INTEGRATING THEORY AND SOCIAL WORK PRACTICE
IN ADULT PSYCHIATRY

by

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Abstract

The intention of this practicum report is to provide further context into the understanding of agency involvement on the adult psychiatry unit at the University Hospital of Northern British Columbia (Northern Health). Adult Psychiatry provides a variety of mental health (co-occurring with addictions) supports to address service users' needs in Prince George, B.C. and surrounding areas. This practicum was a unique venture that included specific learning goals pertaining to professional practice and educational development in the area of mental health and addictions services. This report will include a detailed description of integrative practice that includes practice models/theoretical frameworks, values, ethics, strategies, and skills. This report is a synthesis of observations, research, and participation that highlights critical reflection, hands-on and insightful learning on the adult psychiatry unit within the social work field.
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Chapter One

Introduction

Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality (Canadian Association of Social Workers, 2011).

After completing my practicum at the University Hospital of Northern British Columbia (UHNBC) adult psychiatry unit (Northern Health), I was able to gain an overarching perspective and understanding of mental health. Clearly, mental health capacities extend to a combination of social, environmental, psychological, and biological factors (Mental Health Commission of Canada, 2006). Contemporary understanding of mental health is more inclusive of the relationships between the individual, the group, and community, where external factors can enhance or weaken mental health (Canadian Association of Social Workers, 2011). For instance, social determinants of health can provide an important explanation of how external factors can predispose individuals to mental health issues. Social determinants of health and mental health acknowledge factors such as adequate housing, employment, education, and income (Regehr & Glancy, 2014). Clearly, social workers play an important role in addressing these factors through assessment, treatment, and discharge planning process on the adult psychiatry unit. This practicum supported a model of practice where recovery principles are important in promoting mental health capacities and successful reintegration back to the community.
The duties performed by social workers vary depending on the specific health care settings. As part of my practicum, it was important to develop goals that would facilitate a deeper understanding of social workers’ roles and responsibilities that would be beneficial for service users accessing psychiatry services. Although this practicum was rewarding, there were many challenges that social workers have to deal with in the psychiatry setting. In this report, I will provide an examination of how perceptions of mental health have changed throughout history leading to a contemporary mental health policy. This practicum paper will also include a detailed account of social workers’ responsibilities on the adult psychiatry unit, as well as my personal experiences and learning processes. These experiences relate to specific goals pertaining to professional development, ethical responsibilities and challenges, diversity and differences, and historical/social/systemic barriers. This practicum promoted learning new knowledge and skills needed to perform tasks essential in providing social services for individuals with mental health concerns and addictions issues.

This integrative practicum report is divided into five chapters. The literature review in Chapter One will provide an overview of the understandings and treatments of mental health issues throughout history. Chapter Two includes an overview of the adult psychiatry practicum setting and a description of social work roles and responsibilities within the mental health and addictions field. Chapter Three will outline a practicum learning contract, including general tasks performed, and specific goals carried out on the adult psychiatry unit. Chapter Four will critically analyze my personal values, ideologies, and practice theories/models as they relate to social work practice on adult psychiatry. The goal is to provide a comprehensive understanding of social workers’ experiences, as well as challenges on the adult psychiatry unit.
Mental Health Definition

The objective of defining the following term is to ensure that the average layperson can gain full understanding and recognition of the information throughout this practicum report and examine the importance of definitions as they relate to a practicum on adult psychiatry. Perhaps individuals can adjust their language that supports an individual’s potential for recovery.

Society often refers to individuals with mental health problems as having a “mental illness,” which is a concept that is predominantly reflected from the bio-medical model. A “mental illness refers to a wide range of mental health conditions — disorders that affect your mood, thinking and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors” (Mayo Clinic, 2015). Although the concept “mental illness” can be used interchangeably with “mental health issues” within the healthcare profession, there may be some unintended consequences for using this term. In some cases, the concept of “mental illness” may become part of someone’s identity, where individuals may look at mental health problems as something that is primarily diagnosed and treated. This label directs focus on the individual rather than external and social factors that influence mental health. Using the term “mental health issues” extends beyond the diagnosis and treatment of a mental illness. Mental health issues not only encompass biological functioning of an individual, but also social, environmental, spiritual, cultural, and psychological influences on people to meet the demands of challenges in daily life. When individuals feel “mentally healthy,” they may have positive relationships with their family or community, have enough finances to buy groceries and to have a place to live, and develop sufficient emotional regulation skills to resist struggles that may arise in daily life. Therefore, I will be using the concept “mental health issues” as a holistic concept.
rather than "mental illness" in this practicum report.
Chapter Two

Literature Review

"The care of people with mental and behavioral disorders has always reflected prevailing social values related to the social perception of mental illness" (World Health Organization, 2001).

Social perceptions of mental health issues have undergone many changes. These perceptions may include changes in definitions and terms, as well the understanding and reactions to mental health issues. The purpose of this literature review is to examine how social perceptions of mental health have changed at different points of time, particularly how individuals understand and react to mental health issues. Too often, society defines the accepted wisdom of what is ‘right’ or ‘appropriate’ or ‘normal’. Some cultures may attribute certain behaviors as a desirable quality, while others may see behaviors as undesirable and condemn these individuals. Other cultures may understand mental health issues relating to psychosocial influences, genetic endowments, biological abnormalities in the brain, or spiritual abilities. What will emerge from examining literature is that the conceptualization of mental health has radically changed in very recent times, resulting in very specific understanding and reaction to mental health issues. Very specific social perceptions can influence public policy when providing mental health and addictions services. As a result, mental health is culture-bound, meaning that some behaviors may be acceptable in some cultures while the same behaviours fall outside of the norm of acceptable behaviors in different cultures (Moran, 2009). The social constructivist approach assumes that there are numerous and diverse realities and individuals develop and attach a subjective interpretation of their experiences towards certain objects and things (Creswell, 2009). Social perceptions
can be traced to influences from social, religious, cultural, and economic change throughout history. Understanding the history of mental health movements can provide health care providers with a comprehensive understanding of how mental health services have evolved to the current state.

A History of Mental Health – The Shifting Paradigm

Through history, people with mental health issues have been treated in different ways. Perspectives on mental health have changed throughout the course of history. Early writings showed that the Greeks, Chinese, and Egyptians attributed certain behaviors to be a result of angry gods or demons (Butcher, Mineka, & Hooley, 2013). This understanding led to treatments involving exorcism using prayer, incantation, noise making, or magic to cast an evil spirit out of the afflicted person. Although this understanding of mental health was widespread, there were some progressive individuals that rejected the idea of deities and demons. Hippocrates (460-377 B.C.) (among other Roman and Greek physicians) believed that mental health issues had natural, physical causes and appropriate treatments (Butcher et al., 2013). Greek and Roman therapeutic treatments would include sobriety, exercise, massages, healthy diets to less desirable treatments of bloodletting, purging, and mechanical restraints (Butcher et al., 2013). A Greek physician, Galen (A.D.130-200), attributed mental health issues to the result of head injuries, excessive use of alcohol, shock, fear, adolescence, menstrual changes, economic reversals, and disappointment of love (Butcher et al., 2013). Despite the significant advancements during the Greek and Roman era, the understanding of mental health drastically regressed back to supernatural beliefs and severe inhumane treatments. From the 5th to 15th century in Europe, there was a belief that individuals with mental health issues were possessed by demons or practicing witchcraft (Butcher et al., 2013). As a result, individuals were tortured, burned at the stake, or hanged to liberate
demonic possessions (Butcher et al., 2013). The use of electro-convulsive therapy (electric shocks) was later developed in 1937 by Cerletti and Bini as a treatment for schizophrenia (Basavanthappa, 2011). Clearly, the understanding of mental health issues evolved to include different perspectives and treatments. As time progressed, humanitarian and scientific advances eventually contributed to our current understanding of mental health issues.

**Understanding of Mental Health from an Aboriginal Perspective**

For hundreds of years, Aboriginal people in Canada have thrived with viable social arrangements, political practices, traditional knowledge, and health traditions. After European contact, many historical injustices associated with colonialism, assimilation policies, and residential schools have displaced many of the notions of aboriginal traditions and healing (Kirmayer, Simpson, & Cargo, 2003). Much traditional knowledge, specifically in regards to mental wellness, was disregarded by western culture (Blackstock, 2008). Currently, many problems of suicide, depression, substance misuse, and domestic violence are significantly higher for aboriginal people. It is important to recognize that Canadian mental health services are heavily rooted in a past that disregarded the Aboriginal worldview. Vukic, Rudderham, and Misener (2009) indicated noticeable gaps in Aboriginal Mental Health Services, including lack of culturally appropriate services, the use of Western labels of mental illness, and disregard for culturally appropriate assessments. Acknowledging differences between cultures is important, as understandings of mental health and wellness can have an impact on individuals seeking mental health and addictions services. A diagram below is a model of indigenous mental health and healing, which illustrates a different perspective in comparison to mainstream, western society.
Stewart (2008) explored how narratives from Indigenous counselors in a Native community derived a model of Indigenous mental health and healing. Stewart emphasized that community is a necessary component, as there is a connection to community wellness and the mental and physical well-being of an individual (Stewart, 2008). In addition, Stewart

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discussed that a strengthened cultural identity is important in promoting mental health and wellness such as speaking native language or practicing spiritual dances or ceremony. Traditional practices ranged from ritual chants, ceremonial dances, drumming, ritual journeys, communal sweats, and other spiritual rites (McCormick, as cited in Goldner, Jenkins, Palma, & Bilsker, 2011). Also, a holistic approach is important as this focuses on diverse aspects of physical, emotional, spiritual, and cognitive health (Stewart, 2008). Stewart acknowledged that mental health does not exist on its own, but is instead linked to the balance of these four dimensions of individual and collective wellness. This holistic approach involves “having food in their counselling sessions, integrating ceremony or prayer into their practice, including Elders or traditional healers in the process, and taking clients into nature or into their social community” (Stewart, 2008, p. 53). Lastly, interdependence is an important part of being mentally and physically healthy within an indigenous context, which involves developing relationships with family, community, and community to community (Stewart, 2008). Indigenous cultural values and perspectives have a huge influence on how individuals understand and react to mental wellness. This Aboriginal understanding of mental health is different in comparison to the western perspective. Western perspectives on mental health tend to focus on “mental illness” through neurobiological explanations associated with pathology, structural abnormalities, and treatment (Vukic, Gregory, Martin-Misener, & Etowa, 2011). It is important for healthcare providers to exercise a degree of collaboration and sensitivity with individuals that have different worldviews and cultural perspectives towards mental health.

There has been a long history that demonstrates how different worldviews influence a specific understanding and reaction to mental health issues. These worldviews are invariably different dependent on cultural, social, political, and economic factors that influence these
worldviews. At different periods of time and places, understanding and interventions were often inhumane, ignorant, and unjustified while other historic figures demonstrated a more humane and sympathetic approach to mental wellness. Although our current perspective of mental health is centered mainly on the medical or disease model, it appears that there is a shift to include a diverse understanding of mental health issues.

**Canadian history – Institutional Era**

Prior to the 19th century, individuals with mental health issues in Canada were often incarcerated in jail or placed in poorhouses (Geoffrey, 2006). Canada adopted hospital facilities across the country from the mid to late 1800s to the 1960s (Goldner, Jenkins, Palma, & Bilsker, 2011). Institutional reforms to psychiatry reflected growing sensitivity to individuals with mental health concerns. Originally, Phillippe Pinel, a doctor in France (1793), advocated a moral treatment approach that emphasized sympathetic, humane care in hospital or asylum settings (Arnett, 2006). This shift in care changed the perception that mental health issues were as a result of a “disease”, which is referred to as a “mental illness” (Heinonen & Spearman, 2006). This “mental illness” resulted from physical brain damage, despite there being a lack of understanding about specific brain structures (Goldner, Jenkins, Palma, & Bilsker, 2011). Some treatments that many hospitals used were psychosurgery, hydrotherapy, insulin coma, and electroconvulsive therapy (Arnett, 2006). Although many practices have ceased, electroconvulsive therapy is currently used to treat major mood disorders at UHNBC (University Hospital of Northern BC). These changes in care were evident during this era of institutionalization and the development of the medical or disease model as a model of care.

Although the institutional era was formally established in Canada, British Columbia has a unique history that was considerably different than its counterpart in the United States.
or Eastern Canada. Ferguson (2002) explained that history was different in comparison to Eastern Canada, as British Columbia did not immediately adopt the ‘asylums’ and ‘moral treatment’ approach. From 1848 to 1858, individuals with mental health issues lived in small colonies on Vancouver Island, British Columbia and were taken care of by family or friends or shipped back to England (Ferguson, 2002). After 1858, many individuals were often placed in “dark, foul smelling jail cells” or they would have to pay for passage back to England (Ferguson, 2002, p. 64). Ferguson further discussed that over the next ten years, many calls to establish an asylum in British Columbia were ignored, as economic priorities of the government did not extend to compassionate care for the “insane”. From 1869 to 1872, increased public opinion pressured the BC government to establish a facility in 1872, but there was little motivation to establish an asylum based on the principles of moral treatment (Ferguson, 2002).
Although the building of the first asylum in British Columbia was considered progress, there remained many issues with the implementation and care of individuals with mental health issues. Ferguson (2002) discussed past issues with the building’s security and inadequate repairs done to the facility, lack of humane care, and the cost saving strategies involving not replacing employees. In 1878, the government built an asylum in New Westminster, but this facility was fraught with patient abuses and mismanagement (Ferguson, 2002). In 1894, *A BC Royal Commission Report on the Asylum for the Insane* documented that individuals in asylums were “tightly clinched in straightjackets, handcuffed, and dunked in vats of cold water with their feet and hands bound” (as cited in Regehr & Glancy, 2014, p. 32). By 1901, “insanity” in BC was understood to be influenced by heredity, intemperance,

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2 *Figure 2.* From website “British Columbia Mental Health and Substance Use Services,” by BC Mental Health & Substance Use Services, 2015, http://www.bcmhsus.ca/history. Copyright 2015 by BC Mental Health & Substance Use Services. Reprinted with permission.
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syphilis, and masturbation (BC Mental Health and Substance Use Services, 2013). From the 1930s to 40s, the neuropsychiatry model recommended treatments including insulin shock therapy, electroconvulsive therapy, and prefrontal lobotomies (Regehr & Glancy, 2014). The beginning of care for individuals with mental health issues in Canada included a transition from reliance on families and neglectful practices in prisons to institutional care. Despite the intention to provide humane care, there remained many issues within institutions that triggered more changes to Canadian mental health policies.

Era of Deinstitutionalization

From the 1960s to 1970s, the advent of the deinstitutionalization movement occurred when institutional care for individuals with mental health issues was transferred to outpatient community services (Arnett, 2006; Canadian Association of Social Workers, 2011; Sealy & Whitehead, 2004). This transition from institutional settings to community care was a significant point in history that set the standard for the majority of contemporary mental health services. The transition resulted from overcrowding and rising operating costs of hospitals, the development of useful neuroleptic medications, and changes in provincial/federal funding for psychiatric units in hospitals (Arnett, 2006). Community care would provide quality community services and supports available through local mental health centers (Heinonen & Spearman, 2006). The goal was to provide services in the community so the need for hospital care would only occur for crisis or critical care. However, this transition of individuals from institutions to community care was fraught with many issues. The government of Canada implemented cost saving policies and budget cuts during the advent of community care, which limited many services and supports for individuals with mental health issues (Arnett, 2006; Heinonen & Spearman, 2006). As a result, many individuals with mental health issues did not receive the appropriate supports
after being discharged from the hospitals, resulting in homelessness, and increased delinquent behavior and incarceration (Arnett, 2006). The lack of community services translates into the “Revolving Door” phenomena, where individuals are frequently admitted and discharged from inpatient mental health units (Arnett, 2006; Regehr & Glancy, 2014). Between 1980 and 1998, provincial funding for mental health supports increased, which established supportive housing programs, assertive community treatment, and mental health and addictions centers (Regehr & Glancy, 2014). Although there was an increase in funding, there were many individuals that had concerns about the services and supports offered by the current mental health system.

A national report on mental health, “Out of the Shadows at Last,” outlined the service users’ and family caregivers’ concerns about limited supports and services, and societal stigma and the resulting fear of accepting mental health services (Mental Health Commission of Canada, 2006). In reaction to this report, a Mental Health Strategy was created in Canada, offering a ‘blueprint’ for changes at the national level (Mental Health Commission of Canada, 2012). This report outlines six strategic directions (Mental Health Commission of Canada, 2012, p. 4):

1) Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.

2) Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.

3) Provide access to the right combination of services, treatments and supports, when and where people need them.

4) Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
5) Work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights, and cultures.

6) Mobilize leadership, improve knowledge, and foster collaboration at all levels.

Canadian mental health policy has seen considerable change throughout history. The current community-based system is transitioning from a medical treatment perspective to more of a psychosocial approach while focusing on the individuals’ functionality and unique needs within communities. However, there are many challenges when transitioning to a mental health policy that endorses Canada’s National Mental Health National Strategies. The shift in mental health policies supports adequate housing, vocational opportunities and security, educational prospects, and sufficient income. However, provincial governments have the fiscal responsibilities of allocating funds to support additional programs and supports, and the federal government can also play a role in supporting this transition in mental health policy.
Chapter Three

Overview of Practicum and the Role of Psychiatric Social Workers

I decided to pursue a practicum at the University Hospital of Northern British Columbia (formerly Prince George Regional Hospital) in Prince George, a large acute health care facility in the northern interior region of British Columbia. UHNBC is currently under the jurisdiction of the Northern Health Authority, which provides mental health and addictions services to many northern BC communities. The location of UHNBC is on the traditional territory of the Lheidli T'enneh Nation.

My practicum supervisor, Kristine Henning, has been employed with Northern Health for many years as an MSW graduate and currently provides social work services to individuals with mental health and addictions issues. Throughout my practicum, Kristine provided supervision when learning new knowledge and applying practical skills to real situations, problems, and concerns. The practicum included learning new knowledge about community resources and theoretical frameworks, as well as a wide range of clinical skills in developing trusting and empathetic working relationships. In addition, this supervision was important in developing an increased self-awareness by recognizing my individual strengths and weaknesses, as well as assessing my personal values, attitudes, and life experiences in my practice. In many respects, I can say that this practicum was a positive and meaningful experience. I also spent time with other social workers, and health practitioners in the Quick Response Program, Assertive Community Treatment (ACT), and Community Outreach Assertive Services Team (COAST), among other important community services and supports.

During my practicum, I allocated time on the adult psychiatry unit; Monday to Friday from 8:30 to 15:45. Every Friday, I intended to complete weekly journaling tasks and critical
reflective activities. Due to the short-term and acute nature of adult psychiatry, I made adjustments to my practicum schedule and allocated time at home to complete these journaling tasks. Many individuals that access adult psychiatry services reside on the unit from a few days to a few months. Some individuals may need minor stabilization, medication adjustments, and access to social services, while others may experience treatment resistant psychosis who require a longer stay (between 3 - 6 months) at tertiary psychiatric facilities. Individuals with treatment resistant psychosis may be consistently experiencing visual or auditory hallucinations with limited relief from psychotic symptoms. Considering that the majority of individuals have a short-term acute stay on the adult psychiatry unit, there is an immediacy to start assessment and discharge planning as soon as individuals are admitted to the unit. My caseload would vary from week to week, from a minimum weekly average of four individuals to a maximum of six individuals on a caseload. In addition, I facilitated morning verbal support groups that focused on coping strategies, and relaxation therapy that covered guided imagery, progressive muscle relaxation, mindfulness relaxation, and grounding strategies, among others. The group therapy was not attempting to “fix” problems or delve into the past, but instead focused on social skills and problem-solving. My intention was to engage in activities that would challenge myself beyond my competencies, and open myself to supervision and feedback to improve practice in managing group sessions.

Practicum Setting

This paper describes a unique practicum experience on the Psychiatric Intensive Care Unit (PICU) and a general inpatient program in Prince George at the University Hospital of Northern British Columbia (Northern Health). There are two separate units on the adult psychiatry floor at UHNBC. Individuals admitted to the Psychiatric Intensive Care Unit (PICU) have safety risks for harming themselves or others, or being disruptive on the general
inpatient ward (Province of British Columbia: Ministry of Health, 2011). The PICU provides stabilization, containment, and observation in separate locked rooms on the general psychiatric inpatient unit (Province of British Columbia: Ministry of Health, 2011). During my practicum, a qualified registered psychiatric nurse supported and stabilized individuals admitted to the PICU. Social workers would have minimal contact with individuals in the PICU until a level of stabilization could be achieved on the unit, unless there is an immediacy to address social issues. Often patients in PICU can transition to a bed on the general inpatient unit. The general inpatient unit “encompasses all patients requiring psychiatric care who do not meet admission criteria for other specialized units” (Province of British Columbia: Ministry of Health, 2011, p. 16). The general inpatient psychiatric unit has 20 beds, a common area, recreational room, kitchen, group room, and a dining area. This general inpatient unit provides “concurrent, multidisciplinary assessment and treatment for people with psychiatric disorders as one component of a continuum of care” (Province of British Columbia: Ministry of Health, 2011, p. 16).

Adult psychiatry is an exclusive environment where the interdisciplinary teams attempt to “prevent health problems that have already emerged from developing into a worsened state” (Cowles, 2003, p.14). Admission to inpatient psychiatry occurs when community outpatient resources fail to address the acute and life-threatening symptoms (danger to self or others) of a mental health crisis (Munich & Greene, 2009). When a crisis occurs in the community, inpatient psychiatry acts as an emergency level of care for individuals with mental health issues, including concurrent issues with addiction. In this setting, social workers work alongside many professionals, often collaborating with nurses, physicians, psychologists, occupational therapists, and psychiatrists (Sederer, 2010; Toseland, Palmer-Ganeles, & Chapman, 1986). This increased level of collaboration among
health care practitioners promotes greater insight surrounding the multi-faceted needs of individuals with mental health concerns. The hope is to assess an individual’s biological, psychological, social, and family functioning so that interventions can empower clients toward a successful recovery in the community (Sederer, 2010, p. 293). There are many health care providers on the adult psychiatry unit that have a number of roles and responsibilities in providing support for individuals with mental health issues. According to Ovsiew and Munich (2009, pg. xi), acute inpatient psychiatry includes some fundamental principles:

- A comprehensive database: There are opportunities to gather detailed information about the patient in the Psychiatric Intensive Care Unit. A comprehensive database will help develop an understanding about which factors could have led to a mental health crisis, and compile missing information about the patients that was not previously known. In addition, this information assists in determining the accuracy of pharmacologic and psychological treatments and formal diagnosis.

- Continuity of care and discharge planning: This refers to the integration of inpatient care with the outpatient care to ensure that valuable information prior to and following admission to a psychiatric inpatient setting is a paramount consideration. Also, this involves developing a plan of care that takes into consideration the successful and ineffective interventions prior to admission and after treatment when the consumer returns to the community.

- An integrated team: Inpatient psychiatry care consists of an interdisciplinary team that provides various supports and services for the patient.

- Working with families involves attending to and resolving problems and recognizing
the strengths in the patient’s support community networks.

- Attention to meaning: This involves attempts to understand the patient to ensure that there is “improved specificity and acceptability of interventions in all treatment domains” (2009, pg. xi).

- Medical sophistication: Considering the challenges with general-medical illnesses and social/behavioral obstacles for care, the multidisciplinary team in inpatient psychiatry attempts to integrate the psychological, behavioral, psychopharmacological, general-medical, and neuropsychiatric care for the patient.

**Hospital and Psychiatric Social Workers**

The profession of medical social work in Canada was largely influenced by the United States, often sharing common theoretical/practice models and establishing similar professional associations and regulatory bodies (Lundy, 2011). In 1905, a nurse, Garnet I. Pelton was the first appointed medical social worker in the Internal Medicine Clinic at Massachusetts General Hospital (MGH) (Cowles, 2003). Ida Cannon then replaced Pelton, and became a prominent figure in the history of medical social work at Massachusetts General Hospital (Cowles, 2003). Initially, Cabot (as cited in Cowles, 2003) explained that medical social workers would remove social barriers to effective treatment. Cannon (as cited in Cowles, 2003) additionally stated that medical social workers modify the social, environmental, and psychological circumstances to hasten the recovery or reduce the barriers to recovery. In 1914, the growing interest in medical social work spurred the development of a social work program at the University of Toronto, including a sub-specialty medical social services training (Graham, 1996). The growth of social work services within hospital settings in Canada was notable, but the integration of social workers in psychiatric settings occurred at a later time.
Prior to the 1920s, there were no functional delineations between medical social work and psychiatric social work (Cowles, 2003; Grob, as cited in Stuart, 1997). After the 1920s, psychiatric social workers developed a further psychological understanding of the patient and aspired to provide direct treatment, as well as addressing social conditions that contributed to mental health issues (Stuart, 1997). In 1947, Mora Skelton was the first social worker at the Toronto Psychiatric Hospital, who focused on patient advocacy, social justice, as well as examining financial, housing, or employment pressures in the community (as cited in Regehr & Glancy, 2014). In 1952, Mort Teicher, the chief social worker at the Toronto Psychiatric Hospital, described that social worker’s focus on continuity of care, and assessing the patient’s and his/her relatives’ perspectives in relation to mental health treatment, as well helping individuals process feelings associated with hospital and clinical services (Regehr & Glancy, 2014).

Although psychiatric social work is a relatively new profession, there are many aspects of this field that continue to follow roles and responsibilities from early social workers. Currently, the Canadian Association of Social Workers defined three general functions for social workers working in mental health settings:

- Prevention: “aims to reduce the incidence of disease or dysfunction in a population through modifying stressful environments and strengthening the ability of the individual to cope. Prevention involves the promotion and maintenance of proper health through education, attention to adequate standards for basic needs and specific protection against known risks” (Canadian Association of Social Workers, 2011, Specific roles section, para. 2).

- Treatment: “aims to reduce the prevalence (number of existing cases) of a disorder or dysfunction and includes early diagnosis, intervention and treatment” (Canadian
Association of Social Workers, 2011, Specific roles section, para. 3). Social workers can act as primary clinicians, who can conduct assessments and family interventions, and develop plans with the family for aftercare (Munich & Greene, 2009; Sederer, 2010; Toseland, Palmer-Ganeles, & Chapman, 1986).

- Rehabilitation: “aims at reducing the after effects of disorder or dysfunction, and involves the provision of services for re-training and rehabilitation to ensure maximum use of remaining capacities by the individual” (Canadian Association of Social Workers, 2011, Specific roles section, para. 4).

Psychiatric social workers, like other professionals on an interdisciplinary team, possess knowledge and skills that are essential to meet the comprehensive needs of patients and successful reintegration into the community. Although there are many health care providers, social workers have more focused goals directed towards psychosocial assessments, discharge planning, and liaising with other government organizations/services, social and community resources, and family. In addition, social workers may facilitate individual or group counseling sessions to address a variety of concerns relating to individual or family supports. Additionally, social workers may arrange and participate in treatment or discharge meetings to ensure appropriate supports and services are set up in the community. The goal is to utilize an individual’s strengths and capacities to promote optimal functioning in the community to reduce recidivism and readmission to hospitals.
Chapter Four

Practicum Learning Contract

General Social Work Activities

During my practicum, I had the opportunity to complete many tasks within the adult psychiatry setting at UHNBC. Considering the number of responsibilities, I will be outlining the tasks that were most important in shaping my practice and learning experience. These tasks include many general activities, as well as specific goals stated in my practicum learning contract. Although some tasks were not in my learning contract, they were useful in providing knowledge and skills that are valuable for practice.

Shadowing and Supervision

One of the most important aspects of learning in a practicum setting was having a registered social worker as a practicum supervisor, and other healthcare providers to accomplish supervision and consultation goals. According to the Canadian Association of Social Work (CASW) Code of Ethics (2005a), competence in professional practice maintains that social workers “have a responsibility to maintain professional proficiency, to continually strive to increase professional knowledge and skills, and to apply new knowledge in practice commensurate with their level of professional education, skill and competency, seeking consultation and supervision as appropriate” (p. 8). This ethical value corresponds to professional obligations that social workers maintain professional knowledge and skills in the workplace. This goal included shadowing my practicum supervisor, and adjusting my practice as necessary.

From the beginning of my practicum, I was assigned an observational role in the process of delivering social work services and supports on the adult psychiatry unit. The main task of shadowing my supervisor, Kristine Henning, included observing psychosocial
assessments, witnessing what interventions are appropriate for patients and attending interdisciplinary team meetings and family/discharge meetings. These observational tasks set precedence about how to conduct oneself as a practicum student with clients and other healthcare practitioners. As the practicum progressed, I found myself completing more tasks independently, and obtaining a caseload of individuals that required social work supports. My practicum supervisor helped enhance my training through critical feedback when conducting social work assessments and interventions. This feedback helped support self-reflection about practice issues, case presentation, and potential ethical dilemmas. Taken together, I found that supervision and consultation were important in understanding the influence that social issues have on mental health functioning in the community.

In addition, I was able to attend weekly social work meetings at the hospital. Social workers attended this conversational meeting at a designated time to bring forward practice concerns, ethical dilemmas, case presentations, and other supervision questions. In addition, there would be speakers from different community organizations that presented new community resources and educational opportunities to further training. For instance, Service Canada provided information about a variety of Canada Pension Plan (CPP) income and disability assistance programs. The Community Care Centre in Prince George also supplied information about supports offered to individuals who are in need of immediate emergency resources. I found these regularly scheduled meetings with other hospital social workers important in providing a safe space for critical reflection about my practice.

**Standardized Charting System**

An important part of mental health and addictions services within Northern Health is the integration and standardization of mental health and addictions services within the current health care system. The SYNAPSE system provides comprehensive notes and
program referrals from a variety of community and inpatient mental health and addictions programs. Synapsee charting included documenting assessments, interventions, treatment plans, advocacy notes, multidisciplinary team and family meetings, among other tasks. Most importantly, this communication tool offered information sharing services between addictions and mental health programs. This system not only functions as a charting tool, but also waitlists and enrolls individuals to Northern Health mental health and addictions programs within the northern BC geographical jurisdiction. This charting system is important in addressing the integration of services, transition to supports, and collaboration among practitioners. I had the opportunity to complete SYNAPSE training and use the system as part of charting progress notes.

**Interdisciplinary Meetings**

I had the opportunity to participate in interdisciplinary team meetings on the adult psychiatry unit. The purpose of these interdisciplinary meetings is to update plans of care for individuals to provide quality healthcare and plans for discharge. These meetings included comprehensive team discussions about patient circumstances relating to medical, social, and functional issues. The psychiatric social workers provided an update about the progress towards resolving current social issues. These issues may include dealing with housing, financial, education, vocational, or transportation issues. Social workers also provided updates about referrals to mental health or addictions services throughout the province. Psychiatric social workers arranged family meetings to address any family concerns, and ensured any family supports are incorporated into the patient’s plan of care. During these meetings, I found it particularly easy to communicate the progress of social work interventions. Many other health practitioners (nurses, psychiatrists, occupational therapists,
etc.) recognize the importance of addressing social issues, and they respect the work that social workers do on the unit.

**Facilitating Verbal Support Groups/ Relaxation Groups**

There were plans to co-facilitate verbal support groups on the unit with my supervisor and a team leader, but these plans were changed due to time constraints and the demands of the psychiatric unit. As an alternative, I facilitated a number of verbal support and relaxation groups in the morning, with the clinician’s assistance. The goals of these verbal support groups were to practice verbal and non-verbal communication skills, learn how to manage a group session, and create a therapeutic learning environment. During these groups, I inquired about an individual’s recent struggles and how they dealt/coped with these struggles, and utilized suggestions and encouragement from other group members. Lastly, I shared inspirational quotes from philosophers or short stories that had therapeutic messages that focused on strength, self-esteem, healthy relationship, goals, patience, etc. From this, I prepared questions that would promote discussions with other group members about these topics. Another group that I facilitated on the adult psychiatry unit was the relaxation group, which involved guided imagery, progressive muscle relaxation, mindfulness relaxation, among others. I always received positive feedback from other clinicians and individuals about the group therapy sessions.

**Specific Goals: Practicum Learning Contract**

The practicum learning agreement reflects learning goals and objectives on the adult acute psychiatric unit in Prince George at the University Hospital of Northern British Columbia. The goals were initially developed and modified throughout the duration of the practicum.
Knowledge Development Goals

This practicum was a challenging, yet a rewarding undertaking that facilitated a number of goals relating to psychiatric social work. According to the CASW code of ethics, professional development is aligned with competence and quality social work practice informed by current theory, research, and techniques (Canadian Association of Social Workers, 2005a). Throughout my practicum, reading literature and attending workshops was an important part of learning related to adult psychiatry. One goal was to develop an understanding of mental health concerns, by reading journal articles, books, the Diagnostic and Statistical Manual (DSM) IV – TR (American Psychiatric Association [APA], 2000), and reviewing case information. I found that reviewing information in the DSM was important in developing a common “language” among many nurses, physicians, and psychiatrists about mental health issues. This DSM is a tool that is widely used in adult psychiatry, and many physicians and psychiatrists use this as a diagnostic tool and understand mental health issues as an “illness.” Due to the extensiveness, it is important that social workers understand the DSM manual in the mental health field as part of treatment and discharge planning.

Another goal was to develop an understanding of social, psychological, and health factors, and their interactions with an individual’s mental and physical health. I not only had discussions with my practicum supervisor, but also read literature relating to the social determinants of health and psychosocial rehabilitation. These discussions and literature provided an understanding about some of the social factors that are important over the course of treatment planning and how these factors are relate to community functioning and discharge planning. These professional development goals included a substantial critical reflection and self-corrective practice to ensure that individuals receive optimal social worker services.
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Knowledge of Northern Health Programs and Community Supports

As part of the learning agreement, it was important to develop an understanding of Northern Health inpatient and outpatient supports offered to service users and their families. It is clear that an individual’s physical and mental health is influenced by a variety of environmental and social factors. From this, access to services and supports can be helpful to address some psychosocial stressors that may contribute to an individual’s mental health capacities. As part of the evaluation, I compiled a binder of resources and supports that I found useful in addressing stressors in an individual’s life. In addition, my goal was to meet and arrange tours of a variety of resources to develop an increased knowledge of Northern Health Programs and community supports. This increased understanding of these resources was important to ensure appropriate continuity of care and discharge planning for patients accessing psychiatry services.

I was able to arrange a tour and gain knowledge about the following Northern Health community resources: three long term and short term supported or transition housing facilities and an outpatient treatment service. The long term supported/transition housing included Iris House and Urquhart residence. Iris House is a long-term specialized treatment and rehabilitation facility for individuals with mental health problems, designed to provide a variety of services with guiding psychosocial rehabilitation principles. Urquhart residence is another supported long term housing resource that provides assistance with daily living tasks and provides increased access to community resources. Another resource is Davis Drive, a short-term (3-4 week maximum) supported housing, which provides individuals with a smooth transition into the community by requiring assistance or monitoring from health care practitioners. For instance, patients may utilize this resource to address financial or housing concerns, transition to addiction rehabilitation programs, or address other medical concerns.
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(medication monitoring, transitional mental health assessment, among others. A social worker on adult psychiatry can provide recommendations to the psychiatrist for a referral to these facilities. Due to the limited number of beds in Iris House and Urquhart residences, and the long-term residency of these resources, there were no referrals made to these resources during the course of my practicum.

In addition, I had the opportunity to spend a few days with two Northern Health community programs: Community Outreach and Assertive Services Team (COAST) and Assertive Community Treatment (ACT). COAST is a resource that “provides comprehensive treatment for adults based on a psycho-social rehabilitation model with a DSM-IV diagnosis: Psychosis NOS; Schizophrenia; Schizoaffective disorder; Bipolar I and II; Co-occurring Substance-Related disorders; Developmental Disabilities above 70” (Northern Health, 2014). Assertive Community Treatment is where a multidisciplinary team provides continuous high-service outreach program for clients with severe and persistent mental health concerns that significantly impair their functioning in the community (Northern Health, 2014). The goal of ACT is to provide comprehensive supports and services that would relieve the use of general hospital psychiatric services, specialty hospital services, tertiary level services, or psychiatric emergency services (Northern Health, 2014). During my time at these two programs, I was able to shadow a social worker (ACT team) and a nurse (COAST) to gain an understanding about the outreach work that is provided for adults with mental health concerns and/or addiction issues. During my limited time at ACT, I was able to participate in medication outreach deliveries, multidisciplinary meetings, engagements with clients for counselling or life skills purposes, and supporting clients to access community resources/ vocational supports. At COAST, I was able to participate in outreach work that focused on client engagements for counseling and life skills purposes, supporting clients to access community
and vocational services, and multidisciplinary meetings. Although this list of activities is not indicative of the expansive roles and responsibilities, these tours were important in providing a better understanding of available community supports.

During my practicum, there were many referrals made to provincial tertiary acute beds that provide further assessment, stabilization, and treatments of individuals who may access mental health and addictions services. These referrals were made to tertiary resources, as primary care services (family doctors) and secondary care services (Prince George Hospital, ACT, COAST, etc.) were unable to meet an individual’s mental health needs due to the ongoing difficulties with treatment and management of mental health concerns in the community. For instance, the Hillside Center in Kamloops or the BC Psychosis Centre may be utilized for further diagnosis and medication clarification, stabilization, treatment, and rehabilitation strategies for community reintegration. Although I did not arrange tours of these tertiary resources, I did familiarize myself with these resources by health care provider inquiries and subsequent online research.

**Knowledge of Community Resources**

In addition, I was able to familiarize myself with community supports that provided a variety of mental health and addictions services. These resources included basic primary care services such as walk-in medical clinics and Central Interior Native Health Society. These primary care services are an important part of discharge planning to ensure that individuals followed up with physicians, which can proactively address any health or mental health concerns. As part of recognizing expanding community resources, I developed a pamphlet that provides information on Primary Care Homes (see Appendix A for more information on Prince George Walk-In Clinics and Patient Clinics). In this project, primary care homes are characterized as clinics within Prince George used to address needs for individuals who do
not have access to a family physician within the community. The purpose of this project was to provide information for follow-up in the community to address any medical concerns after being discharged from the hospital. The potential implications may lead to less pressure on acute hospital settings by addressing specific medical needs within the community.

I also arranged a tour of the Ketso Yoh men’s shelter, Active Support Against Poverty (ASAP), Activity Centre for Empowerment (ACE), St. Vincent De Paul Society, and Canadian Mental Health Association Connections Clubhouse. Touring these facilities allowed for greater appreciation and more effective utilization of these community resources.

I also utilized a variety of provincial and federal government programs, including provincial and federal programs such as income assistance, disability assistance, and employment insurance. It is important to recognize that this is not an exhaustive list of resources that I utilized during my practicum. In order to retain information about these resources, I compiled a resource binder that will help contribute to my future practice in the social work profession.

For individuals who requested access to community resources and services, I provided assistance with applications or advocated that the client should have access to specific community supports. Considering the nature of the acute psychiatric facility and individual’s mental health concerns, I adjusted my practice to meet the needs of the patient. Some patients required more assistance to access community resources while others were able to access community supports/service more independently. I made these adjustments to my practice dependent on the patient’s circumstances (social supports, mental health capacity, accessibility, etc.) and their desire to access community resources. From this, a social worker’s knowledge about community resources and supports are essential in navigating community services and supports.
Knowledge of BC Mental Health Act

Mental health policy is important in governing criteria for admissions, treatment, and discharge on adult psychiatry for individuals with mental health concerns. I planned to develop sufficient knowledge and understanding of the legislation that governs adult psychiatry admissions and discharges. During my practicum, I continually used the BC Mental Health Act (2005) as a reference, as sections of legislation would be relevant in many situations. I was able to review circumstances where individuals would be involuntarily admitted to the adult psychiatry unit, or when discharges include some mandatory conditions under the BC Mental Health Act. In addition, I often reviewed an individual’s rights under the BC Mental Health Act, attended review panel hearings (a right under the Mental Health Act) and developed an understanding of the process of determining an individual’s suitability under the BC Mental Health Act.

Communication, Assessments, and Interventions Skills

One of the primary goals was to develop effective communication skills by building rapport with patients through mutual trust and understanding. Effective communication could allow patients to share information openly about their circumstances, concerns, and feelings. To achieve this goal, I had to challenge some underlying “stereotypical” beliefs that would have clearly influenced my working relationships with individuals with mental health concerns. Admittedly, I knew that there are many inaccurate assumptions portrayed in the media, but I still had reservations due to the widespread message in the news and media. In media, individuals with severe mental health concerns are often portrayed as “confused,” “aggressive,” “dangerous,” and “unpredictable.” I knew that I would have to include this goal as part of my practicum as I did not want this inaccurate assumption affecting the therapeutic relationship. I was able to identify and challenge beliefs through education and
working directly with individuals with mental health. As a result, I was able gain an understanding that mental health issues are a struggle in an individual's life, rather than having individuals characterized by the media in negative terms. From this, I found that taking a non-judgemental stance is important in developing an appreciation of the patient's circumstances, and expressing a genuine intention to provide support.

Another goal was to conduct assessments effectively to provide direction about which community services and supports would be suitable options for appropriate intervention. Prior to meeting to an individual, I would often review an individual's medical file to obtain information relevant to social work interventions. This medical file information may be received from allied health progress notes, nurses' notes or doctor consultations. For instance, a psychological assessment may determine an individual's eligibility for services available through the Brain Injured Group (BIG) or Community Living British Columbia (CLBC), or a psychiatric diagnosis may determine eligibility for federal or provincial disability programs. In many cases, this information from a medical file is important in complementing social work assessments. In other cases, information gathered from other assessments may be important to revisit due to missing information or perhaps an individual's circumstances in the community may have changed. After reviewing the information, I was expected to meet with patients to assess which services were needed as part of their discharge plan.

After I completed social work assessments, I always had my practicum supervisor review the assessment information and ensure that all relevant information was collected for social work interventions. After suggestions from my supervisor, I was able to adjust my practice to include new information that I previously did not ask during the initial assessment. In addition, there can be challenges when conducting assessments or
Interventions on the inpatient psychiatry unit. It is important to ensure that individuals are healthy enough to answer questions. For instance, an individual may not be able to complete the assessment in one 60 minute meeting due to specific mental health issues. Individuals may be experiencing a lot of stress or anxiety, or may be too overwhelmed by hearing voices or delusional beliefs that result from schizophrenia. As a result, social workers may have to make changes to their practice to complete an assessment with shorter time intervals or wait until the individual’s mental well-being is more stable. Taken together, the goal of assessment and intervention planning is to provide relevant supports and services to prevent future hospital admission and assist with adequate psychosocial functioning in the community.
Critical reflection includes assessing underlying values, assumptions, ideologies, and theories/models that help develop the characteristics of social work practice (Heinonen & Spearman, 2006). During my practicum, critical reflection was an important part of continuous learning on the adult psychiatry unit. There are many demanding tasks that involve difficult human interactions with individuals who were involuntarily admitted under mental health legislation. There are other challenges associated with a diverse value system; specifically the interplay between personal values, group values, societal values, and agency values. Healthcare practitioners can have distinct personal values, which can influence the delivery of health care services. As a result, there can be disagreement between values, which often evokes personal feelings associated with situations in the healthcare sector. Also, helping professionals develop an image shaped by an ideological lens, and this image (interpretation) shapes perceptions and interactions with people in society (Heinonen & Spearman, 2006). Ideological lenses can vary between physicians, nurses, occupational therapist, and social workers. For instance, some healthcare practitioners may value the diagnosis and treatment (medications) approach to mental illness, while other practitioners may value interventions focused on addressing social factors that led to a mental health crisis. Yet other practitioners may rely mainly on medications when a crisis arises, instead of encouraging the client to use coping skills to get through the crisis. A personal value reflects an individual’s belief system that is desirable and valuable (Heinonen & Spearman, 2006). Personal values implicitly influence the ethical decision-making process, as well as explicitly influence overt stereotypes and biases (Frankena as cited in Dolgoff, Loewenberg, & Harrington, 2009). In addition, individuals seeking mental health and addictions services
may have personal values, which may not align with healthcare practitioners' values. Lastly, there may be overarching societal, political, and organizational/agency values in policies, legislation, and cultural norms. The diagram below illustrates the complexities of competing values that could occur in the social work profession.

\[\text{Figure 3. Competing Values within the Social Work Profession}^{3}\]

The goal to develop self-awareness through critical reflection is important, as many

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\(^3\text{Figure 3. From "Values and ethics in social work," by C. Beckett & A. Maynard, 2013, International Journal of Health Promotion and Education, 21, p. 51. Copyright 2015 by Chris Beckett and Andrew Maynard. Reprinted with permission by A. Maynard.}\)
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experiences and personal background are important in shaping beliefs and behaviors. The following sections will explain specific critical reflection tasks and how social workers experience many real difficulties resulting from these differences in value locations and ideologies.

**Personal Values**

From September 2004 to September 2014, I worked in a variety of social services sectors including working with youth, adolescents, and adults with mental health and addictions issues. Working with these mental health and addictions community-based organizations included working with people with Autism Spectrum Disorder, Fetal Alcohol Spectrum Disorder, Obsessive Compulsive disorder, and co-occurring addictions, among others issues. My previous employment opportunities taught me to appreciate the importance of community resources, and the contributions that frontline workers make to individuals and society in general. At the same time, I have come to appreciate the importance of advocating for improved social supports, as well as focusing on capacities and strengths as important determinants of an individual's functioning in the community. In addition, my educational experiences include psychology that focuses mainly on individual behavior and internal thoughts and feelings, and social work that focuses on the individual within the context of a broader social environment. The combination of these education experiences contributed towards a perspective that uniquely addresses the importance of how social/ contextual influences affect an individual’s behavior, thoughts, and feelings.

In regards to mental health issues, I do not have any known extended family members that have a mental health history. On the other hand, I had previously experienced a tragedy when I was ten years of age that included burns to 25% of my body. During my time in the hospital, I was under significant duress and required morphine (IV drip) to manage pain.
resulting from the burns. Morphine can have psychiatric side effects including thinking disturbances, psychosis, and hallucinations (Drugsite Trust, 2014). From this hospitalization, I remember experiencing auditory hallucinations of buzzing flies, and tactile hallucinations of flies crawling on my face. Although my mother attempted to verbally challenge these thinking disturbances, it was hard to accept beliefs and thoughts other than my own. I understand that these experiences have impacted the way I perceive and interact with others who have mental health concerns. As a result of my personal experiences, I always strive to be non-judgmental, open, and respectful in social work practice. The next section will examine societal influences on practice, and strategies I utilized within my practicum setting to resist such widespread beliefs.

Group Values

Group values are important to recognize in practice, as there are diverse values among different groups that have diverse cultural standards and beliefs. During my practicum, I encountered many individuals from different cultural and religious backgrounds, equaling individual differences in regards to beliefs and behavior. Although I hold no religious beliefs, I found the strength that religious affiliations can have for some individuals functioning in their community. These beliefs can be a source of strength when coping with mental health concerns or issues. It is important to recognize cultural differences, as there are stark differences when comparing an individualistic or collectivist culture. These cultural differences have important implications in social work practice. Throughout my life, I grew up valuing a sense of independence in my decision making and behaviors. Independent values hold that individuals must find their path, and make decisions that promote the right of the individual. However, many collectivist cultural groups favor interdependence among their members through loyalty, dependence, and connection to the group (Dolgoff,
Loewenburg, & Harrington, 2009). For instance, an Indigenous model of mental health and healing emphasizes the importance of community, as well as developing relationships with family, community, and community to community (Stewart, 2008). This Aboriginal understanding of mental health and health is different in comparison to the western perspectives of mental health. As a result, it is important for social workers to promote self-determination of individuals that have different worldviews and perspectives.

**Differences in Professional Ideologies**

An “Ideology shapes values, and assumptions about social issues and how they affect people, and the public provisions that are necessary” (Heinonen & Spearman, 2006, p. 31). Interdisciplinary teams work together from different professions in order to provide quality care to patients. Despite the advantages of providing well-rounded care, there may be some challenges and contention associated within each profession. The move to integrating services involves practicing with interdisciplinary teams that may operate from different ideologies and theoretical frameworks related to their field of specialty. Different professions come together with different beliefs and knowledge about mental health concerns.

The hospital psychiatry unit dominantly operates from a disease or medical model when understanding and responding to mental health issues. This not to say that there is ignorance of social and psychological factors associated with mental distress, but rather mainstream approaches have highlighted a diagnosis of mental illness and pharmacological interventions. Psychiatrists often define people as “patients” with observations of behavior and emotions, identification of pathological symptoms, and prescribing the appropriate treatment (Heinonen & Spearman, 2006). In addition, current mental health policy outlined in provincial legislation reflects the medical model, which outlines guidelines for admission and treatment of mental health disorders. The principles of the medical model co-occurs with
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the Diagnostic and Statistical Manual of Mental Disorders IV – TR (American Psychiatric Association, 2000), which is a diagnostic and classification system that provides a psychiatrist with an understanding about the symptoms of a mental illness. Coppock and Dunn (2010) discussed that the DSM is constantly under negotiation and changes over time that suggest that understanding of mental health is occasionally under the influences of social, cultural, and political contexts. Since the release of the DSM-I in 1952, the number of disorders has significantly increased to 374 in DSM-IV-TR, the disorder of “homosexuality” as a disorder has been eliminated, and “a religious and spiritual problem” has been added in the DSM – IV (Coppock & Dunn, 2010). In addition, with the new release of the DSM – 5 there have been changes to eliminate, substitute, or add mental disorders, following suit with previous versions. Another significant development in the DSM-5 is that less emphasis is put on social processes, while there is an increased emphasis on biological factors that contribute to an individual’s mental health capacities. As a result, primary care physicians that practice from a medical model tend to provide services that are restrictive in addressing the complex health concerns of patients (Arnett, 2006; Berkman, 1996). Social workers operate from a psychosocial model that attempts to improve environmental conditions such as, socio-economic status, housing, ethnicity, gender, age, as well as other factors. (Arnett, 2006; Cates, as cited in Haddock, 2009). Social workers address these psychosocial and environmental issues as a focus on early interventions that may lead to complex health issues (Berkman, 1996). The mental health system can be devalued at the expense of an overreliance on the medical/disease model.

Although the medical profession endorses a dominant medical model, there is an increased recognition among many health care professionals about the importance of social and environmental factors on an individual’s health. During my practicum on the UHNBC
adult psychiatry unit, there was intent from other health practitioners to include input from
the social workers in all discussions about patients. On many occasions, psychiatrists and
nurses would recognize the importance of addressing social or environmental factors in the
community, as part of treatment and discharge planning. Although health practitioners can
endorse an ideology, it is important to recognize the challenges that social workers face when
a system dominantly values an ideology.

Societal Values

It is clear that individuals with mental health concerns have to cope with many real
difficulties. An individual with depression may have to deal with feelings of sadness, low
energy, or loss of interest in usual daily activities. An individual with schizophrenia may
have to deal with psychotic symptoms of visual or auditory hallucinations and delusional
thinking processes. Along with real difficulties associated directly with the mental health
issues, there are many social stigmas associated with mental health issues. It is important to
recognize that those with mental health issues can be productive members of society, rather
than relying on negative, biased understandings of mental health.

Stigma refers to negative, unfavorable attitudes and the behavior they produce. It is a
form of prejudice that spreads fear and misinformation, labels individuals and
perpetuates stereotypes. Stigma against people with mental illnesses is oppressive and
alienating; it prevents many from seeking help, denying them access to the support
networks and treatment they need to recover (Mental Health Commission of Canada,
2014).

Many individuals in society have negative and skewed representations of individuals
living with mental health concerns. The mass media often portray individuals in movies,
books, or the news on the basis of false assumptions for the purpose of entertainment and
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pleasure. This image may be reinforced by the messages that we receive from friends and family, or modern culture in general. What many individuals in society do not understand is that there are devastating implications resulting from these negative stereotypes. As a result, there is a stigma that is attached to mental health concerns, as well as animosity when reaching out for help from family, community, or healthcare supports.

Many widespread stereotypes of individuals with mental health issues often lead to discrimination. This discrimination could include withholding a job, excluding individuals from services and supports in the community, and limiting housing or educational opportunities. In addition, there may be additional consequences of decreased self-esteem, lower confidence, and increased risk for depression. As a result, individuals with mental health concerns may be less inclined to seek assistance due to the stigma associated with negative stereotypes, prejudice, and discrimination. It is important to understand the impact that discrimination has on people as well as to assess the origin of stereotypes. McKeown and Clancy (as cited in Anderson, 2003) assert that media representations have a significant impact on the perceptions of people with mental health concerns. Mass media stereotypes associate individuals with mental health concerns as “confused,” “aggressive,” “dangerous,” and “unpredictable,” but research indicated these are inaccurate representations (Wahl, 1992). Currently, mental health issues are often portrayed in the news through stories of violence, creating a reaction based on inaccurate generalizations. In reality, representations of violence among individuals with severe mental health concerns are rare (Mayville & Penn, 1998). Given the devastating consequences, it is important for healthcare workers to utilize approaches that help reduce the stigma associated with severe mental health concerns.

There are many biased stereotypes in society about people with mental health concerns, and this perception can influence the quality of services that individuals receive
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from healthcare practitioners. Considering that there is significant conflict between societal stereotypes and the nature of social work, it was important to engage in critical reflection tasks and actions that do not reinforce stereotypes. Throughout my practicum, I had to examine the validity of these dominant assumptions and beliefs, and recognize the importance of resisting these assumptions when working with individuals with mental health concerns. Mayville and Penn (1998) examined a number of strategies that help reduce the stigma associated with these aforementioned stereotypes. Education through a variety of mediums under certain circumstances can change attitudes and behaviors about severe mental health concerns (Mayville & Penn, 1998). As a result, I would examine literature about accurate knowledge that would enable more respectful and effective interactions with individuals that have mental health concerns, rather than relying on false stereotypes that portray individuals in a negative light. Another strategy that helps reduce negative attitudes is increased interpersonal contact with individuals with mental health concerns (Mayville & Penn, 1998). Throughout my practicum, I had the opportunity to work directly with individuals through conducting social work assessments and interventions to challenge and resist dominant stereotypes. Lastly, “Value Self-Confrontation” is an important principle that allows individuals to reflect on how stigma-related attitudes may conflict with endorsed values (Mayville & Penn, 1998). After further reflection, my personal and professional values that endorse equality, integrity, and nonjudgemental beliefs conflict with the inaccurate, stigma-related assumptions that are often portrayed in the media. Altogether, the promotion of personal contact, education directed towards the issues of violence, and the value-confrontation activity were important suggestions to challenge stereotypes associated with individuals with mental health concerns.
Social Work Ethical Framework in Mental Health

Many healthcare professionals such as physicians and nurses all have their codes of professional ethics, as do social workers. The important values that guide social work practice are addressed in professional ethics. The Canadian Association of Social Workers (2005a) Code of Ethics guides social workers’ conduct and decisions in their professional and personal lives. These ethical codes of conduct include:

1) Respect for the inherent dignity and worth of persons
2) Pursuit of social justice
3) Service to humanity
4) Integrity in professional practice
5) Confidentiality in professional practice
6) Competence in professional practice

Many of these CASW ethical values are similar to the BC Association of Social Workers (BCASW) Code of ethics. For instance, the BCASW code of ethics (2009) involves maintaining the best interest and respecting the intrinsic worth of the client, practicing with integrity and objectivity, upholding competence, confidentiality, and excellence in practice, and advocating for change in the client’s best interest and overall benefit of society.

Throughout my practicum, many situations arose where professional ethics provided clarity about specific practice situations. There are unique situations that arise on the adult psychiatry unit that are not similar to situations that occur in community programs. The adult psychiatry unit is an environment where individuals are involuntarily admitted to a unit that provides stabilization, assessment, treatment, and discharge planning. Individual confidentiality may be at risk considering issues with safety. Or there may be social justice issues resulting from lack of resources that may effectively address an individual’s basic
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needs in the community post-discharge. For these reasons, it is important to be aware of the challenges that can potentially arise within psychiatric social work, and take appropriate actions to deal with these issues.

**Respect for the Inherent Dignity and Worth of Persons**

Considering that mental health issues affect individuals from different cultures and backgrounds, it is important to respect diversity and unique beliefs in practice. This includes showing a greater appreciation and understanding for diverse worldviews and values, developing an awareness of personal assumptions and biases, and utilizing appropriate skills to work with diverse populations (Sue & Sue, 2013). There are many distinct beliefs that arise from different cultures, families, groups, and communities that set individuals apart from the dominant western culture. For instance, the beliefs among many Aboriginal cultures may be in stark contrast to the understanding of mental health in Western European Culture. ‘Healing’ is associated with performing Aboriginal traditions or ceremonies, and utilizing a collective supportive network within the community as a form of healing (Stewart, 2008). Or many individuals may find strength in prayers or meditation associated with a particular religion, as a way to work through mental health issues. For these reasons, it is important to become aware of my own biases and values as there can be difference in beliefs and values, and respect these differences that other people have in their life.

In addition, this value comprises respecting an individual’s right to make voluntary, informed choices, consistent with that person’s capacity and the rights of others (Canadian Association of Social Workers, 2005a). Although individuals can be voluntarily admitted to the adult psychiatry unit, there are instances when social policy and legislation would limit an individual’s self-determination. For instance, individuals admitted to an adult psychiatric unit may have risks associated with mental or physical deterioration, or safety issues relating
to a person’s own protection or the protection of other people (British Columbia Ministry of Health, 2005). As a result, individuals can be ‘certified’ by a psychiatrist or physician as an ‘involuntary’ patient and receive compulsory treatment, under the British Columbia Mental Health Act (2005). As a result, The BC Mental Health Act procedures may clash with an individual’s right to make their decisions. Considering limits to self-determination set by legislation, it is important for social workers to negotiate and attain as much self-determination as possible (Canadian Association of Social Workers, 2005b). There may be some ambiguous feelings and reservations in developing trust with healthcare providers. Psychiatric social workers often have to work within these contexts and attempt to develop a trusting, therapeutic relationship. Social workers can discuss the legal rights under the Mental Health Act, and empower individuals to access supports and services in the community that allow a greater degree of self-determination. Promoting self-determination may involve notifying and involving the client of decisions made about their treatment and discharge planning, and advocating for any reasonable requests with the psychiatrist, nurse, or clinician.

There are other systemic limitations extending from social welfare policy where it is difficult to support an individual’s self-determination. Adult psychiatry is an acute facility where many patients are admitted for a short duration, typically a few days to a few weeks. Psychiatric social workers and the client may have to set priorities about goals, and ensure there is appropriate follow-up in the community. Considering the lack of resources, it is important for psychiatric social workers to connect individuals to a variety of community and non-profit supports. Individuals spending the majority of their income assistance on shelter are often left with inadequate finances for food, transportation, childcare, clothing, etc. Individuals that cannot find affordable rental units may have options of rooming houses or
shelters, which are considered to be inadequate. Clearly, this lack of resources and supports makes it difficult for individuals to be self-determining.

**Pursuit of Social Justice**

Although there was no organized action that took place during my practicum to improve services to clients, this value was very much on my mind. Northern Health is a very good organization that provides access to mental health and addictions services regardless of income level, gender, education, or any other factors. However, there are many systemic setbacks that make it difficult for many individuals to maintain a sufficient quality of life. From a psychosocial approach, social factors are an important component in addressing an individual’s mental health. The biggest challenge as a practicum student was lack of public policy that covers affordable housing, sufficient income to meet basic needs, access to transportation, and other social/environmental supports. In many cases, many individuals remain in poverty, and have a lack of equal opportunities, and experience discrimination. Although these ethical issues arise within certain political contexts, critical thinking and creativity is an important part of practice. This involves finding creative ways to ensure that individuals would have access to community resources that provide shelter, food, clothing, transportation, etc. In addition, I would strive to ensure those clients are aware of existing legal and social rights to empower individuals to make decisions within the current socio-political context.

**Service to Humanity and Integrity in Professional Practice**

According to the CASW (2005a) Code of Ethics, social workers must prioritize needs of clients by focusing on their goal development and pursuit, and advocating towards a progression of a just society. During my practicum, I found it integral to work collaboratively with other professionals, but also holding the client’s needs above any other
self-interest. In addition, social workers must maintain the integrity in professional practice by acting impartially in practice and resisting the imposition of personal values on clients (Canadian Association of Social Workers, 2005b).

**Confidentiality in Professional Practice**

Considering the involuntary nature of adult psychiatry, social work practitioners attempt to establish a trusting and confident working relationship. Setting expectations about confidentiality is one way to develop trust and giving control back to the individual about what information can be shared to specific people. The value of confidentiality involves respecting an individual’s decision to withhold or disclose information pertaining to the delivery of social services as a way to develop trust and confidence (Canadian Association of Social Workers, 2005a). Social work practitioners should inform individuals about their obligation to confidentiality, as well as the exceptions and limitations. Under some compelling reasons, social workers have an ethical obligation to disclose information to appropriate authorities. These exceptions to confidentiality include knowledge of immediate and foreseeable harm to self or others, information about child abuse or a law or court order (Canadian Association of Social Workers, 2005b). There are many instances on the adult psychiatry unit when third parties (including family members, friends, or relatives) requested information about an individual, but only specific information can be released based on detailed criteria. Health practitioners should attempt to receive consent to release of information from the individual accessing psychiatry, or according the *Freedom of Information and Protection Act*, health practitioners employed by a public body may release personal information for the purpose of “continuity of care” in the best interests of the health of the client. (British Columbia Ministry of Health, 2005). For instance, friends or family members may request pertinent information about a patient, only if the information is
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essential to improving individuals’ functioning in the community. On the other hand, there would be instances when the Royal Canadian Mounted Police (RCMP) would request specific information about a client, but I would not be able to reveal any information due to no consent to release information, and these requests do not meet the requirements for continuity of care under *Freedom of Information and Protection Act*.

**Competence in Professional Practice**

The Canadian Association of Social Workers (2005b) described that competence in professional practice corresponds to the ability to conduct assessments and encourage innovative and creative interventions to meet the client’s new and existing needs. A competent social work practitioner pursues ongoing knowledge and skill development and seeks appropriate supervision and consultation (The Canadian Association of Social Workers, 2005b). This value was an important part in deciding to complete a practicum on adult psychiatry at UHNBC. With appropriate consultation and supervision, I was able to learn relevant knowledge and practical skills. In addition, I would attend educational seminars, participate in weekly social work meetings, and engage in any learning opportunities in the community and hospital. Similarly, the BC College of Social Workers (2013) exemplify competence in professional practice through a number of professional development expectations as part of ongoing renewal of registration. These expectations include pursuing activities that enhance quality and delivery of services, develop social work ethical conduct, advance professional skills and knowledge, develop practices that maintain positive outcomes for individuals accessing services, maintain and report continuing development activities, and provide any documentation for auditing and review process (BC College of Social Workers, 2013). As part of this integrative practicum report, the hope is to demonstrate the ability to demonstrated continuing professional development within the
social work profession.

**Service Users’ Values**

Mental health issues affect individuals from different socioeconomic backgrounds, culture, age groups, and genders. In addition, there may be a number of issues that co-occur with mental health concerns, such as addictions, housing, education, or transportation issues. Considering this diversity, it is important to understand that individuals accessing mental health services may have different values and beliefs from our own. Learning about individual differences is important to ensure appropriate collaboration when delivering healthcare services. Considering these individual differences, it is important for social workers to not ignore the client’s value base.

Often social workers need to ensure that patients have adequate supports and services arranged in the community upon discharge. I found myself making assumptions about what social services the patient needs to be successful after discharge. However, some individuals may not desire to utilize specific services and supports in the community. For instance, some individuals may have co-occurring mental health and addiction issues. Even though addictions recovery is an important part of future mental stability, the client may not necessarily value this support for addictions treatment. Despite the clashes in values, it is important to respect clients’ values and the right to self-determination. According to professional ethics, social workers must support self-determination and autonomy, and encourage individuals in making informed decisions (Canadian Association of Social Workers (CASW), 2005a). The CASW emphasized that self-determination refers to the right to self-direction and freedom of choice without interference from others. The client is an active participant in organizing resources and supports, and the social worker may make suggestions and empower the client to complete tasks. As a result, social workers’ values are
not superior, but instead the clients' preferences include a degree of choice and control to
meet their stated goals.

Practice Models and Theories

Considering that there are diverse and complex practice situations, I find that there
are many important practice models and theories that guide practice. Depending on the
practice situation, one perspective or theoretical position may be more influential in guiding
practice than others. The goal of a practice model is to suggest that there are models of
practice that produce improved outcomes. These outcomes can be individual, community, or
organization/political change.

Psychiatric Rehabilitation (Psychosocial Rehabilitation)

In the context of mental health, psychiatric rehabilitation is a recovery orientated-
model important in promoting functionality in the community. This recovery model
emphasizes an inherent belief that individuals can and do recover from mental health issues,
with focus on hope and strength as components to facilitating this recovery (Regehr &
Glancy, 2014). Increasingly, there is an emphasis that solely medical or treatment models are
insufficient in addressing individual’s rehabilitation outcomes and promotion of mental
health. During the era of deinstitutionalization, there was a belief that drug therapy could
eradicate mental health issues by reducing psychiatric symptoms, decreasing the use of
physical restraints, and increasing time spent in therapeutic activities (Anthony, Cohen, &
Farkas, 1990). There is considerable evidence that drug therapy solely does not increase an
individual’s strengths and assets, and benefits received from inpatient therapies do not
reliably predict positive rehabilitation outcomes (Anthony, Cohen, & Farkas, 1990). On the
other hand, research associated with skills development and community supports are
associated with positive rehabilitation outcomes for individuals with severe psychiatric issues
INTEGRATING THEORY

(Anthony, Cohen, & Farkas, 1990). Although the medical model holds significant priority in the hospital environment, recovery perspectives that focus on building skills and adapting to the environment that promote well-being are increasingly important in mental health practice.

Psychosocial rehabilitation is a recovery-orientated model to strive towards in practice. Recovery “is a way of living a satisfying, hopeful, and productive life even with limitations caused by the illness” (Mental Health Commission of Canada, 2006, pg. 42). Psychosocial rehabilitation involves an emphasis on involving adults with severe mental health issues by supporting skills development and environmental supports that help manage their symptoms and build on their strengths and capacities (Anthony, Cohen, & Farkas, 1990). According to Anthony, Cohen, and Farkas (1990), psychosocial rehabilitation principles include:

1) The primary focus of psychiatric rehabilitation is on improving the competencies of persons with psychiatric disabilities.

2) The benefits of psychiatric rehabilitation for the clients are behavioral improvements in their environments of need.

3) Psychiatric rehabilitation is eclectic in the use of a variety of techniques.

4) A central focus of psychiatric rehabilitation is on improving vocational outcome for persons with psychiatric rehabilitation.

5) Hope is an essential ingredient in the rehabilitation process.

6) The deliberate increase in client dependency can lead to an eventual increase in the client’s independent functioning.

7) Active involvement of the client in their rehabilitation process is desirable.

8) The two fundamental interventions of psychiatric rehabilitation are the
development of client skills and the development of environmental supports.

9) Long-term drug treatment is an often necessary but rarely sufficient component of a rehabilitation intervention.

Some psychosocial-orientated components include a person-centred approach, holistic views, and a strengths-based perspective. A person-centered approach recognizes the importance that people are essentially trustworthy, have the potential to understand their own issues, and are capable of self-directed growth (Corey, 2009). This approach corresponds with social work values that emphasize self-determination, and developing a non-judgemental, trusting, and respectful relationship with individuals accessing mental health services. Hostistic approaches acknowledge the importance of recognizing the whole person in the recovery process, including social, mental, physical, emotional, biological, and environmental factors that influence mental health. Lastly, a strengths-based perspective focuses on an individual’s strength rather than deficits, helps people find solutions to problems, and emphasizes self-determination through personal growth and development (Heinonen & Spearman, 2006).

Despite the need for additional community support in Prince George, there are some distinct social rehabilitation programs that focus on changing societal perceptions about an individual’s ability to be successful and satisfied in the community. For instance, Northern Health has identified psychosocial rehabilitation as a quality of care for individuals with mental health issues. Psychosocial rehabilitation is observed through Northern Health partnerships with organizations in the community (Connections Clubhouse) and other Northern Health programs and supports, such as Assertive Community Treatment (ACT), Community Outreach and Assertive Services Team, and Northern Health supported living arrangements. Connections Clubhouse is operated by Canadian Mental Health Association,
which provides skill development and employable services through Two Rivers Catering Company for individuals living with mental health concerns. In addition, Iris House (operated by Northern Health) provides paid employment, which teaches individuals skills related to janitorial services. Lastly, the ACT team connects individuals to access a variety of employment-related opportunities that support skill development and paid employment. Ultimately, vocational activities are an important perspective towards rehabilitation.

Psychiatric social workers should be aware of psychosocial rehabilitation values and principles as they are an important part of discharge planning and community referrals for individuals with mental health concerns. This involves focusing on individual's strengths and capacities, while resisting the negative stigmas associated with mental illness, and holding a sense of hope and optimism in an individual's recovery from mental health issues. In addition, accessing a variety of community supports and services is essential to ensure that there is choice in the most beneficial services. Due to current social and political realities, availability of community supports may be limited in providing individualized services.

**Conclusion**

I know that my personal and work experiences impact the way that I work with individuals with mental health issues, and within the psychiatry unit. Although personal values do influence my personal practice, it is important to manage my personal values in a way that does not interfere with the client's values or professional social work ethics/standards of practice. I acknowledge that my own personal and work experiences did influence my decision to pursue a practicum within mental health and addictions services, and a need for a further examination of how psychosocial needs are addressed within our healthcare system. I was aware that the current health care system is predominantly influenced by the medical model, which further influenced my decision to obtain a practicum
at the hospital. My hope was to develop an understanding of how social workers practice
within a context where there is a conflict in ideologies and values locations. Along with the
influence of personal values, many situations arise in practice where decisions and conduct
are guided by professional ethics.
Chapter Six

Conclusion

I can say that this practicum included many challenging, yet rewarding tasks within a large healthcare system. I thoroughly enjoyed the practicum at UHNBC, and respected the learning opportunities that were presented to me. This opportunity to participate as a social work practicum student at UHNBC Northern Health was an exciting and novel experience for me. Throughout my practicum, I had the opportunity to familiarize myself with mental health and addictions community resources and supports and shadow a social worker on the adult psychiatry unit. This practicum included prospects of learning new practical skills, developing critical thinking skills, and specializing my scope of practice within the mental health and addictions field. In addition, researching relevant mental health literature provided an educational backdrop for enhancing cultural competency, practical skills, relevant mental health and addictions models, and literature pertaining to mental health issues. Kristine Henning and her mentorship style was particularly important in facilitating learning the roles and responsibilities of a psychiatric social worker. Most importantly, this learning environment allowed me to provide input within the interprofessional team with acknowledgement of the holistic needs of individuals. I learned a lot from healthcare practitioners, but also I learned a lot about myself and how I can engage in critically reflective thinking to adjust my practice. Most importantly, I was able to learn how to support self-determination for individuals with mental health issues and how this can be an important part of practice. Overall, this practicum helped build knowledge and skills necessary for my career in the mental health and addictions field.

Through my involvement on the adult psychiatry unit, I hope to continue to develop my skills and learn new knowledge. This experience was a starting point in working within a
field that promoted client-centered service. In the future, I hope to develop more skills that can help promote change within a healthcare system to further develop supports and services for individuals with mental health and addictions issues.
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References


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HealthAddictions.aspx

Retrieved from http://www.northernhealth.ca/YourHealth/MentalHealthAddictions/ProgramDescriptions/AssertiveCommunityTreatment.aspx


Appendix 1

Prince George Walk-In Clinics and Unattached Patient Clinics 2013-2014

Primary Health Care
Primary health care providers are the first people you see when you access the health care system:

Primary Health Care is about:
• Helping people avoid getting sick or injured
• Managing chronic conditions like diabetes or high blood pressure
• People playing an active role in their care
• Making the most effective use of care providers' expertise
• Efficiency and coordination
• Understanding that factors outside the health care system can influence health

Benefits of Primary Health Care:
• Provides continuous, coordinated, comprehensive care for the "whole person"
• Helps keep wait times and waiting lists down
• Reduces pressure on emergency room
• Makes the health care system more sustainable in the long term

Dental Outreach Clinic
If you are unable to afford dental treatment and/or are experiencing dental pain or infection call 250-613-7246 (PAIN) for more information on this non-profit clinic.

University Hospital of Northern BC
1475 Edmonton Street
Prince George, BC
V2M 1Z2
Phone: 250-565-2000
Fax: 250-565-2343

Northern Interior Health Unit
1444 Edmonton Street
Prince George, BC
V2M 6W5
Phone: 250-565-7311
Fax: 250-565-6674

Northern Health Centre for Healthy Living
(community health programs)
1788 D'efenbaker Drive
Prince George, BC
V2L 4V7
Phone: 250-649-7011

Northern Health
the northern way of caring
northernhealth.ca
11-140-6011 (MB 0114)
Walk-In Clinic: Non Emergent Care Clinic

*First Come, First Serve: No appointment required**

Nechako Medical Clinic
761 Central Street W (Spruceland Shopping Centre)
250-563-3399
http://find.healthlinkbc.ca/

Hours of Operation
Monday - Wednesday: 4 pm - 9 pm
Thursday and Friday: 1 pm - 9 pm
Saturday: 9 a.m. - 7 pm
Sun. and Stat Holidays: 10 am - 7 pm

"Hours are subject to physician availability and patient volume, please call prior"

Non-emergent walk-in clinic. Non-emergent care provides access to advice, assessment and treatment for minor illnesses and injuries such as minor infections or skin complaints. Other services include medication prescriptions. Located near a pharmacy.

With HealthLink BC, British Columbians have trusted health information at their fingertips by phone or web. Call 8-1-1 from anywhere in British Columbia to speak with a nurse any time of the day or night. On weekdays, you can speak to a dietician about nutrition and healthy eating. At night they have pharmacists available to answer your medication questions.

Online at www.healthlinkbc.ca you will find medically-approved information on more than 5,000 health topics, symptoms, medications, and tips for maintaining a healthy lifestyle. You can also search the online Directory to find health services near you.
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Dustin Pickens <dpickens1984@gmail.com>

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4 messages

Dustin Pickens <dpickens1984@gmail.com> Thu, Feb 12, 2015 at 8:44 AM
To: cbrice@phsa.ca

Hello Cindy

My name is Dustin Pickens, and I am currently an MSW student at University of Northern British Columbia (UNBC). I am currently doing a practicum report, and I was wondering if I could reuse an image that is on the BCMHSUS website. Specifically, this image in the history section (http://www.bcmhsus.ca/history). This image pertains to “1872 BC’s first asylum for the insane opens: Royal Hospital, a converted cottage that previously served as Victoria’s quarantine hospital, is re-converted to house the mentally ill.”

I completed my practicum on adult psychiatry at the University Hospital of Northern BC, and thought this image with compliment my practicum report, and I am seeking out copyright permission to reuse this image.

Thanks

Dustin Pickens
Thank you for your email. That question may be better answered by the communications representative for BCMHSUS. I have cc'd Theresa Kennedy, our acting Chief Communications Officer to direct you the best person to answer your question.

Hi Dustin,

You are permitted to use the photo as long as you use the following copyright which recognizes that this material belongs to BC Mental Health and Substance Use Services.

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Thank you,

Theresa

Theresa Kennedy, BSc, PMP
Interim Chief Communications Officer
Provincial Health Services Authority

604-675-7401 (Office)
604-790-0034 (Mobile)
theresa.kennedy@phsa.ca

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Better health.
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From: Brice, Cindy
Sent: Thursday, February 12, 2015 8:48 AM
To: 'Dustin Pickens'
Cc: Kennedy, Theresa
Subject: RE: Copyright permission for reuse of image - UNBC Practicum Report

[Quoted text hidden]

Dustin Pickens <dpickens1984@gmail.com>                          Fri, Feb 13, 2015 at 1:11 PM

To: "Kennedy, Theresa" <Theresa.Kennedy@phsa.ca>

Thanks you very much, I will make sure I reference copyrights to this picture belonging to BCMSUS in my practicum report.

Dustin Pickens

[Quoted text hidden]
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Diagram
1 message

Maynard, Andrew <Andrew.Maynard@anglia.ac.uk> Mon, Feb 16, 2015 at 3:46 AM
To: "dpickens1984@gmail.com" <dpickens1984@gmail.com>

Hi Dustin, I would happy for you to use the diagram pertaining to tensions and conflicts. Please let me know how you work progresses.

Regards

Andrew maynard

UK Entrepreneurial University of the Year

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