to support parents to support their child, and that these will generate significant impacts for the child and the family overall.

Often, caregivers come to me because they feel they do not know what to do. They are struggling and hoping I can support their child who is struggling with a mental health concern to improve the situation. Of course, I support children directly, and this is an integral part of my role. However, it is also vital to support the caregiver in becoming well equipped with knowledge and skills to help them feel confident in their abilities to support their child. This can be accomplished by providing accessible, practical, and realistic interventions. Caregiver interventions can empower the caregiver to better support their child and help improve overall family wellness.

Direct parenting skills support is a caregiver intervention that can be helpful. During practicum, I read *The Whole-Brain Child* by Daniel Siegel and Tina Bryson (2011), and I was involved with a Circle of Security parenting group. Both of these models, based on attachment-theory research, were designed to develop parenting skills and offer support. These practicum activities provided me with valuable learning about parenting skills that are useful and evidence based. For example, *The Whole-Brain Child*, identifies 12 parenting skills designed to help caregivers and families thrive (Siegel & Bryson, 2011). The book and the group discussed the positive impacts that strong caregiving skills can have on the child, the child-parent relationship, and the family as a whole. The group also helped me understand how to provide direct parenting skills support to caregivers. Specifically, the importance of creating safe relationships with caregivers by taking a gentle and nonjudgement approach underpinned by empathy and connection. Caregiving is a very personal experience and can often be linked to guilt and shame. Struggles with guilt and shame regarding parenting can be even more difficult for vulnerable families and families that have been involved with institutions, such as child protection. In this context, creating strong therapeutic alliances is critical to providing direct parenting skills that successfully support caregivers.

It is important to be cognizant of the cultural context in which caregiving is provided. Caregiving is value-based work. Upbringing, culture, personal values, family values, and family structure all impact how a person provides childcare. In my work with Indigenous families, my social location is important to acknowledge. Firstly, I am a non-Indigenous person. My Western values, culture, and training shape my ideas about parenting. Secondly, I am not a parent; therefore, I do not have lived experience of parenting that I can share when working with caregivers. In reflecting on my social location, one of my key learnings has been to ensure I am

open to having candid conversations regarding my social location while supporting caregivers. This ensures I am creating therapeutic alliances that are trusting and supportive.

A second area of importance to discuss when providing holistic practice in child and youth mental health is the professional circle of care. For this discussion, the professional circle of care is defined as any other professional, service, or support involved in a child or youth's life such as cultural supports, health professionals, and care providers. As mentioned above, I had the opportunity during my practicum to be part of the case-based learning group. At one meeting, there was discussion about supporting a client in a remote community. A staff member from the community was able to provide a significant amount of information on what needed to be considered when providing support in this area. This experience highlighted the importance of including community voices in the design of practical, achievable treatment plans. In the example discussed above, the community staff member's contributions provided valuable knowledge to ensure a support plan could successfully be developed. The group could explore how to ensure the plan was culturally safe, achievable and practical in a remote practice context, and how the team could work together to ensure the plan was followed by all professionals involved.

The second learning I experienced was how this example demonstrated the importance of collaboration across professionals in the field. We talk about collaboration often and its importance. However, the mental health field is demanding. There are often many needs and much work to be done. Hence, the basics of collaboration, which are listening and understanding, can be missed in the busyness of the work. While in the field, taking time to slow down to fully understand the context and knowledge of everyone involved will be far more productive than

attempting to move to the problem-solving phase as quickly as possible during collaboration, as demonstrated by the practice example.

Interdisciplinary collaboration can create a wealth of knowledge within a professional circle of care. This was demonstrated very clearly when I attended the Compass Case Learning meetings. For example, when we discussed support for a client with complex needs served by the mental health team, I expected the conversation to focus on mental health concerns. Instead, the topic focused on a physical health issue: specifically, primary care professionals providing information about impacts on daily function, what extra supports are needed, and how the physical health concern may play a role in a client's mental health struggles. This was a moment when medical staff communicated valuable and helpful knowledge to mental health staff. In turn, the mental health team provided information about the client's day-to-day functioning, and this helped inform the medical team's treatment plan for the client from their service program. This example demonstrated how collaboration can benefit all involved in the circle of care and improve services for clients.

At the end of the discussion, I asked myself how I would shape my practice to foster interdisciplinary consultation and collaboration. Through clinical supervision and reflection, I have learned about various practical strategies such as writing a letter of introduction to a client's care team members, outlining my involvement with the client, and providing contact information. A second approach is to call other care team members periodically to consult on client care. This would help to develop rapport with care providers and share information, when appropriate, to better support the client. Last, I might take responsibility for arranging care team meetings periodically or ensure I attend scheduled community meetings to support the client. In

practice, these strategies support the same goal: to build working relationships with others within the client's circle of care to provide holistic service.

A final element relevant to providing holistic practice in child and youth mental health is that of engaging Elders and Cultural Knowledge Holders. The importance of these leaders in the community is immense. Their time, knowledge, and teachings provide incredible healing for children, youth, and families. In thinking about engaging with Elders and Cultural Knowledge Holders, I was uncertain what my role would be during this type of work. During group clinical supervision, we discussed how to promote Elder engagement with clients and agreed that Elders and Cultural Knowledge Holders are the experts on how they can support Indigenous children, youth, and families. It was agreed that being mindful and recognizing their role as leaders and the work they do to support the community is vital. My role is to contribute to a collaborative environment in which I follow the guidance of Elders and Cultural Knowledge Holders as they support members of the community.

# Chapter 5: Implications for Personal Practice

My time at Carrier Sekani Family Services gave me many opportunities to identify implications for my future practice. I came to the agency with experience as a child and youth clinician and hoped to improve my clinical knowledge and skills. The experience I gained, along with reflection on my approach to practice, will improve my future practice. Values that I will cultivate and incorporate in future include interdisciplinary practice, holistic care, and self-care.

## Interdisciplinary Practice

Interdisciplinary practice can be defined as a "complex process in which a variety of different experts collaborate together" (Nancarrow et al., 2013, p. 1). During my time at Carrier Sekani Family Services, I attended several meetings in which doctors, nurses, community support workers, clinicians, and management participated in interdisciplinary practice. By sitting (virtually) with many interdisciplinary professionals, the deep value of collaborating across disciplines became clear, as I discussed earlier in this report.

While most professionals understand the value of interdisciplinary practice in their daily work, it can nevertheless be difficult to coordinate this practice due to work demands. In the past, I accepted that this difficulty was a part of the practice landscape and made do with limited interdisciplinary collaboration. However, my experience at Carrier Sekani Family Services taught me that the value of interdisciplinary practice far outweighs the difficulties associated with cultivating and coordinating opportunities for collaboration across disciplines. In future, I am committed to cultivating environments and relationships that promote interdisciplinary practice in my work and treatment strategies. I am confident that incorporating interdisciplinary practice in my work will enhance the quality of services I provide.

**Holistic Care**

Holistic care has been a learning theme throughout my practicum. One of my most valuable insights when learning about holistic care is the importance to strive for excellence in professional practice. As discussed earlier, I had foundational knowledge about holistic care before beginning my practicum; however, I have learned that I had not fully embraced holistic care within my practice. This realization underscores the need to constantly evaluate and be reflective in practice to ensure you are reaching your expectations for your own standards of practice. In this case, I know I need to deepen my knowledge and skills in this practice area. Holistic care is an element I value and believe is important to incorporate in mental health service. However, I recognize that I still have a lot to learn in regards to applying holistic care in my work. In future, I will continue to evaluate my practice through the lens of holistic care to continue to improve my practice.

**Self-Care**

The social work profession has long understood the benefits of self-care. In their study, Green and Thomas (2007) found that most social workers value maintaining a self-care plan. The subject is also a regular part of university courses when training to become a social worker, which was also true in my education.

Personally, before practicum, I believed I had successfully incorporated self-care into my practice. However, during practicum, my ideas and practices were challenged. I learned I could significantly improve my self-care practices by incorporating them within my workday habits. These learnings will benefit me, my practice, and the clients I serve. My most significant epiphany is that self-care is a journey, not a destination, as I had thought it to be. As I continue in my journey as a clinical social worker, my self-care plan will need to change and evolve with me. I am a firm believer in the idea that we never stop learning and growing in social work

practice; it is one of the reasons I love this profession. While my time is often spent focusing on growth in skills and knowledge of clinical practice, I plan to actively work on refining my self-care journey as part of my learning as a clinical social worker.

## Chapter 6: Conclusion

In conclusion, this report has outlined my learning during my practicum experience with Carrier Sekani Family Services that focused clinical social work with Indigenous children and youth. This organization was created to serve the Carrier and Sekani peoples in north-central British Columbia. The organization provides services rooted in Carrier and Sekani knowledge, values, and culture to heal and empower Carrier and Sekani peoples. I was grateful to be able to complete my practicum with the Child and Youth Mental Health Team. During my time at Carrier Sekani services, my goals were to develop my professional identity, gain familiarity with the practice environment, continue to develop clinical social work skills, increase my knowledge of clinical practice with Indigenous peoples, and increase my knowledge of counseling approaches when working with Indigenous children and youth.

In preparing to achieve these goals I began by engaging in critical self-reflection to explore my personal positioning. I explored my social locations, identity, and interest in the mental health field. Special attention was given to acknowledging that my personal positions play a role in my clinical work. Further, I explored my theoretical orientations, which anchor my practice in clinical social work. Social constructivism is the overarching framework that guides my practice, and strength-based practice guides my direct clinical practice.

In preparing for practicum, relevant literature was reviewed relevant to clinical social work. The literature review firstly explored child and youth mental health in Canada, with particular attention to definitions of mental health and context of mental health issues among children in Canada. Secondly, Indigenous child and youth mental health was explored. The literature highlighted the higher prevalence of mental health issues among Indigenous children and youth, and the impacts of colonial trauma within the context of Indigenous mental health.

Thirdly, the literature review explored the importance of providing services to children and youth, emphasizing that mental health difficulties are often present during childhood and adolescence, the importance of early intervention, and the importance of non-Indigenous professionals looking to Indigenous leaders for guidance while supporting Indigenous child and youth. Lastly, the literature review explored practice considerations for clinical social work with Indigenous peoples, with particular attention to the role of clinical social work with Indigenous populations, cultural safety, the Two-Eyed Seeing approach, trauma-informed practice, allyship, and telehealth practice. These practice considerations guided my practice throughout my practicum.

My time at Carrier Sekani Family services provided many incredible learning experiences. I had the opportunity to learn about my professional identity, which focused on self-care, allyship, and how my personal and professional identities intersect. I learned more about my practice environment which focused on providing telehealth services and working from home. I also learned about the people served by the agency, which included 11 member nations. Each member nation was explored, including aspects of culture such as worldview and values, the Bah'lats system, and the Carrier Life Cycle Model.

My clinical social work knowledge was also expanded through my learning experiences at Carrier Sekani Family Services. Holistic care was the central theme of this learning. Learnings that were discussed included Indigenous and Western knowledge in a professional context. Further, I learned about how to engage with caregivers, the professional circle of care, and Elders and Cultural Knowledge Holders as part of integrating holistic care approaches into personal practice.

Lastly, the implications of my learning for personal practice were explored. Implications focused on what I wanted to bring forward when I returned to practice. These included a commitment to integrating interdisciplinary practice and holistic care into my practice. Finally, to recommit to an ever-evolving self-care journey in my professional practice.

I look forward to returning to my practice with Indigenous children, youth, and their families with my new knowledge and growth. In 1995, Nelson Mandela observed, “Our children are the rock on which our future is built” (Nelson Mandela Children’s Fund, 2015). Children and youth are a community’s most valued gift and we must support them to grow and thrive. My goal is to spend my career supporting children, youth, and their families; I am grateful that the practicum experience has better prepared me to fulfill this goal.

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# Appendix

## Appendix A: Summary of Learning Goals Grid

| Learning Goals | Intentions to Help Achieve Goals |
|---|---|
| Continue to develop my professional identity as a clinical social worker | - Adhere to ethical guidelines of practice<br>- Keep a reflective journal<br>- Engage in peer consultation<br>- Maintain professional self-care<br>- Maintain professional boundaries |
| Gain familiarity with the practice environment | - Review the agency's mandates, policies, and practice manuals<br>- Collaborate with colleagues to achieve workplace goals and provide services<br>- Visit various agency sites<br>- Visit various communities that the agency serves<br>- Become familiar with the services provided by the agency and learn how these services are combined to meet client needs |
| Develop my clinical social work skills | - Review theories, frameworks, and knowledge used by the agency<br>- Engage in workplace tasks if possible. For example, intake, assessment, treatment planning, and clinical intervention.<br>- Work directly with clients, if possible.<br>- Engage in individual and group clinical supervision. |
| Improve my clinical skills and knowledge of clinical social work with Indigenous populations to provide the best services | - Gain knowledge and understanding of the Carrier and Sekani peoples by reading available resources<br>- Participate in cultural competency training offered by the agency, if possible<br>- Engaging with leaders and cultural knowledge holders, if possible<br>- Engaging in conversations with collages regarding providing cultural relevant and safe services |

| | |
|---|---|
| Increase my knowledge of various counseling techniques used specifically with the Indigenous child and youth population | - Learn and assess new counselling techniques while using both Western and Indigenous lenses<br><br>- Engage with colleagues on the Child and Youth Mental Health team to learn about the techniques used in their practice<br><br>- Engage in training on counselling techniques employed with children, if possible |