DEVELOPING CLINICAL SKILLS WITHIN CHILD AND YOUTH MENTAL HEALTH

by

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Abstract

Many children and adolescents in British Columbia experience mental health problems that greatly impact their wellbeing and ability to thrive. This report will focus on the learning and experience gained about the Child and Youth Mental Health System and the services provided through Child and Youth Mental Health to help alleviate the effects and impacts of mental illness in children and youth. While the learning through the practicum experience was very broad, limitations were utilized to focus on the assessment and treatment of children/youth with anxiety and depression. A review of the literature provided a context for developing clinical competencies in delivering child and youth mental health care, while shadowing, clinical work, and ongoing supervision provided the practical landscape for skill development.
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Dedication

This paper is dedicated to all my amazing children (from oldest to youngest: Caleb, Seth, Aidan, Sarah, Aiyana, Noah, and Haileigh) and my incredible partner, Corey, who have supported me along the way. I am also grateful to the unflagging encouragement and support from my mother, father, and aunt throughout my years of education, and to my mother in law for taking care of my youngest daughter while I completed my degree. It may be for family that we are driven to strive for more personally but it is also from family to which we grow to meet our potential. I am forever grateful for my amazing family and it is my love for them that pushes me forward each day.
Chapter One: Introduction

This report is a formulation of my practicum experience with Child and Youth Mental Health in the assessment and treatment of child/youth mental health disorders. While the practicum experience was very broad the main goal was to develop clinical skills in the assessment, treatment planning, and therapeutic interventions that would enable me to work effectively and competently at the community level from a feminist, anti-oppressive, structural perspective.

Understanding and treatment of mental health disorders has changed drastically over the past two centuries. We have moved away from historically distorted and polarized views of mental health disorders and their treatment to more integrated understanding and treatment models. Biological and psychological perspectives on mental illness in the late nineteenth century and early twentieth century were often contradictory and rudimentary at best; offering unsafe, inhumane, and often ineffective treatments to mental health disorders which carried heavy social stigma.

Greatly contributing to our early understanding, Kraepelin, was a pioneer in the exploration and systematizing of mental health disorders which provided the foundation for the DSM and the beginning of pharmacological approaches in the treatment of them (Preston et al., 2008, p. 4). Early pharmaceutical medications, while a milestone of the time, were found to provide sedation without any long term symptom relief and were highly addictive (Preston et al., 2008, p. 5). In 1952, the first trials of psychotropic drugs reported symptom reduction in patients with schizophrenia and bi-polar disorders; and the first anti-depressant became available in 1957 (Preston et al., 2008; p. 6). As well in the 1950s, studies began to emerge exploring the roles of
neurochemical transmission and genetics in a number of mental health disorders (Preston et al., 2008, p. 7). The development of pharmacological approaches to treatment made great strides with rather high costs related to their overuse, misuse, and adverse side-effects. Controversy emerged between those who believed in pharmacology and those supporting psychotherapy as the preferred treatment approach (Preston et al., 2008, p. 8-9).

In the 1980s and 1990s, advances occurred with: medications which reduced symptoms; a better understanding of the use of medications and their applicability to differing disorders; an increasing body of research; and neuroimaging techniques; which have helped to increase the effectiveness of pharmacological treatment (Preston et al., 2008, p. 11). Also, during this time period, research studies began to emerge substantiating the efficacy of psychotherapies. In particular, cognitive behavioral therapy and interpersonal therapy were found to be effective treatment approaches that could be widely applied for mood and anxiety disorders (Preston et al., 2008, p. 12). The merging of psychotherapy and pharmacology as combined approaches to treating particular disorders has proven to increase the effectiveness of reducing emotional suffering and enhancing mental health outcomes (Preston et al., 2008, p. 12).

In recent years we have been utilizing integrated models of practice for mental health services. Burgeoning research in psychology, social work, psychiatry, and the medical profession provide theories of etiology and treatment methods that can be integrated to inform and guide clinical practice and treatment.

Today’s mental health services in BC communities are delivered through an integrated network of both formal and informal services. The formal services are inclusive of: “primary care mental health services, psychiatric services, community mental health services, and long
stay facilities and specialist psychiatric services” (RCY, 2013, p. 31). BC Children’s Hospital in Vancouver and The Maples in Burnaby offer the most specialized level of mental health assessment and treatment for children and youth in BC. At the community level, CYMH services offer: specialized assessment, treatment, and referrals to other supports and services. Pediatricians and family doctors are often involved in the care and treatment of mental health disorders and hospital emergency rooms respond to mental health crises and provide referrals to CYMH teams.

Informal services are those services that support mental health indirectly (such as schools, youth drop in centers, police, vocational programs, sports, arts, etc). Family, friends, and self-care can also fall under informal services that contribute to mental health. Recognizing that there may be a mental health problem and seeking help is integral to accessing more formal services. Many informal services can work to support awareness of mental health, decrease stigmatization, and provide linkage to more formal services. In addition, support from family and friends, community supports and self-care are a significant part of treatment once someone is accessing more formal mental health services. Through personal participation in treatment planning to developing ways to manage stress, keeping physically active, cultivating healthy relationships, and asking for help when needed, youth and their families can learn to play a key role in achieving health and well-being.

While the province strives to provide integrated mental health services to children/youth and families, this is sometimes easier said than done. The 2013 Representative for Children and Youth (RCY) report (p. 48) on mental health services found that, “there are significant gaps in the continuum of mental health services available to youth”. They (RCY, 2013, p. 48) identified “a lack of crisis response services” throughout the province resulting in emergency rooms being
utilized as revolving doors to mental health crisis. Another gap in formal services identified by the RCY is the “lack of community-based intensive intermediate mental health care” (RCY, 2013, p. 51). In the Northwest, the emergency room acts as a holding pen while youth in crisis wait to be transferred to more intensive intermediate services in other parts of the province. The emergency room does not work to stabilize a youth in crisis and actually often escalates the crisis. First we have to wait for a bed in an alternate hospital and then await patient transportation. It is often a waiting game for the air ambulance to be able to transport youth to intermediate services and often those services cannot hold a bed while transportation is arranged. In addition, parents often have to find their own source of transportation. Ultimately, while hospitals and emergency rooms provide safety, it is not a therapeutic environment.

Also, the RCY found that “existing services do not provide adequate capacity or clear mandates for addressing the mental health needs of transition-age youth” (2013, p. 59). CYMH works to bridge servicing for transition age youth to Adult Mental Health and Addictions Services and possibly Community Living British Columbia. While in theory this is usually possible, at the community level, there are still challenges with this process at the adult servicing end. While gaps will probably always exist between services, an increased recognition of gaps within our mental health system and areas of need and development is integral to ensuring youth are not lost in the transition.

The most prevalent disorders found in children and youth in BC are: “anxiety, conduct, attention and depressive disorders” (Sheppard & Waddell, 2002, p. 3). These prevalence rates are based on studies that identified the disorders as causing significant distress and impaired functioning within their lives. Altogether, Sheppard and Waddell (2002, p. 3) approximated that in BC “140,000 children and youth experience mental disorders”. A multi-faceted approach to
addressing mental health services for children and youth in BC is recommended by Sheppard and Waddell (2002, p. 3) inclusive of “universal programs to promote health for all children, targeted programs for children at risk, and clinical services for children with severe disorders”.

**Personal Interest in CYMH**

I love working with children and youth. I began with the Sexual Abuse Intervention Program in June 2008 where I gained knowledge, experience, and skills working with children and youth that had been sexually abused and their families. I have found this to be a particularly difficult area to work in as the complexity of trauma can sometimes be overwhelming and heart breaking. It is with incredible support and gratitude that I continue on my journey to develop competence in clinical practice to benefit the children and families that I am fortunate to work with. My belief is that all children and youth deserve to be safe and supported through difficulties so that they have the opportunity to heal, to thrive, and to realize their potential.

My practicum goals included: broadening my trauma focused knowledge base to encompass a more comprehensive understanding of mental health and wellbeing; secondly, developing an understanding of mental health disorders and their impact on children, youth, and families; and thirdly, engaging in comprehensive assessment and evidence based treatment for mental health disorders to enhance my capability in working with children, youth, and families. The practicum placement with Child and Youth Mental Health (CYMH) was a gift from their amazing team in Prince Rupert who supported my learning throughout with openness, generosity, and creativity.

Developing knowledge and skill in the area of child and youth mental health initially took place through shadowing clinicians and participation in the team environment and then moved to
participation in clinical treatment with children, youth, and families. Under supervision and through team consultation I was able to gain experience with intake, assessment and standardized instruments, treatment planning, and therapeutic approaches centered in evidence based practice. The practicum provided a broad exposure to child and youth mental health problems/disorders and the child/youth mental health system.

It was my hope in choosing the practicum with CYMH that I would further develop clinical social work competencies that would enhance my social work practice. Personally I find working with children/youth to be an incredibly vivid and enlightening experience. They bring such candor, colour, vibrancy, and innate wisdom to the capacity to heal through great difficulties: making the therapeutic work absolutely engaging, energizing, and inspirational.

**Personal View**

I grew up in Vancouver BC in a white middle class family. My father is a renowned jazz musician and my mother was a dancer (now dance teacher); careers which did not draw incredible financial wealth but which provided an openness and acceptance of being. My paternal grandmother and paternal aunt were both teachers with the Vancouver School Board. Education and the arts were highly prized within my family that also possessed a critical social/political perspective and openness to cultures and traditions from around the world. After graduating from high-school I endeavoured to discover the world for myself. My travels found me in Southeast Asia studying traditional meditation and yoga and teaching English. The experience of travelling and living in other cultures fostered for me a deepened respect for the traditional knowledge and cultures of humanity within our diverse global community. Returning to Canada after years away I endeavoured to apply myself to my grandmother’s love of
education and applied the focus I'd learned abroad to the study of social work practice. Social work was an area of study which both pulled on my heart and fit with my soul; bringing western and eastern, right brain and left brain principles together into life, practice, and being.

Over the past nine years I have worked within a feminist organization providing services to children and families that have been victims of violence and working with dedicated women in the pursuit of ending violence against women and children. Speaking the unspeakable and engaging in consciousness raising work together to create change and healing within our patriarchal world culture; as Judith Herman (1997, p. 1) states, “remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims.” It is from this practice framework that I work to include a structural social work framework and further develop an anti-oppressive practice framework. While the three theoretical practice models are somewhat contextually different on the surface they all have similarities in their work to strive for equality and social healing.

**Theoretical Orientation**

“Feminist analysis not only decodes patriarchy and stresses the links between the personal and political better than any other theory, it, like structural social work, emphasizes transformational politics. Some feminist theorists do not limit this transformation to a constituency of women but seek the end of domination and oppression of all people” (Mullaly, 1997, p. 131).

Feminists undertook great challenges over the past century; vying for equal rights for women and speaking to atrocities faced by women, children, and marginalized populations within Canada and around the world. Consciousness-raising has brought women’s issues into the spotlight, increasing awareness of inequalities faced by women, and violence perpetrated
against women. Moving into the future, we are inundated by views that decentralize feminism's place within contemporary issues. Feminism's stance against patriarchy from a white glorified Eurocentric worldview may typify what feminism is thought to be without acknowledging its ability to profoundly speak to continuing oppression, violence, and injustice occurring around the world. I believe that feminism today must go beyond a quest for equality to a stance against injustice and violence; a stance which includes the voices of women, children, and men of all ethnicities. Feminism must incorporate differing worldviews, giving voice and perspective to other ways of being in the world, relationship, and community.

Patriarchal ideologies so deeply rooted within our structures and systems have been planted over centuries and spurned to grow through practices of colonization, assimilation, and hegemony. Supported through paternalized beliefs and values honoring individualism, materialism, and globalization, these ways of life govern our systems, ignoring the impact on our collective well-being. Feminist deconstruction of these systems allows space for other worldviews and voices to be heard and seen, challenging the dominant ideologies that disempower and negate wrong doing. Without this, individual pathology is utilized as a scapegoat for responsibility within our patriarchal structures without acknowledging the social history and current context through which oppression and marginalization occur. It is with this understanding that I approach child and youth mental health. Our children and youth are our voices of tomorrow. Their symptoms occur in the context of our history and times. By acknowledging the social, cultural, and structural context in which problems occur we acknowledge the process of empowerment as a vehicle for agency within a climate of oppression.
Cross-cultural social work grounded in a structural approach to practice creates the opportunity for social workers to impact racism and discrimination on many levels. At the heart of racism and discrimination lies oppression. As Mullaly (1997, p. 139) states, “If an individual is oppressed, it is by virtue of being a member of a group or category of people that is systematically reduced, molded, immobilized”. Though we see some forms of overt racism and discrimination in Canadian society today, most go unnoticed or hidden within the fabric of our institutions and structures. Mullaly (1997, p. 145) contends that, “oppression occurs through the systemic constraints on subordinate groups that take the form of unquestioned norms, behaviours, and symbols and in the underlying assumptions of institutional rules”. Oppression that is systemic or structural is less visible, hidden in capitalist ideologies that blame the victims for their place in society, lack of movement forward, and inferior status.

Two goals of structural social work that are inherently beneficial to cross-cultural practice are: first, “to alleviate the negative effects on people of an exploitative and alienating social order” and second, “to transform the conditions and social structures that cause these negative effects” (Mullaly, 1997, p. 133). Working within community we become aware of the effects our social order has on people’s wellbeing and ability to thrive. Dialogical relationships create the foundation for discussions that give light to barriers, racism, and discrimination faced by people. These enlightening conversations create a space to analyze the negative impacts our society has on people and allows us the opportunity to contextually understand the dynamics that undermine the ideal of a social order based on social justice. Taken forward we can look to create changes within our communities and social structures to better serve all cultures.

Social justice is defined by Hare (2004, p. 416) as, “an ideal condition in which all members of a society have the same basic rights, protection, opportunities, obligations and social
benefits, along with solidarity and social inclusion”. Social exclusion is, “a process which restricts the access of certain social groups to valued resources and entitlements, relegating them to the status of social outsiders” (Hare, 2004, p. 417). Community based practice strives to attain social inclusion for all cultural groups, creating access to resources, social/political influence, education, and employment. Gilbert, as cited in Hokenstad (2004, p. 76) asserts that, “the socially excluded are usually poor, but they suffer from more than just a shortage of money, they endure multiple deprivations, the cumulative impact of which leaves them detached from the mainstream of society”. Social exclusion often involves, “exclusion from the labor market, goods and services, security, human rights, and land, particularly in developing countries. Other aspects of social exclusion involve a lack of participation in community life, insufficient access to social benefits, and exclusion from decent paying jobs” (Gilbert, 2004, p. 76).

Rights and opportunity are thought to be universal and equal to all within Canadian society. Mullaly (1997, p. 141), defines rights as,

“Not things but relationships: institutionally defined rules specifying what people can do in relation to others. Rights refer to doing more than having, to social relationships that enable or constrain action. In other words, people may have certain rights but be unable to exercise them because of particular social constraints based on class, gender, race, and so on.”

While we all have rights there are circumstances which may limit those rights, for example, I have a right to a lawyer in a court of law but I may not have enough money to afford one. Having rights does not mean that everyone has equal access to them. Being aware of how individuals’ and groups’ rights are impacted and advocating for resources that allow people to attain those rights is crucial.
Opportunity is similar to rights in that though everyone may have the opportunity, for example, to a higher education in Canada, there are many that may not be able to access it. Mullaly (1997, p. 141-142) explains,

“Opportunity refers to doing rather than to having. It is a condition of enablement rather than of possession and usually involves a system of social rules and social relations, as well as an individual’s skills and abilities. Just like people may have certain rights but are unable to exercise them, so too, might people have certain opportunities but because of particular social relations and practices be constrained from using them.”

Awareness of barriers or social/political conditions that diminish people’s access to opportunity is an area where social workers can advocate for change or work with communities to support increased opportunities.

In developing a deeper understanding and focused analysis of inequalities and oppression within our social structure we are able to take blame off individuals and confront the racism and discrimination that exist within our society. Through self-reflection and dialogue that contextualizes people’s experiences of racism and discrimination we are able to make the unseen visible, giving us something to work with. Understanding the impacts of oppression on the people we work with in our communities through a culturally competent model of practice provides us with a framework through which to understand the oppression they are experiencing.

Effective cross-cultural practice demands that the social workers possess enhanced listening and communication skills, good interpersonal skills, and an understanding of the cultural, community, societal, and historical context of the people with whom he or she is working. Working from this practice framework enables the social worker to address structural oppression within clinical social work practice. Mullaly (1997, p. 166) elaborates,
“understanding the political reasons for private troubles enables the worker to communicate this information to the persons experiencing difficulties and to put their situation into its proper perspective, thus reducing some of the internalized guilt and blame that many people experience as part of their troubled situations”.

People’s increased awareness and understanding of their social situation is empowering and liberating; moving one from a place of coping to one of action.

Listening, reflecting, validating, and understanding people’s experiences in Canadian society through their own cultural, historical, and life perspective can be a liberating experience for both social worker and social service user. Barriers and oppression can be identified and personal experiences understood from a social/political perspective; which can be validating, making the personal political and creating space for change. The process alleviates blame, honoring the personal context within which the person is experiencing struggles. Problem solving then turns to the social/political environment rather than focusing on the person as being deficit.

“Empowerment is a goal and process for overcoming oppression.”

(Mullaly, 1997, p. 170)

Developing a trusting relationship built on collaboration engages both the service user and social worker in a mutual learning experience through which both parties have the possibility of experiencing epiphanies. Illuminating moments provide the basis for empowerment and change. Mullaly (1997, p. 167-168) states, “the empowerment process involves the psychological, educational, cultural, and spiritual dimensions involved when individuals are helped to understand their oppression and to take steps to overcome it”. The social worker helps
the individual to connect their understanding of personal powerlessness with its structural sources. The individual is able to link their own personal experiences individually and as a member of an oppressed group; enabling him/her to “take more control of their life, set goals, access resources, articulate needs and ambitions, and create or join associations or organizations of members of similar social groupings” (Mullaly, 1997, p. 160). Social groups are powerful sources of empowerment providing tools, resources, sources of support and places where social/political advocacy can gain power. Cultural communities help to maintain cultural identity, celebrate traditions, provide social support and cohesion, and honor the sense of self that belongs to that community.

“Neither the life of an individual nor the history of a society can be understood without understanding both.” (C. Wright Mills 199:3; as cited by Mullaly, 1997, p. 165)

Globalization has changed the context from which social work originated. Practicing social work in today’s world requires reflection on personal, historical, social, and global conditions. Globalization has social, demographic, political, and cultural dimensions, and operates as “a process of global integration in which diverse peoples, economies, cultures, and political processes are increasingly subjected to international influences” (Hare, 2004, p. 408). The impacts of globalization are felt worldwide, not only impacting immigration to Canada, but the Canadian economy itself. Becoming globally aware is essential in our increasingly complex and interconnected world. Hare (2004, p. 417) states, “Social workers worldwide must learn more about the global forces affecting societies in various stages of economic development. They must broaden their conceptions of social work’s potential contributions to contemporary issues and problems”.

Impacting racism and discrimination within society today is not only necessary but an integral aspect of social work. Understanding the personal experiences, cultural and historical contexts, and social/political environment is essential to having a deepened appreciation of the struggles people face and the systemic oppression that is ever present in our society today. The core definition for social work practice states, “The social work profession promotes social change, problem-solving in human relationships, and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work” (Hare, p. 409). If we are to abide by this it is our duty to address oppression and impact change within society. Through a structural approach to practice, empowerment and consciousness-raising, we have the tools to effect change and address oppression within society on a daily basis.
Chapter Two: Practicum Setting

Description of Agency

The Ministry of Children and Family Development (MCFD) aims to increase capacity, build resiliency, and foster good mental health outcomes for children and families contending with mental health problems. The Child and Youth Mental Health program serves the broader community through prevention programs and intervention through individual therapy, group therapy, family psycho-education, and support. Serving a vast geographical area, age range, and mental health spectrum this diversified clinical team strives to meet varying challenges while providing specialty in a generalized setting. The team is now supported through Tele-health by psychiatrists out of Vancouver Children’s Hospital. The Tele-health system is not only confidential and reliable but incredibly convenient; allowing for psychiatric consultation to take place on a weekly basis if needed.

The CYMH office in Prince Rupert is located within the MCFD office. The team is currently led by acting team leader Sharon Watson and has four clinicians all holding MSW degrees. CYMH clinician Kerry Crump supervised the practicum; her amazing grace, knowledge, and refined skill set fostered an amazing atmosphere for learning. I commenced the practicum in June 2013 beginning with part-time hours that led into full time hours through July and September and then went back to part time hours for October, November, and December. Half days in the beginning supported orientation, participation in team meetings, Tele-health psychiatric consultation meetings, training, and shadowing of clinicians; while moving into full time hours in July allowed me to focus on learning in an integrated and comprehensive manner through participation in clinical work and allowed me to carry a small case load. In the fall the shift back to part time hours facilitated continuing clinical work.
Delimitations and Limitations

There were a number of limitations impacting the knowledge gained during the practicum experience. Experience working with different ages and different mental health issues were influenced by the referrals, presenting cases, and waitlist during the time of the practicum. In addition, ethical considerations considering the timeframe of the practicum in respect of children presenting with issues that would have spanned a longer treatment span than that of the practicum limited the possibility of working with some children and mental health issues. Shadowing clinicians on differing cases helped to alleviate this limitation and provide exposure to cases otherwise not possible.

Delimitations helped to set the parameters of the practicum so that the goals were realistic and could be met within the indicated timeframe and set hours. I worked with Kerry, my practicum supervisor, to set and review realistic parameters regarding number of files, types of files, and activities throughout the practicum.

Learning Goals, Objectives and Activities, Monitoring and Evaluation

The practicum with CYMH fostered growth through the ongoing development of a literature review, shadowing of clinicians, participation in the team environment, and clinical work. I was able to apply learned knowledge of the theoretical foundations in child and youth mental health best practice into personal practice through the practicum experience and into a developed framework for personal practice.

The knowledge and skill development gained through the practicum experience have supported the development of professional competencies and a grounded model of practice which supports future professional growth. The learning goals, objectives and activities, and evaluation are described in Table 1 Goals, Activities, and Evaluation.
<table>
<thead>
<tr>
<th>Learning Goals</th>
<th>Objectives &amp; Activities</th>
<th>Monitoring &amp; Evaluation Criteria</th>
</tr>
</thead>
</table>
The practicum with CYMH provided a wide range of experience towards developing knowledge and skills in the provision of child and youth mental health services. Individual, family, and community work were inclusive of intake, assessment, treatment, consultation, case management, education, support, and supervision; all supported by a dynamic team. Differing theoretical models utilized were distinguished and examined from a critical standpoint to develop an understanding of use and efficacy in practice. I have been able to consider the mental health system through a structural lens that recognizes inherent problems within our systems and from an anti-oppressive practice lens which acknowledges barriers to services in order to better conceptualize the impacts of oppression on those impacted by mental health problems in BC.

Standards of practice were maintained and followed the Ministry of Children and Family Development Child and Youth Mental Health Standards (2006), the British Columbia Association of Social Workers Code of Ethics (2003), and the Canadian Association of Social Workers Code of Ethics (2005). Adhering to the practice standards and codes of ethics guided best practice to meet efficacy in service delivery.

The focus of the practicum was geared towards developing knowledge and skills through the activities outlined in the above table. Supervision was provided weekly and encompassed all direct services provided, including: intake, assessments, treatment plans, and treatment interventions. The caseload was based on presenting cases at the time of the practicum experience. The practicum was inclusive of educational activities such as: video/audio conferencing training, case conferences, workshops, and on-line training pertinent to child and youth mental health.

The practicum supervisor conducted informal evaluations throughout the practicum through weekly/bi-weekly supervision; reflecting my performance and learning goals. Personal
self-reflection and written evaluation was an on-going activity throughout the timeframe of the practicum to enhance self-reflective practice. I also kept a reflective journal throughout the practicum experience to enhance the development of self-awareness of personal biases and assumptions and identify areas of growth over the practicum.

The learning throughout the practicum experience helped me to better formulate and articulate an effective and evidence based practice model and provided the foundation for future professional growth and development.

Table 2 Practicum Timeline demonstrates the time-line of the practicum:
Table 2: Practicum Timeline

<table>
<thead>
<tr>
<th>June 2013</th>
<th>July 2013</th>
<th>August 2013</th>
<th>September 2013</th>
<th>October to December 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>68 Hrs.</td>
<td>144 Hrs.</td>
<td>27 Hrs.</td>
<td>144 Hrs.</td>
<td>198 Hrs.</td>
</tr>
<tr>
<td>Complete and submit practicum proposal.</td>
<td>Developing and articulating a knowledge base in the therapeutic treatment of behaviour disorders, mood disorders, anxiety disorders, eating disorders, and crisis intervention.</td>
<td>Explore best practices in assessment and treatment planning.</td>
<td>Learn about prevention and awareness group programs offered by CYMH.</td>
<td>Prepare for wrapping up practicum hours, closing files, and finishing group work.</td>
</tr>
<tr>
<td>Orientation to placement; commencing with half days.</td>
<td>Shadowing of clinicians.</td>
<td>Demonstrate ability to carry case load.</td>
<td>Facilitate prevention/awareness group in the schools.</td>
<td>Work to close or transfer caseload by the end of the month.</td>
</tr>
<tr>
<td>Receive final approval to begin practicum.</td>
<td>Shadow and work with intake worker.</td>
<td>Mid-way evaluation.</td>
<td>Continue to carry caseload.</td>
<td>Final evaluation.</td>
</tr>
</tbody>
</table>

**Supervision**

Social work supervision occurs within a complex context of interceding and interacting forces. The broader cultural context from which we live deeply impacts the work we do as social workers. The organizational culture from which we practice articulates the goals and objectives
along with the practice policies, standards, and guidelines informing and guiding our practice.

Our own personal experiences, the culture we come from, and our knowledge and skills have their own personal impression on practice. The culture, experience, and values of the supervisor play an integral role in the process. And the culture, experiences, and values of the client, as well as, their view of the problem greatly influence the helping relationship. This intricate web of relationships interplays amongst one another within the supervision process; reflecting Tsui’s (2005) comprehensive model of social work supervision which contextualizes the supervisory relationship to comprise of the agency/organization, supervisor, supervisee, and client. From a structural social work perspective I would contend that this model also needs to consider the broader social context in which we practice.

The objectives of social work supervision directly reflect the relationships involved in the supervisory process and the outcomes of supervision. Tsui (2005, p. 15) distinguishes these objectives stating,

"First, supervision should ensure that clients receive maximum benefits and prohibit inappropriate staff responses to clients. Second, supervision enables supervisees to deliver more effective care, get a second opinion, raise concerns about their own intervention, pursue professional development, receive feedback, deal with their own feelings, and enhance their own self-management. From the supervisor’s perspective, supervision is used to maintain standards and morale in service units; monitor workload levels; review and plan interventions; maintain objectivity; provide critical analysis; keep senior staff informed about the performance of frontline staff; ensure court orders, statutory requirements, and other obligations are discharged; and maintain good standards of professional performance."

These objectives reflect the broader influences and relationships involved in social work supervision. Within the practicum placement these objectives were met through the weekly clinical supervision sessions with Kerry Crump, weekly CYMH team meetings, psychiatry
consults, and invitation by team members to sit in on their supervision sessions with Team Leader Sharon Watson.

Tsui (2005, p. 33-34) elucidates the empirical and theoretical base of supervision’s seven basic principles. The first principle highlights the competence and experience of the interpersonal transaction that ensures quality service to clients (Tsui, 2005, p. 33). The second principle establishes the agency objective to the supervisee through the supervisor (Tsui, 2005, p. 34). The third principle recognizes the difference of power within the supervisory relationship, the exchange of ideas and expression of emotions. Tsui (2005, p. 23) notes that, “the competence model has been found to be more effective in creating a high level of interaction, satisfaction with the supervisory process, sense of accomplishment, and job satisfaction”. Power may be seen as authority given by the agency but also can manifest through a supervisor’s charisma, expertise, access to information, use of force, or use of rewards. Effective use of power to create a safe place to share information, knowledge and skills, and foster emotional expression further establishes the supervisor relationship as encompassing agency and client objectives. The fourth principle acknowledges that indirectly supervision maintains professional social work values (Tsui, 2005, p. 34). The fifth principle encompasses the monitoring of job performance, conveyance of professional knowledge, values, and skills, and the provision of emotional support. The sixth principle establishes effective supervisory evaluation to encompass supervisee satisfaction with supervision, meeting job objectives and positive client outcomes (Tsui, 2005, p. 34). The seventh principle recognizes holistically the four parties involved in the supervisory relationship as: the agency, the supervisor, the supervisee, and the client.

Kerry’s supervision throughout the practicum experience encompassed the values of these seven principles. She was incredibly open, creating a safe space to share expertise and
reflect on knowledge and skills, foster emotional expression, encompass agency and client objectives, maintain professional values, monitor performance and develop competence, while meeting job objectives and positive client outcomes. I am incredibly thankful for her dedication, knowledge and skills, openness, and giving heart to which she shared throughout the practicum. This gift from Kerry is something I hope to carry forward in my personal practice.

In the social services field we have come into an era of fiscal restraint in the provision of healthcare and social services. Noble and Irwin (2009, p. 350) note, “while the ideologies of economic rationalism are shaping the organizational and professional landscape of social work practice, paradoxically, theoretical developments in social work have moved away from structural analysis of the socio-political and religious-cultural relationships to a more fragmented, uncertain, and wide-ranging array of views”. The impact of changes within the socio-political landscape on social work supervision may be seen by a change in focus. Noble and Irwin (2009, p. 352) state, “the changing context of supervision has meant that supervision has changed from being a priority of the profession to a priority of management”. Noble and Irwin (2009, p. 352) argue, “the move to restrict supervision to monitoring worker performance at the expense of professional and intellectual growth is inhibiting the possibility of new and challenging practice dialogues and learning opportunities from emerging”. I greatly valued the holistic approach to supervision, going beyond managerial obligations to encompass the integrity of the profession, to which the CYMH team in Prince Rupert practices.
Chapter Three:
Defining Mental Health

How do we define mental health? And what makes a person mentally healthy? "Mental health" as defined in the CYMH Plan (2003, p. 2) "includes all aspects of human development and wellbeing that affect emotions, learning, and behavior". To broaden this definition MoH and MCFD refer to the World Health Organization’s definition of mental health:

"Mental health is essential to physical health, personal well-being, and positive family and interpersonal relationships. The World Health Organization describes mental health as a state of well-being in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively and contributes to his or her communities. Good mental health is much more than the absence of mental illness — it enables people to experience life as meaningful and to be creative, productive members of society." (RCY, 2013, p. 13)

In contrast a “mental health problem” as defined in the CYMH Plan (2003, p. 2) "is used to describe any emotional or behavioral condition that may cause significant distress and impair functioning, but not to a degree that meets diagnostic criteria for a mental disorder". And "mental illness" and "mental disorder" as defined in the CYMH Plan (2003, p. 2) "are used interchangeably to mean any emotional, behavioral, or brain-related condition that causes significant impairment in functioning as defined in standard diagnostic protocols such as the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-IV)(APA, 2000)".

While the answer to the question of what makes a person mentally healthy would be a multi-faceted and dynamic response it also poses quite the challenge in divergent thinking. Families today are different than generations ago; today in many cases both parents are working, there is less extended family support, more single parent families, and many low income families. The importance of healthy diet, positive supportive home environment, and active
lifestyle are often difficult for families to juggle within the busy schedule of today’s family life. Television, social media, the internet, and video-games dominate many children’s lives; creating less opportunity for positive family interaction and healthy activities. The importance of attachment, developing a positive sense of self, and the ability to develop a healthy range of emotional expression is integral to early childhood development. Emphasis placed on healthy family environments reflected by healthy family behaviors supports the psychosocial processes that create a foundation for health in later life.

Daniel J. Siegel (2012, p. 10 – 11) illustrates another way of looking at mental health as “living in a state of integration” which he describes as, “a river of well-being”:

“Imagine a peaceful river running through the country side. That’s your river of well-being. Whenever you’re in the water peacefully floating along in your canoe, you feel like you’re generally in a good relationship with the world around you. You have a clear understanding of yourself, other people, and your life. You can be flexible and adjust when situations change. You’re stable and at peace.”

Siegel (2012, p. 11) illustrates one bank of the river being the bank of chaos and the other bank of the river being the bank of rigidity. Neither extreme represents the vitality and health as the gentle flow of flexibility and adaptability found in between. Through this metaphor mental health represents a well-integrated brain that is able to flow through life with flexibility, stability, and adaptability; thereby experiencing “the river of well-being”.

Siegal refers to two types of integration which are integral to mental health and wellbeing: “horizontal integration” (Siegal, 2012, p. 18) is defined as the communication between the left brain and right brain which allows our logical side to be integrated with our emotional side to create a balanced experience. Siegel describes “vertical integration” (2012, p. 39) as when the “up-stairs brain” or cerebral cortex (thinking brain) is integrated with our “downstairs brain” or amygdala (instinctual brain).
Through each stage of development, the challenge for children and families is to work to achieve balance, integration, and wellbeing; culminating in an experience of mental health whereby one is able to realize their potential. Understanding mental health from a developmental perspective provides a context for intervention while the integration model presented by Siegel helps us to conceptualize wellness from the perspective of the brain.

As determinants of health have changed over the past century so too has our understanding of what leads to healthy behaviours and good mental health. Wellness in today’s world is a complex puzzle made up of many pieces. There is no doubt, our thoughts affect our health and wellbeing; an idea recognized by yogic practices that focus on awareness of the mind and the power of word through mantras and great thinkers like Mahatma Gandhi who said, “Always aim at complete harmony of thought, word and deed. Always aim at purifying your thoughts and everything will be well”. The connection between mind and body has been recognized throughout many ages. However, only in recent years have studies begun to establish this connection and the effect it has on longevity, health, and wellness.

The human mind acts as an intermediary between our physical, psychological, social and spiritual worlds; interpreting, evaluating, applying beliefs and knowledge to develop our understanding. The impacts of which are relayed through our physical systems. Psychoneuroimmunology, as defined by Ray (2004, p. 31), “the science and paradigm of health incorporating the mind, the endocrine system, the nervous system and the immune system”, helps us to understand how our thoughts are connected to our ability to fight off disease, illness, and maintain health. Ray (2004, p. 32) states that, “from the bio-psychosocial perspective, the
mind is one activity of the brain, and this activity of the brain is the body’s first line of defense against illness, against aging, against death, and for health and well-being”.

How one perceives the world, life events, finds meaning, and carries oneself forward greatly affects wellbeing. Stress or allostatic load is felt when one falls out of equilibrium with the demands either perceived or real in their life. Resilience is impacted by: a person’s knowledge of the world we live in, inner resources, beliefs, and outlook on life; all directly impacting health and well-being. Positive social support and spiritual beliefs also play a role.

Increased understanding of the connections between mind and body are still ongoing. Many studies have established strong correlations between the mind and physical health and wellbeing. Though there are direct relationships between behavioral and social determinants of health it is the mind that links these with our physical body systems. Our personal way of being in the world is our personal blueprint of how we will adapt and achieve health and wellness.
Chapter Four: Literature Review

New developments in our understanding of the etiology of mental health disorders help to inform and guide intervention, assessment, and treatment. Determining whether the mental health disorder is biologically based, non-biological (as in emotional or psychosocial), or whether together they are both contributing as interactive agents is complex. Biologically based psychological problems have been put into three categories, “due to medical illnesses, due to drugs, or endogenous mental illness” (Preston et al., 2008, p. 17). In addition, increased research over the past three decades has shed light on our understanding of the impact of psychological and environmental processes or stressors on biological and neurological systems (Preston et al. 2008, p. 17-19). As well, sleep has been found to be a significant contributor to and/or inhibitor of physical and mental health. Assessing sleep in the treatment of child psychiatric treatment is integral to better supporting treatment and overall outcomes (Alfano & Gamble, 2009, p. 335).

Mood Disorders

Mood fluctuations throughout the lifespan are normal; however, what distinguishes mood disorders is their duration and severity. Differing theories of etiology of mood disorders work together to help us understand the contributing role of genetics, psychological and environmental development, cognitive processes, interpersonal styles, life stress, childhood abuse, and biological factors (Dozois & Firestone, 2010, p. 173-176). While it is normal for emotions to come and go, depressive feelings often occur with anxiety, fear, anger, irritability, despair, worthlessness, self-blame, and hopelessness; all feelings which can lead to self-critical toxic thinking. (Kabat-Zinn et al., 2007, p. 19) Our thinking, the running commentary of our minds, interprets our world like a silent movie, applying meaning to events that are coloured by our emotional experience. The ABC model of emotions explicates this trajectory; the situation as a
camera would record it, it would then be interpreted by our mind which is reflective of our feelings at the time, and then lastly we would react to our interpretation (Kabat-Zinn et al., 2007, p. 21). Self-awareness is a life process which leads to an understanding of how we learn to be in relationship with the world around us and with ourselves; creating a space for development, self-acceptance, and understanding.

I loved Kabat-Zinn’s (2007, p. 22) metaphorical description of depression, “It’s as if depression is a war we wage against ourselves, and we marshal every bit of negative propaganda we can muster as ammunition”. In other words, “depression is the harshly negative views of ourselves that can be switched on by unhappy moods that entangle us...transforming passing sadness into persistent unhappiness and depression” (Kabat-Zinn et al., 2007, p. 24).

Depression can lead to dysregulation of sleeping, eating, and energy levels; further exacerbating how one thinks and feels about self. The body can also be affected by depression in ways that often go unseen and are not understood. Our brain is designed to react to threats in our environment, like a predator that we need to escape; immobilizing body responses to deal with the threat. For our brain there is no distinguishing between real danger and perceived danger; the same body responses are drawn on, all in preparation for freeze, fight, or flee. As Kabat-Zinn et al. (2007, p. 25) explicate, “once the body reacts in this way to negative thoughts and images, it feeds back to the mind the information that we are threatened or upset”. This illustrates that “it’s not just that patterns of negative thinking can affect our moods and our bodies. Feedback loops in the other direction, from the body to the mind, also play a critical role in the persistent return and deepening of unhappiness and dissatisfaction” (Kabat et al., 2007, p. 26). Once feeling down, people often have less energy for or stop doing the activities that provide a sense of joy or well-being which results in deepening the depression. The exhaustion funnel (Kabat-Zinn et al.,
2007, p. 29) illustrates this effect, highlighting the accumulating symptoms and increased exhaustion felt during depression.

Depression can be extremely painful and last for extended periods of time during which youth miss out on important social/emotional/intellectual development with each episode leaving scars. Untreated depression in youth can be a major contributing factor to suicide and lead to increased episodes of depression in adulthood (Empfield & Bakalar, 2001, p. 21-22). These are all reasons it is important to diagnose and treat each depressive episode.

Diagnosis can be complex as depression falls into differing severities with differing symptoms; as Empfield & Bakalar (2001, p.38) explicate, “psychiatrists divide the severity into three categories -- mild, moderate, and severe -- but of course the symptoms exist along a continuum with infinite variations from one person to another and within the same person at different times”. Depression is not considered a single disease but an overlapping group of diseases which “experts have classified into types of depression, described their symptoms, and devised treatments for them” (Empfield & Bakalar, 2001, p. 33).

Also complicating the treatment of depression is the likelihood of depression occurring with other disorders. Alcohol, for instance, is a substance commonly used by adolescents but when used while experiencing depression; it can complicate the mood disorder and increase the risk of suicide. “Studies have found that somewhere between one-third and one-half of kids who abuse alcohol also suffer from a mood disorder, most commonly major depression and dysthymia” (Empfield & Bakalar, 2001, p. 100). As well, anxiety disorders commonly occur with depression in close to forty percent of cases. While both are treated with antidepressant medications, Empfield & Bakalar (2001, p. 103) states, “they must be selected and prescribed differently when both illnesses are involved”.
The role of sleep in youth depression is significant as “ninety percent of depressed children and adolescents report problems with their sleep”; often resulting in longer and more severe depressive symptomatology (Alfano & Gamble, 2009, p. 330). Given that the correlation between sleep problems and depression is so high, Alfano and Gamble suggest that treating depression and sleep problems at the same time may have the most efficacious clinical results. (2009, p. 331)

Following numerous research studies supporting a “contextual view for the development of mental disorders” Weitzman (2006, p. 40) considers the etiology of adolescent depression to emanate from the “confluence of genetic, social, familial and contextual variables that produce a teenager who is more vulnerable to emotional dysphoria.” While many family factors may impact an adolescent’s inclination towards depression Weitzman (2006, p. 39) concludes,

“a lack of family support, parental psychopathology and the presence of immediate psychosocial stressors can clearly combine to confound an adolescent’s need to master the developmental tasks of individualizing from his or her family system, develop new attachments and grow in competence, responsibility and independence.”

Flowing from this understanding, Weitzman (2006, p. 37) “advances a position of using a family-oriented approach to treat adolescent depression despite the current gap in studies that might otherwise validate its efficacy.”

A family-oriented approach to the treatment of adolescent depression that addresses the role of family factors implicated in the onset, maintenance, and treatment of depression incorporating family education has been found to produce efficacious results. While the research is still limited in determining which specific family therapy models are best suited to relieving the experience of depression it ultimately comes down to the fact that there is enough compelling
evidence telling us that family factors are very significant in the onset and maintenance of adolescent depression and therefore addressing these factors within the treatment process enhances the treatment outcomes for depressed adolescents.

**Anxiety Disorders**

Anxiety is the overarching umbrella term for many mental health problems in childhood and adolescence; these include: specific phobia disorder, generalized anxiety disorder (GAD), social anxiety disorder, separation anxiety disorder (SAD), panic disorder, obsessive compulsive disorder (OCD), and post traumatic stress disorder (PTSD). While being the most common of all disorders, anxiety can have genetic or biological, environmental, and psychological etiological origins (Dozois & Firestone, 2010, p. 96-101). Anxiety is a disorder that has both high rates of recovery and recurrence and the course of the disorder can be highly chronic; thus early recognition and treatment is efficacious in practice (March, 2013, p. 5).

Anxiety disorders can affect a child/youth’s functioning across many domains; one domain that has significant impact is sleep. According to Alfano and Gamble (2009, p. 329) “night-time fears that are co-accompanied by severe and persistent sleep problems may be symptomatic of an underlying anxiety disorder.” Children/Youth with anxiety disorders often take longer to fall asleep, have difficulty staying asleep, and have decreased deep sleep (Alfano & Gamble, 2009, p. 329). The presence of sleep disturbance for children with OCD compared to healthy adolescents showed significant differences. Children with OCD were fifty percent more likely to have trouble sleeping and experienced daytime tiredness (p. 329). Researchers rate both environmental and biological factors as contributing agents impacting sleep in children/youth with anxiety disorders. Environmentally, sleep is impacted by the routine and functioning in the family home. While biologically, anxiety is thought to cause changes to the “hypothalamic
pituitary adrenal axis, impacting the timing and patterns of children's sleep; resulting from higher levels of cortisol being released during the pre-sleep period in anxious children compared to healthy controls” (p. 330).

Cognitive Behavioral Therapy and exposure-based behavioral therapy have been found to be the most effective therapies in the psychological treatment of anxiety disorders (Dozois & Firestone, 2010, p. 111). As well, in addition to or in conjunction with psychotherapy, pharmacological interventions have been found to be effective in reducing anxiety symptoms (Dozois & Firestone, 2010, p. 388).

Exposure has been found to be an integral component of CBT, which is effective across cultures, ages, and settings. Exposure has been shown to have efficacious results for child anxiety. Flannery-Schroeder et al.’s. (2005, p. 136) article provides guidelines for “creating and implementing effective exposure tasks when treating anxious youth”. Effective exposures provide the opportunity for developing coping skills while counter-conditioning fear responses and challenging cognitive distortions. Initially children/youth learn to identify physiological responses of anxiety and how to relax. The next step brings awareness to self-talk specific to expectations and fears of the situation. The child/youth then utilizes this awareness in problem solving, which may change actions and thoughts to help better cope with the fear situation. The last step involves evaluation and reward for work done.

Bouchard et al. (2004, p. 56) describe exposure as, “any procedure that confronts the person with a stimulus which typically elicits an undesirable behavior or an unwanted emotional response”. The literature as cited by Bouchard et al. (2004, p. 57) is supportive of its use as a “therapeutic ingredient” in CBT treatment of anxiety disorders. Considerations must be made
between the age of the child, ability, and therapeutic approach utilized. With young children, a strong behavioral component is recommended; whereas, with older children a combined cognitive behavior approach can be rendered as they may have more advanced cognitive skills (Bouchard et al., 2004, p. 59). Integral to therapeutic success is the “accurate case conceptualization, collaborative development of a fear hierarchy, introduction of skills to question predictions and beliefs, graduated exposures to test predictions and practice coping, drawing conclusions from the experience, and, finally, rewards for facing a fear” (Bouchard et al., 2004, p. 59). In addition, making therapy fun for children and building an engaging relationship supports success.

Exposure involves utilizing task work to facilitate healing and neutralize the impact of the anxiety. In this phase of treatment imaginal and in-vivo exposure tasks are developed to foster coping skills, challenge expectations, and develop mastery. Exposure based work can be done both in and out of session through planning and modelling with parents. SUDS (the acronym for subjective units of distress scale) are utilized throughout exposure work. Children learn to rate their level of anxiety and are able to chart or map changes throughout treatment. Rewards are developed into the planning in order to support compliance and encourage child/youth to learn to self-reward.

Parental involvement in therapy for anxiety has a number of benefits to treatment outcomes. As parents become involved in treatment they learn to be aware of their child’s avoidant behaviors that could otherwise have been maintained and/or strengthened in the family setting. According to Bouchard et al., (2004, p. 60) “parents often allow the anxious child or teen to avoid situations as a way of lessening their anxiety and unwittingly reinforce the child’s avoidance; and moreover, anxious parents can model anxious behaviors; or they may allow an
anxious child to avoid stressful situations because the parents cannot tolerate the commotion that their child engages in to stay away from the feared stimuli.” Inclusion of parents in treatment for anxiety disorders helps to move treatment beyond the therapy office into real life; increasing opportunities for healing.

When it comes to exposures the recommendations for children and youth are, “fears should be faced gradually, working from slightly difficult to the most difficult; the child must stay in the feared situation long enough to learn that the bad things he or she fears will not happen; and practice and repetition are the keys to success” (Bouchard et al., 2004, p. 60-61). Collaboration should be maintained in the therapeutic alliance throughout treatment allowing children/youth to develop competence. As a key component of CBT for anxiety disorders exposure based work has incredible benefits to alleviating the fear related symptoms and cognitions of anxiety and thus changing behavior.

Assessment

The assessment report and treatment plan is a written formulation of theory into practice. The assessment brings together information from different areas of a child’s life and development, incorporating family history and background, developmental history, academic ability, medical, and psychiatric history. The clinician also assesses the child’s mental status, suicide risk, and other areas that are significant to the presenting issues. She may also utilize appropriate standardized measures as needed. The client’s perceptions of the problem and current functioning are included to better conceptualize the current situation. The formulation of the assessment clarifies the hypothesis of the presenting issues/problems to develop an overall picture of the presenting problems and prioritize the issues as well as plan treatment strategies.
A provisional diagnosis is established directly flowing from the data from the clinical interviews and information gathered. Goals for treatment are developed in collaboration with the child/youth/ and the family; goals are “specific, measurable, attainable, realistic and time limited” (North Region CYMH Assessment and Treatment Planning Manual, p. 48). A plan is then conceptualized on how the goals will be met and how we will know when we have reached the goals. The anticipated length of treatment is established and frequency of contact is agreed upon. Discharge planning is a collaborative process throughout treatment; assessing progress throughout clinical work helps to guide therapy and allow room to make changes when needed. Discharge planning is ongoing for the purpose of: assessing progress, determining when the child/youth/family no longer needs ongoing treatment, and for planning should relapse occur.

Session notes are documented after every appointment with a child/youth/family. They record current mental status, any red alerts, diagnostic changes, situational changes, medication status, interview content, interventions, special concerns, and plans for next appointment. These notes are progressive throughout treatment as they help to guide and inform the clinician of progress and areas of concern or need for re-assessment. Clinical supervision is provided throughout the treatment process to ensure integrity of services provided and to help develop clinical competence and promote professional development.

Incorporating assessment of sleep in the treatment for childhood and adolescent psychiatric disorders may be done through various means. Clinical interviews through child and parent reports provide an understanding of sleep history, current schedules, sleep behaviours and habits, along with sleep difficulties. Sleep diaries can be utilized over a one or two week period to provide a detailed depiction of sleep while avoiding “potential biases associated with retrospective reporting of sleep” (Alfano & Gamble, 2009, p. 334). Questionnaire measures are
also available and have been validated to assess sleep. The Children Sleep Habits Questionnaire, the Sleep disturbance scale for Children, and the Sleep Self Report are all tools that can be utilized by clinicians in the assessment of sleep. Assessment of sleep can include various methods and should be ongoing throughout treatment to support mental health outcomes.

The Children’s Depression Inventory psychometric scales (Kovacs, 2003), short and long version, are practical tools utilized for assessing and tracking depressive symptoms in children aged 7 to 12 and 13-17. The instrument validly monitors the levels of depressive symptoms over time and during treatment with a quantifiable rating that can be utilized as an asset in assessment of depressive symptoms and for identifying specific problem areas for treatment (Kovacs, 2003, p. 29).

While it is normal and adaptive for children to experience mild and transient fears and worries, it is when they become excessive or developmentally inappropriate that they are considered clinically significant. The MASC2 is a multi-dimensional, self-report measure designed to be “quick and easy to administer” and “allow evaluators to capture a wide range of important anxiety dimensions from the youth’s point of view and to access internal symptoms that are only available from introspective reports” (March, 2013, p. 6). There are two forms: the MASC2 youth form and the MASC2 parent form. Ideally the youth and both caregivers complete the forms; allowing the assessor to develop a more comprehensive picture of the anxiety; recognizing possible under-reporting on the part of the anxious youth. This assessment tool comes in both paper and computerized methods.
Evidence Based Treatment Approaches

Bradley and Westen (2005) take a critical stance in their analysis of the evidence-based practice movement. They argue that it has been operationalized and predicated on a limited construct and research base but has become a phenomena within the psychotherapy world. Recognizing the need for promising treatment approaches to common mental health disorders, the evidence-based practice movement sought to provide empirical data supporting brief treatments for discrete disorders. This concept follows the impetus that the pharmaceutical model began with drug trials; however, psychotherapy in the real world does not exist in a vat pertaining to only one discrete disorder. Bradley and Westen (2005, p. 267) suggest that treatment efficacy would be better obtained by studying doctoral level clinicians working in community with complex cases. This model may better develop evidence based psychotherapy than comparing mainstream brief therapies to control groups where all research participants have had to meet criteria to qualify for the study. The complexity of mental health work within community does not mirror the controlled environment from which our evidence-based practice research is derived. In addition, our developing understanding of the role personality plays in psychopathology recognizes the complexity of mental health and the limits of applying “brief, focal treatments” (Bradley & Westen, 2005, p. 268). While not dismissing the significance of the research that has been done on evidence-based practice and the role it has played in supporting psychotherapy, Bradley and Weston explicate the need for other research and broader definitions for evidence based practice.

Cognitive Therapy

As the grandfather of cognitive behavioral therapy, Ellis’s rational emotive behavior therapy laid the groundwork to understanding the connections between cognitions, emotions, and
behaviors; culminating in tools that are learned through the therapeutic process to make changes (Corey, 2009, p. 276). Internalized personal judgments of self; impact how we feel and act within our everyday lives. Corey (2009, p. 279) explains that, “most cognitive behavioral therapists have the general goal of teaching clients how to separate the evaluation of their behaviors from the evaluation of themselves”; therefore, leading to the unconditional acceptance of self and others. Through a process of developing self-awareness specific to irrational beliefs one is then able to detect and discriminate between helpful and unhelpful cognitions and replace them with positive self-talk which ultimately works to change how one is feeling (Corey, 2009, p. 278).

Cognitive therapy developed by Aaron T. Beck is “an insight-focused therapy that emphasizes recognizing and changing negative thoughts and maladaptive beliefs” (Corey, 2009, p. 287). Leahy (2003, p. 1) explains that, “the cognitive therapy model is based on the view that stressful states such as depression, anxiety, and anger are often maintained or exacerbated by exaggerated or biased ways of thinking”. Designed as a therapeutic approach to treating depression, cognitive therapy addresses self-criticism, exposes ambivalence, and shrinks problems to manageable proportions while using humor and lightheartedness to counter sadness (Corey, 2009, p. 295).

Three therapies are commonly used in the treatment of mood disorders: cognitive behavior therapy, interpersonal psychotherapy, and mindfulness. Cognitive Behavioral therapy (CBT) applied to a mood disorder is based on the cognitive theory of etiology; which recognizes that emotions are connected to one’s thought processes about problem situations. The exploration of one’s thoughts and changing of behaviors through CBT has been successfully
found to allow a person to change beliefs and entrenched patterns that impact functioning and wellbeing (Dozois & Firestone, 2010, p. 180).

Interpersonal psychotherapy (IPT) recognizes the contribution of disorderly attachments in the etiology of mood disorders. The focus of the therapy is on relieving interpersonal dysfunctions in four domains: “interpersonal disputes; role transitions; grief; and interpersonal deficits” (Dozois & Firestone, 2010, p. 181).

**Mindfulness**

An area of study emerging in the literature is that of mindfulness with children. Coholic (2011, p. 1) studied aspects of: improved self-awareness and resilience in young people; through their participation in an arts-based mindfulness-based group. Qualitative results from the study were promising though it is still an area for much future study. Children participating in the group were engaged in a non-threatening manner and learned to focus on thoughts and feelings without judgment; with the goal of developing self-awareness that would help enhance resilience, improve coping and social skills, develop problem solving skills, and increase self-esteem (Coholic, 2011, p. 12). Coholic (2011, p. 12) highlights that this style of group was beneficial to traumatized children lacking stability and children that lacked the cognitive ability to participate in a mindfulness-based cognitive behavioral therapy group. While this group approach may not yet meet evidence based practice standards it is interesting to note other approaches emerging in the literature that may work for children which may not be reached with other treatment approaches.

The study of mindfulness based approaches to treatment of youth psychiatric disorders is still in its infancy. Martin and Tan’s (2012) Australian study on the efficacy of mindfulness based approaches to treatment of adolescent psychiatric problems showed promising results in
improving mental health outcomes. Utilizing a five week program “Taming the Adolescent Mind” mindfulness based approaches were shown to help youth develop the ability to modulate their responses to stress; regulate their emotional responses; and increase self-esteem. Another benefit of mindfulness as opposed to CBT is that it is applicable to adolescents with intellectual or language impairments; offering a less intellectual approach to healing. Martin and Tan (2012) adapted this mindfulness based program to the adolescent population by modifying exercise length and frequency, adolescents need for movement, at home practice through homework, and the use of technology by recording mindfulness instructions on their mobile phones to increase accessibility and availability. In addition, for each group session handouts used limited text, larger font size, cartoons, and pictures to make it friendlier to the adolescent population. At the end of the study and three month follow up youth identified a significant decrease in psychological distress, improvements in self-esteem and mindfulness, and significant reduction of behavior problems and psychological symptoms from parent reports (Martin & Tan, 2012, p. 308).

Kabat-Zinn et al. (2007) offer The Mindful Way through depression, a mindful-based cognitive therapy developed to stop the quicksand effect of depression and allow a person to free themselves from its grasps. They (Kabat-Zinn et al., 2007, p. 2) pose the question

“What if, like virtually everybody else who suffers repeatedly from depression, you have become a victim of your own very sensible, even heroic, efforts to free yourself – like someone pulled even deeper into quicksand by the struggling intended to get you out?”

Spiralling mood exacerbated by efforts to free ourselves from the pain we are trying to escape; depression is the quicksand of mood, despite the brains thrashing to be free one is pulled deeper into its murkiness. Mindfulness based therapy allows the individual to learn to be in the present
which alleviates the constant rumination and negative thinking that impacts mood and functioning.

Zack et al. (2012) suggest that utilizing clinical judgement to determine the “cognitive capabilities, behavioral issues, interpersonal strengths and weaknesses, and suicidality level” of the youth will lead the skilled therapist to appropriately employ the most suitable evidence based treatment (Zack et al., 2012, p. 38).

**Community Based Practice**

Improving on evidence based practice from a community approach to treatment is as integral to the success of treatment as the therapeutic approach utilized. Considering the contextual factors that impact community mental health services Baker-Ericzen et al. (2010, p. 397) looked at clinician and parent perspectives of the treatment of children with behavior problems. Interestingly, parental stress and inadequate social support were most frequently discussed by parents as factors impacting treatment efficacy. Parents identified that having these issues addressed within their child’s treatment would help to better support their child and family wellbeing as a whole. Baker-Ericzen et al. (2010, p. 414) suggest “that a clinician must understand client characteristics related to the entire family” when developing a treatment plan to meet their needs.

Kendall and Podell (2011) consider the outcome effect of parental involvement in a CBT 16 week treatment in the outcome for children with anxiety disorders. They looked at the impact of mother attendance and father attendance in sessions and found correlations between improved child outcomes with both parents involvement. This study (Kendall and Podell, 2011, p. 192) found that “including parents as co-clients in treatment enables them to learn better strategies for managing their own and their child’s anxiety”.
The need for parent involvement in child and youth mental health services was a concern echoed in the recent RCY (2013, p. 43) report. They found, “mental health services are fragmented, difficult to navigate, and too often do not support and involve families in caring for youth who are experiencing mental health problems”. While families usually provide the primary care for children and youth living with mental health problems they identified the need for

“the recognition of Caregivers’ as equal partners in the planning and treatment of their youth’s mental health needs; mental health professionals who value caregivers insight and experiences with their youth’s mental health problem; practical education on how to understand and manage their youth’s mental illness; and mental health professionals who proactively find a balance between involving families and respecting the youth’s confidentiality” (RCY, 2013, p. 46).

The RCY (2013, p. 46) report identifies a useful resource for supporting families called “Strengthening Families Together”. This resource was developed by the Schizophrenia Society of Canada and is a ten session education program which provides support, awareness, and tools for families and friends of individuals living with mental illness. Another unique resource available is the Mental Health First Aid Canada Program that “trains people to recognize the signs and symptoms of mental health problems, provides initial help and guides a person towards appropriate professional help”. This can be found at www.mentalhealthfirstaid.ca (RCY, 2013, p. 40). Also available to families, is a resource called Families Matter, A Framework for Family Mental Health in British Columbia (RCY, 2013, p. 47). This document is designed to meet the needs of parents and caregivers to “cope and parent well despite their own or their children’s mental illness; to encourage mental health services to have a stronger family focus; and to assist
individuals, families and communities increase control over their own mental health” (RCY, 2013, p. 47).

Early psychosis intervention has been developed collaboratively between MoH and MCFD in BC with specific standards and guidelines. Fraser Health has developed and coordinated an EPI Advanced Practice that offers, “a web-based provincial training program, forums for networking and sharing resources and evaluation site reviews” (RCY, 2013, p. 68). This collaborative approach to developing a practice model for EPI services has resulted in “consistency in how services are delivered, meet their clients range of needs and bridge youth and adult mental health services” (RCY, 2013, p. 68). The success of this framework may possibly be carried over to other mental health services with the hopes of filling the current gaps in the system.

**Applicability of Treatment Approaches across Differing Cultures**

As an evidence based practice approach to the treatment of many mental health problems, cognitive behavioral therapy has also been found to be culturally friendly as it utilizes “the individual’s belief system, or worldview, as part of the method of self-challenge” (Corey, 2009, p. 300). Another benefit of the approach across cultures is that it supports individual functioning within community; which honors diversity and interdependence. Specific benefits noted by Corey (2009, p. 301) include: “individualized treatments, focusing on the external environment, active nature, emphasis on learning, reliance on empirical evidence, focus on present behavior, and brevity”. One of the cautions to the utilization of cognitive behavioral therapy with diverse cultures is the need “to have some understanding of the cultural background of clients and to be sensitive to their struggles” (Corey, 2009, p. 301).
Though youth are not considered a culture of their own, having young voices included in what services are offered, how they are offered, and what is effective for them is integral to meeting their needs. In the RCY (2013, p. 42) findings, youth stated that mental health services were effective for them when they were:

“treated with respect; remembered them and what was going on in their lives; gave them positive feedback; asked questions and included them in decisions; did not stereotype; did not judge them for their substance use, but sought to understand the underlying mental health challenges that led to the substance use; helped them set and meet goals; offered some structure in their lives; included them in their diagnosis rather than just giving them a label; explained their diagnosis to them and what services and supports they could access; were flexible and creative; completed the tasks they promised to keep; took the time to build and engage in an ongoing relationship; kept professional boundaries; acted as a positive role model; were knowledgeable about local resources and how to access them; did not treat them like a number”.

Services for youth need to reflect the culture that they are reaching while coming from an adult system that can be overwhelming and alienating. Youth identified that services should be central, convenient, accessible, flexible, and utilize sources of communication that work for youth (such as text, email, and phone to stay in touch) (RCY, 2013, p. 42).

Cross-Cultural Supervision

Cross-cultural supervision is inclusive of integrating culture as an integral component of the supervision; bringing a cultural perspective inclusive of the culture of the supervisor, the culture of the supervisee, the culture of the client, and the culture of the theoretical model utilized throughout the helping relationship by the therapist and supervisor (Young, 2004, p. 48). Young (2004, p. 41) describes cultural supervision as, “the process of supervision whereby the supervisor demonstrates knowledge of individual differences with respect to gender, race,
ethnicity, culture, and age and understand the importance of these characteristic in supervisory relationships."

Although culture can be difficult to define or contextualize, Tsui (2005, p. 46) contends that, "It is easy to distinguish and identify. It is the way of life and the way of viewing the world of a specific social group. Distinct cultural traits can be identified". These cultural traits are influenced by gender, age, religion, socioeconomic status, social status, sexual identity, and language use; and may be subtle or complex. As well, we all belong to and participate in many communities that coexist within our broader cultural communities; these smaller communities also have a culture of their own which make them unique in and of themselves.

The role of the supervisor is to ensure inclusion of multicultural issues within the supervisory process, explore racial-ethnic assumptions, attitudes, and values that may impact treatment efficacy, and recognize subtle differences that may not be noted otherwise (Young, 2004, p. 40). In addition, Young (2004, p. 43) emphasizes the importance of promoting cultural awareness, identifying cultural influences on patient behavior, identifying cultural influences on psychoanalyst-patient interactions, identifying it in the supervisory relationship, and providing culturally sensitive support and challenge to the supervisee as an ongoing process.” This process of cultural supervision is integrated throughout the supervisory process and relationship; reflecting not just a piece but the whole.

Tsui (2005, p. 46) establishes the role of social work supervision as “a part of a complex theoretical and professional value system and a service network situated inside a particular culture.” It therefore needs to consider more than the culture of the participants involved but also the culture of the agency, management, funding sources, community, and profession (Tsui,
2005, p. 46). Understanding our own cultures that we bring to the relationship along with the cultures of others involved is critical in developing a comprehensive cultural model of practice.
Chapter Five: Practicum Placement Experience

The practicum took place over a twenty-five week period incorporating part and full time components that enhanced the learning experience. The initial orientation was part time and fostered adjustment to the practicum setting, team, and varied caseload. The CYMH team in Prince Rupert was incredibly inviting to shadow sessions and supervisions; attend family meetings, trainings, Tele-health psychiatric assessments and follow-ups, other assessments and meetings, and team meetings. This immediately created an environment of learning and growth as the exposure was so great. In September I took on a small caseload reflective of files that would possibly be of appropriate duration for the extension of the practicum to December 2013. Carrying the caseload was a great way to bring the learning into practice through the intake, assessment, and treatment process. I had originally wanted to include group work in the practicum experience; however, this was not possible during the timeframe of the practicum. Instead focus was maintained on an individual caseload of presenting cases at the time.

Following are some case studies illustrating the clinical assessment and treatment of differing disorders that presented during the timeframe of the practicum and demonstrated some of the learning and clinical practice gained. For the purposes of this report each case has been altered using aliases and pseudonyms and changes were made to the personal and family histories so that their identification is not possible.

Case One

This first case clearly developed and provided the opportunity to apply theoretical knowledge of anxiety disorders, assessment of anxiety, and CBT treatment for anxiety into practice. I was very fortunate to have the opportunity to work with this amazing youth from
beginning to end and benefit from their hard work and dedication to treatment which had efficacious results. In this report I refer to this youth as Michaela Evans as any identifying information has been altered to protect the identity of this youth.

Michaela Evans was referred to CYMH by her family doctor after expressing difficulties with anxiety symptoms which began in May 2013. At the end of May, during her practice for the graduation walk-up, she became increasingly anxious. She worked through the anxiety to participate in her graduation and managed to get through it. The anxiety continued through the summer of 2013 while Michaela was working long hours. She felt that the stress of graduating and not knowing what career path to take triggered the anxiety symptoms she had been feeling. Michaela noticed that the symptoms became worse when she met new people or when she was in groups where she did not know people well, and also when she thought about her future. She found that the anxiety symptoms lasted about half of every day, making it difficult to fall asleep at night and participate in social activities. Her parents also noticed that she has been more shy and withdrawn over the past few months before treatment.

Michaela shared that her grandmother struggled with anxiety many years ago. She said her grandmother tried medication (which she reported did not work for her) and then saw a counselor which helped to alleviate the symptoms.

She describes her family as being close knit and supportive. She gets along well with her parents and extended family and states that they help her out. Michaela has a younger thirteen year old sister named Sarah with whom she has a good relationship with. The family lived in Prince Rupert until she was seven years old and then moved to another community for five years before returning to Prince Rupert when she was in grade ten. The initial move was a difficult adjustment for her socially but moving back to Prince Rupert was comfortable as she maintained
friendships from her childhood. She has close friends her age which she spends time hanging out with and she has many enjoyable interests. While she states that she does not make friends easily, it appears she has made and maintains friendships well.

She did well throughout school, maintaining above average grades and participating in school activities and sports. She rarely drinks (only on special occasions) and stopped very occasional (once a month) marijuana use in April 2013. She does not smoke cigarettes and barely consumes any caffeine (a few sodas and maybe one coffee a week). Michaela does not have any allergies, vision/hearing problems, or serious medical conditions. Approximately three years ago she was hospitalized for one month with pneumonia. The illness was quite severe and she remembers being very faint in hospital, barely able to stand or walk due to weakness. Since this sickness, Michaela worries when she gets sick that it could happen again.

Michaela is currently attending the local College to up-grade some of her high school courses in order to be accepted into the business administration program or another college/university program. She has been working all summer to save money and hangs out with friends on occasion. She worries frequently about the future; in particular what career path she should take. She is specifically worried that she might choose the wrong path and have to start all over again. She notices that her worries are worse when she is stressed. To alleviate stress she spends time with family, listens to music in her room, watches movies, works out at the gym, and hangs out with friends.

Michaela presents as a kind, caring, insightful, together young woman. Her posture is good, her expressions are appropriate, her body movements are appropriate, and her speech is clear, consistent, and appropriate to the conversation. She was very cooperative and open in sessions making good eye contact throughout. Michaela’s activity level and energy level are
average on most days. Approximately one day a week she says she just stays in her room and lies around, having difficulty doing anything. Her appetite and weight are normal, though she notices that she eats more on days when she is stressed. Approximately two days a week she describes her mood as being irritable and one day a week sad/depressed during which she loses interest/pleasure in day to day living and becomes somewhat withdrawn. The rest of the week is pretty normal, though about half of everyday of the week is impacted by feelings of anxiety.

Michaela describes her anxiety symptoms as: trembling/shaking, light-headed/dizzy, heart pounding, some sweating and nausea, shortness of breath, restless/edgy/tense/unable to relax, difficulty controlling worry, headaches, and feeling hot and speaking with a high pitchy voice when nervous. She fears big crowds, what people think, and worries daily about the future. She has not experienced any trauma that has been significant. She has not been feeling suicidal and has not had any recent suicidal thoughts. Though in the past she thought about what would happen if she died this isn’t a predominant thought for her presently. When feeling down she turns to the support of parents, grandparents, and friends. Michaela is a bright, articulate, friendly, and respectful young woman. She is very helpful to friends and family, is hard working, and has a good sense of humor.

Michaela completed the MASC2 Self-Report during our second session to assess anxiety symptoms. She had very elevated scores for Generalized Anxiety Disorder, Physical Symptoms and Panic. She had elevated scores for Social Anxiety, Performance and Tense/Restless. Falling in the slightly elevated range were Separation Anxiety/Phobias, Humiliation and Obsessive/Compulsive. Harm/Avoidance fell into the average range. Michaela’s total score was 82 which is in the very elevated range. These scores substantiate the symptoms Michaela has been experiencing and indicates that she is being significantly impacted by anxiety.
Cognitive behavioural therapy was utilized as the evidence based treatment approach in weekly sessions with Michaela. Each session encompassed: psycho-education in developing awareness and understanding of anxiety; developing anxiety management coping skills; exposure for tolerating uncertainty; cognitive challenging; and relapse prevention. We focused on generalized and social anxiety and panic/physical symptoms. Michaela was very motivated in and out of sessions. Each week we made goals that she worked on through the week and we talked about at our next session. The weekly goals were reflective steps to her overall treatment plan goals. Treatment went for twelve sessions over a three month period. She reported that her anxiety diminished quite quickly and then stayed down towards the end of treatment. Her family noticed that she became less withdrawn and was more like herself again. At our closing session Michaela reported that she was feeling well and felt like she had the skills to handle anxiety if it came up again for her.

Case Two

Case two helped to apply learned knowledge of depression and its treatment into practice. While treatment was incomplete at completion of the practicum this case provided incredible insight into the complexities of treating depression in youth and need for an integrated approach to treatment of depression. Parent involvement in treatment was integral to this case; explicating the incredible role parents can play in their child’s healing. In this report I use the alias Ally Jones for this youth and any identifying information has been altered to protect the identity.

Ally Jones was referred to CYMH for depression by her family doctor. Ally describes her predominant mood as being mediocre: she does not enjoy anything, does not feel happy, and feels sad or neutral most of the time. She has very little appetite; eating nothing for breakfast, a
granola bar and water for lunch, and regular dinner. She says she thinks she’s not hungry because she does not do too much. Ally’s energy level has been low and her motivation to do things is low though she forces herself to maintain activities and school. Over the past few years she began spending more time drawing and writing. She has difficulty sleeping; at nighttime she reflects on the day and if anything was wrong her mind starts to worry and then her thoughts snowball from there. Ally believes her mood has been like this since she was in grade five at elementary school though she has been healthy throughout her childhood. Ally’s mother has had depression for many years and treats it with medication.

Ally had thoughts of suicide often during summer 2013 and over the past year. She said she would have suicidal thinking approximately two times a week and the thoughts would last for an entire day and sometimes until the next morning. When the thoughts are severe or overwhelming she does not feel like doing anything, she just lies on her bed and does not talk to anyone. She has never attempted suicide in the past, does not know anyone personally that has, and she does not have a plan to kill herself. In the past when she had suicidal thoughts she said that she did not follow through because she was not sure how so she just kept on going. For Ally the personal meaning of her thoughts of suicide is attached to her belief that she does not do anything good and that it would be better off for her family if she were not here. Ally feels that suicide would provide relief for her family. Currently she feels in control although there have been times in the past where this was not so. She does not use any substances and has not been taking any unusual risks. She says that what keeps her alive right now is that she wants to live. Ally does not have much conflict in her life currently and, with some reluctance, she believes her father, mother, and brother care for her and supports her. She states she does not really have any intention of acting on the thoughts of suicide. Ally has a safety plan and agrees to talk to a
support person, CYMH clinician, school counselor, or her parents if the thoughts become overwhelming.

Ally completed the CDI2 during our second session together: all scores were in the very elevated classification; emotional problems at 82, negative mood/physical symptoms at 74, negative self-esteem at 85, functional problems at 90, ineffectiveness at 82, interpersonal problems at 90, and total score at 88.

Ally met with the writer for four sessions in October where we began gathering assessment information, psycho-education around depression, and cognitive behavioral approaches to help alleviate the symptoms of depression. Ally was setting the alarm on her watch to exercise and to go to sleep each day. She made an effort to eat meals and participate in regular activities. Despite her ongoing efforts the depression did not improve and in November Ally began feeling more hopeless again. At this time suicidal thoughts returned and Ally stopped making regular scheduled appointments to the CYMH office. The writer met with Ally’s parents to discuss progress and treatment options; they gave consent for the writer to set up a tele-health session with psychiatry through BC Children’s hospital.

The tele-health session took place with Ally and both of her parents meeting with the psychiatrist from BC children’s hospital via video link at the CYMH office. The psychiatrist went through an assessment and through conversation felt that Ally’s depression was most likely of genetic etiological origins; which was good in that it was likely to respond well to an anti-depressant. The recommendation was made for Ally to start on an anti-depressant medication which she and her family chose to do right away. Her parents noticed a difference right away with improved sleep and appetite. The suicide symptoms came down very quickly as well. The therapeutic alliance was maintained with Ally and her parents to support healing and evaluate
improvements. Ally felt relieved that the symptoms of the depression receded so quickly and she was able to develop awareness and understanding of depression and its effect on her thoughts, feelings, and behaviours; thus alleviating feelings of shame and blame associated with the depression. Including her parents in therapy made space for them to develop an understanding of the symptoms their daughter was experiencing, develop tools for supporting her, and alleviate their own guilt and shame that their daughter was struggling with such severe symptoms.

Case Three: Shadowing

This case was particularly interesting in that a confluence of events appeared to co-exist exacerbating or perhaps igniting anxiety for this youth. I use the pseudonym Kenneth Cam to refer to this youth in order to conceal identity. All personal details have been changed for the purpose of this report. Prior to moving to Canada, Kenneth describes himself as an outgoing boy who had many friends at school and who was not anxious. Difficulty adjusting to the change of country, culture, schools, climate, family and friends at a sensitive developmental time of puberty perhaps overwhelmed his natural ability to cope and respond to the new social environment. Therapy became his only place to talk about and understand the difficulties he’s had since moving to Canada.

Kenneth Cam is a quiet fifteen year old boy that moved to Prince Rupert from Malaysia two years ago. Since arriving in Canada he has been plagued by what he describes as social anxiety. A very analytical boy, who self-diagnosed himself, Kenneth states he is very stubborn and does not like to be wrong. He feels like his peers are always thinking bad things about him; thus making social relationships near impossible. Kenneth has been avoiding social situations over the past few years; preferring the comfort of his home which he shares with his mother, father, and brother. Kenneth does not want his mother or father to be part of his treatment as he
feels that they have enough on their plate and he does not want to burden them with his problems. Kenneth initially presented very nervous during therapy but slowly began to relax into the process. He started to feel safe discussing his problems as this was probably the one safe place for him to do so. Kenneth has started to do deep breathing when he feels panic walking down the halls at school and in other social situations where he can feel his anxiety escalating. He appears to defend himself rapidly when cognitive behavioral strategies are used in therapy to contend with distorted thinking linked to his anxiety. Mindfulness and IPT appear to be more receptive treatment options for Kenneth. There is some query as to whether there is an element of Obsessive Compulsive Disorder operating with the social anxiety, as Kenneth clearly describes his social anxiety in the context of being scared that something bad is going to happen. Kenneth is not currently interested in psychiatric involvement in his treatment. He has progressed nicely so far with psychotherapy; making progress at school and with beginning to develop friendships. He has been pushing himself to interact with peers and participate in his classes. At night time he is still ruminating about his day and worrying about bad things happening.

Case Four: Shadowing

This last case illustrates the complexities of assessing and treating longstanding OCD in a northern community setting. It also pronounced the difficulties of accessing more formal mental health services from our northern location. I use the alias, Alexis Grant, to conceal this youth's identity and have altered all identifying information.

Alexis Grant is an eighteen year old girl who accessed CYMH services and psychiatry briefly last year for Obsessive Compulsive Disorder (OCD) and a possible eating disorder. At the time, the psychiatrist had considered hospitalization and to commit her under the mental
health act because she was not eating. After agreeing to therapy he contended she could stay home. It wasn’t long after that when she stopped coming for treatment and after numerous attempts to reach her; her file was closed. She re-emerged early this summer requesting help again. Her OCD and difficulties eating had landed her in the hospital in Toronto when she was visiting her friend. Upon returning home she was concerned by the fact that she was unable to eat anything for extended periods of time, was concerned about her father’s pressure for her to move out and support herself, and about her inability to get better on her own.

In order to access more formal services through APAU in Prince George Alexis and her family agreed to have her certified under the mental health act. She was given a bed in the Prince Rupert hospital while awaiting a bed to become available at APAU in Prince George. After a week of waiting in the Prince Rupert hospital a bed became available in Prince George but it was not possible, due to weather, to arrange transportation. She continued to wait in hospital and then when medical transport was available there was no longer a bed. Frustrated with the system Alexis and her family asked her doctors to decertify her so that she could go home. It was a very frustrating process for the whole family and in the end, though her case was complex and definitely deserved to be seen at APAU, she did not access the services because of the complexity of coordinating beds with transportation.

This case also provided valuable learning in that it clearly showed how important it can be to have family support the treatment process, while at the same time illustrating how family can collude in enabling psychiatric disorders in children/youth. While it is no wonder the family was frustrated with the system of care; the severity of the OCD, after going undiagnosed and untreated throughout this young woman’s childhood, had become so normal within her family that recognizing the severity and need for intensive treatment seemed illusive. Her father in
particular, was not available to meet with the clinician or participate in his daughter’s treatment; an integral component to treatment in such a severe case of OCD. His father would put up barriers to service and undermine the treatment process. Alexis ultimately chose not to partake in treatment and while meeting with her paediatrician to monitor her physical health she was referred to the adult mental health system.

**Conceptualizing the Learning**

These case studies help to elucidate the learning gained throughout the practicum experience. While these are only a few of the cases I worked with and shadowed, they help to contextualize the learning gained through the practical application of knowledge and skills gained in practice. This learning would not have been possible without the experiential setting of the practicum placement and the openness of this amazing team to share their practice, helping to mold the experience from abstract knowledge into a concrete learning experience.

The process of intake and assessment gave me the opportunity to conceptualize and formulate each case individually. This is a unique and integral piece of clinical work, as it defines the problem/s and leads to the path of treatment. Each case was discussed through clinical supervision throughout the intake, assessment, and treatment process, to guide practice, and reflect culture and theoretical orientation throughout. Competencies were gained in developing an awareness/understanding of differing disorders, their assessment, and treatments.

Each case that I got to be a part of was incredibly unique and provided a different learning experience. Throughout the course of the practicum many disorders emerged: different types of anxiety presented; differing ages, onsets, and types of depression; differing comorbidities of disorders; differing attachment disorders; tics; inversion disorder; trauma; grief
and loss; and psychosis. The exposure was great for the development of clinical competencies in intake, assessment, and treatment planning in a community based generalist setting.

I found the Tele-health psychiatric services to be an amazing resource for child/youth/families and their clinicians. Psychiatrists helped to provide diagnostic clarity, medication reviews, short term treatment, urgent assessments, and second opinions. The knowledge gained through participating in and shadowing psychiatry assessments and follow-ups was phenomenal. The psychiatrists through BC Children’s hospital patient outreach provide an amazing support to the therapeutic services being offered through Child and Youth Mental Health while also providing pharmacological treatments and ongoing psychiatric consult when needed. I believe this is a great specialized resource for clinicians working in a generalist child and youth mental health setting, like that of northern British Columbia.
Chapter Six: Reflection

Praxis as described by Zuber-Skerrit (p. 11) is, “the interdependence and integration – not separation – of theory and practice, research and development, thought and action”. It is a one word descriptive analysis of learning throughout the practicum experience. Emphasis is placed on the dialectical relationship between learning/research and action. Zuber-Skerrit (p. 12) describes research as, “understanding, creating and advancing knowledge through reflection, inquiry and critical evaluation”. Action is the “activities, concrete experiences, practical trials, explorations, or applications” (Zuber-Skerrit, p. 12). The process between research and action is cyclical in nature, interdependent, each one leading to the other; it is both action and reflection. It was from this rich context of learning, practice, and reflection through which the practicum provided valuable learning and growth.

Excerpts from my journal

I believe it is important to illustrate my learning process through a few excerpts from the journal that I kept through the course of this practicum. Going into the practicum I wrote:

“I started my practicum this week. It took me so long to get here and now I am here and wonder why it took me so long. It feels right though...I feel ready...ready to learn....not as nervous or overwhelmed...and grateful to be here with a dynamic and inspiring team. I feel like there is so much I don’t know and that there is so much to learn, beyond the limits of my practicum about CYMH, disorders, and treatments. But I don’t feel completely out of my scope as far as the practice. This is a nice feeling. It sort of creates a space for growth that is uncomfortable but not unbearable.”

During week two I was beginning to feel more involved in activities that were going on with the team:
“I was able to attend a teleconference OCD training. It was a really fantastic training as it elucidated my understanding of OCD and its treatment. Also exciting this week I attended the CYMH team meeting, had training with Melody regarding intake, and attended the regional Infant Mental Health Meeting. Each activity has helped my orientation to the practicum placement and deepened my understanding of services being offered through Child and Youth Mental Health. Kerry invited me in on two of her sessions this week. The first was with a seven year old boy with Tics. His mother was part of the session and both appeared comfortable allowing me to shadow Kerry. Kerry’s second session was with a seventeen year old girl overcoming depression. It was Kerry’s closing session and the girl’s mother attended with her. She recounted the progress she had made in treatment and how she is feeling today. I admire Kerry’s open, genuine, caring, and positive energy and style. She displays genuine caring, while being very positive, and intuitively addressing presenting problems with a gentleness that I think is probably a very unique gift. Her sessions are very organized, fitting the time allowed and covering what is necessary for teaching and modeling the necessary tools for growth or healing.”

During week five I was beginning to integrate the reading with the shadowing and experience within the practicum setting:

“This week I began reading about CBT treatment for anxiety, I covered: OCD, Specific Phobia, Social Anxiety, and Generalized Anxiety. Still to go are: PTSD, Separation Anxiety, and Panic Disorder. I hope to read those early next week. Kerry and Natalie invited me into their supervision sessions with Sharon this week. These were great to be a part of for learning about their caseloads, treatment, interventions, and supervision. On Wednesday I was able to attend a discharge meeting for one of Kerry’s clients at BC Children’s Hospital, P1, in Vancouver. The meeting was great exposure to transition planning from inpatient care back to community.”
Regarding weekly team meetings I wrote,

"I like the team meetings; as it is great to be a part of a shared team. This is an aspect of the work with SAIP that I have missed out on. It is amazing to have the support of a healthy team environment; inclusive of peer support and clinical supervision."

This was an excerpt from week eleven:

"I read an article on exposure based CBT treatment for anxiety this afternoon. I spoke briefly with Sharon about the reading afterwards and she gave some interesting points. I spoke to a point mentioned in the article about the finding that exposure based treatment while on medication had been found to not transfer learning to a different state therefore when the individual went off the medication they recommended that the exposures continue to allow for transference. Sharon mentioned the difficulty sometimes being that when youth are on medication (typically SSRI's) for a first depressive episode it is recommended that they are on the medication for a long time; because shorter periods on the medication have been found to correlate with increased incidence of suicide. This impacts treatment and can complicate issues around caseload when a youth may initiate treatment and go through CBT in the first three to six months and yet then the file needs to be kept open for a year or more to allow the youth to finish the medication and then initiate more exposure based CBT sessions. It is interesting to consider the many factors that impact treatment and service delivery."

Following is an entry from week twenty:

"When I think of mental health and mental health treatment I think we all fall into the category of almost normal. We all have our cognitive truancies and somewhat oddly maladaptive behaviors and ways of being in the world that somehow make our very experience quite unique. Existing within a complexity of social and personal relationships these nuances somehow become more
pronounced in some individuals and go less noticed in others or maybe they just fit the social landscape of the time better. Perhaps as we take that meditative stance of self-awareness, that glance inwards, that begins to show us our own unique ways of being in the world, we begin to realize our own abnormal or subnormal or almost normal tendencies. When I think of treatment for the many mental health illnesses that plague our time, the shadow/veil of shame is lifted by the insight of awareness that tells of a world that does not foster balance and spiritual well-being, health and wellness. We all exist within a monetary world driven by the need for things. Stress and anxiety producing pressures emanate throughout society; depression and sadness infecting those who are susceptible due to genetics or life circumstances; trauma impacting many. Health and wellness to me is not something for the few, but a craze for the many. Mental health is something to be fostered, to be prized, and to be nourished. We must take the time to feed that part of ourselves that drives our lives, our almost normal brain that needs to be taken care of. Practices like mindfulness, meditation, awareness, education, psychotherapy; focus on the relationship between all aspects of being and the need to create awareness, balance, and health in our lives.

Conclusion

This practicum report has sought to encapsulate and formulate my experience and learning throughout the practicum with Child and Youth Mental Health. I worked to develop a generalist understanding of mental health, mental health disorders, their treatment for children and youth, and a working understanding of the mental health system; while incorporating and applying social work theoretical orientations that encompass: feminism, structuralism, and anti-oppressive practice. Through direct clinical work and shadowing of clinicians I worked to gain competencies in service to children, youth, and families seeking help for mental health disorders.
Chapter one of the report introduced the practicum placement, my personal interest in child and youth mental health, my personal view, and theoretical orientation. This chapter provided the base for my learning in the practicum setting. Chapter two descriptively looked at the practicum setting and established: goals, timeline, activities, monitoring, and supervision. These helped to provide a context to guide learning throughout. I then included chapter three to consider what mental health is and what we look to achieve when we are doing this work. This is something I only managed to touch the surface of for it is a chapter which many over the centuries have dealt with in numerous text books and journal articles. Chapter four was a review of the literature to develop an understanding of the history of mental health and our current understanding of mood and anxiety disorders, their assessment, and evidence based treatment approaches. Again, while the practicum exposure was so broad the literature review had to be limited to focus on anxiety and depression as the core focus. In chapter five I discussed the practicum placement and utilized case examples to illustrate the learning experience and my formulation of the learning. Each case and all those I was unable to include provided valuable knowledge and experience to my learning. Finally, chapter six sought to reflect and summarize the learning gained.

Child and youth mental health in the remoteness of northern British Columbia is set within a complex web of differing contexts which interplay to create a fascinating and challenging setting for providing generalist mental health services. Working at a provincial level is necessary to utilize specialized resources which complement the delivery of services in remote, small, culturally and socially diverse communities. The histories of the peoples of Northern BC, along with the current socio-political context which we are living, constitute an implicit understanding of the need for healing, resources, and services. Decreasing the barriers
set out by distance, cultural history, oppression, colonization, and poverty is necessary to foster healing at a community level. While the setting of Northern BC provides unique challenges, innovative clinicians, teamwork, and community work supersede gaps and overcome barriers to meeting the needs of the communities they work in.
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