

Cognitive Behavioural Therapy in Corrections: An Advanced Clinical Practicum with  
Correctional Service Canada

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A thesis submitted in partial fulfillment  
of the requirements for the degree of  
Master of Social Work

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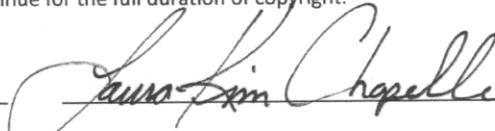
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### **Abstract**

This advanced practicum research report describes my practicum experiences within a federal correctional facility, the incorporation of cognitive behavioural therapy in corrections, group work within the correctional environment, clinical discharge planning, social work supervision, and the role of clinical social workers as members of an interdisciplinary team. The literature review will provide a summary of cognitive behavioural therapy in a criminal justice setting in Canada, incarcerated individuals with mental health problems, the role of social workers in criminal justice settings, discharge planning in criminal justice settings, social work practice with groups in criminal justice settings, social work clinical supervision, and clinical discharge planning. Following this, a discussion of the practicum process will occur. Next, a discussion of my reflections and critical analysis related to my practicum experience will provide a discussion of major themes demonstrating the growth of my theoretical knowledge and clinical skill sets throughout the practicum process. Throughout the report, I will highlight the major themes revealed within my reflective practice, divided into five various categories: the cognitive behavioural therapy model in clinical corrections practice, social work group practice in corrections, social work clinical supervision in the correctional system, awareness of the responsibilities of clinical social workers as members of an interdisciplinary team in the correctional system and discharge planning in the correctional system. The report will then conclude with a summary of my experience as a clinical social worker in the federal correctional system and a discussion relating to implications for social work practice.

*Keywords:* cognitive behavioural therapy, social work with groups, discharge planning, clinical supervision, corrections, mental health, interdisciplinary

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## Introduction

Humanitarian and ethical injustices experienced by persons with mental illness in correctional settings have been lamented by prison reformers and inmate advocates for more than two millennia (Olley, Nicholls, & Brink, 2009). The primary duty of prisons is to ensure the safety of society so that the security of the institution is of primary concern (Hoke, 2015). Correctional facilities present a myriad of challenges in relation to the provision of effective mental health service delivery (Kolodziejczak & Sinclair, 2018; Tamburello, Kaldany, & Dickert, 2017). Additionally, mental health treatment for minority ethnic prisoners is greatly needed, as white prisoners access those services at a higher percentage than minority ethnic prisoners (McKenzie, Killaspy, Jakobowitz, Faranak, & Bebbington, 2019). Unlike traditional hospitals or treatment organizations, correctional facilities present a required symbiotic relationship between the operational requirements of the institution and the provision of mental health services (Kolodziejczak & Sinclair, 2018; Tamburello et al., 2017). Mental health care units must reinvent their service provision methods in relation to the operational requirements of the correctional facility (Kolodziejczak & Sinclair, 2018; Tamburello et al., 2017). Mental health providers in corrections utilize a variety of detection strategies available for psychological evaluations and assessments. However, it is an inherently difficult process (Felthous, 2009). This involves limited interaction time with incarcerated individuals that are scheduled within specific daily timeframes. In addition to rigid availability for individual interventions, should the operational component of the organization place the units on lockdown, mental health care practitioners are unable to access their clientele (Kolodziejczak & Sinclair, 2018; Tamburello et al., 2017). The conditions of the operational and mental health services departments can result in interrupted programming, increased recovery times for patients, and less than optimal provision

of mental health service provision to individuals requiring intense mental health interventions (Kolodziejczak & Sinclair, 2018; Tamburello et al., 2017). Additionally, constitutionally mandated community standards of care have improved correctional community standards of care, resulting in some inmates feigning symptoms of psychiatric disease to possibly obtain safer conditions or escape work demands (Felthous, 2009).

Within the literature I reviewed, limited social work research has been conducted in forensic settings. This has resulted in limited availability of research or employment within the field of corrections for social workers in general (Reamer, 2008). This researcher was unable to locate research completed by social workers in federal penitentiaries. This research may be a first among its type, especially with the specific and identified parameters.

To fulfill partial requirements for the Masters of Social Work (MSW) degree at Laurentian University, I chose to complete my practicum placement within Corrections Canada, at the Regional Treatment Centre (RTC), High-Intensity Intermediate Care (HIIC) unit at Bath Institution. This medium-security prison is located in Bath, Ontario, and shares the same property as Millhaven Institution. The goals of the RTC include treating inmates experiencing a degradation of their mental health condition(s) who require high intensity or intermediate care. The mental health symptoms of an individual may be addressed by any assigned individual specialist or regulated professional such as nurses, social workers, occupational therapists, behavioural sciences technicians, and psychologists. Depending on the individual service needed, the assigned specialist will complete the required tasks within his or her scope of practice. For example, if an individual required complex discharge planning, this component would be assigned to the social worker of the interdisciplinary team.

## **Chapter 1—Literature Review**

In this section, I will begin with a description of cognitive behavioural therapy before discussing the criminal justice setting in Canada and barriers to effective social work interventions. I will then provide a review of incarcerated individuals with mental health problems prior to examining discharge planning in correctional settings and the role of social workers in criminal justice settings. Social work practice with groups in criminal justice settings will be reviewed prior to discussing social work supervision, clinical discharge planning, and implications of social work practice prior to concluding the document.

### **Cognitive Behavioural Therapy (CBT)**

CBT focuses on how individuals develop cognitive functioning and learn through acting on their environment (McLeod, 2017). The primary concepts are that our cognition, emotions, and behaviours interact (McLeod, 2017). Essentially, CBT research has demonstrated that our thoughts determine our feelings and our behaviour. Approaches and practice interventions include behavioural interventions such as classical or operant conditioning, positive or negative reinforcement, time-limited, problem-focused interventions, and the cognitive reframing of automatic thoughts about presenting problems to facilitate change (McLeod, 2017).

CBT is a psychosocial intervention which aims to improve mental health via challenging and changing cognitive distortions and behaviours, while improving emotional regulation and the development of personal coping strategies (Beck, 2011; Benjamin et al., 2011; Field, Beeson, & Jones, 2015). These coping strategies focus on solving current problems (Beck, 2011). CBT is a combination of the basic principles of cognitive and behavioural psychology (Beck, 2011). These basic principles entail the reciprocal interaction among environment, cognitions, behaviour, and emotions (Beck, 1967, 1972). CBT is a problem-focused and action-oriented form of therapy

utilized to treat specific problems relating to diagnosed mental health disorders (Schacter, Gilbert, & Wegner, 2010). CBT maintains that thought distortions and maladaptive behaviours are involved in the development and maintenance of psychological disorders, with symptoms and associated distress reduced by teaching new information-processing skills and coping mechanisms (Field et al., 2015). CBT assists individuals in replacing maladaptive emotions, cognitions, and behaviours with more adaptive behaviours through challenging an individual's behaviour and thinking (Hassett & Gevirtz, 2009). A total of six phases in CBT include: assessment or psychological assessment, reconceptualization, skills acquisition, skills consolidation and application training, generalization, maintenance and, post-treatment assessment follow-up (Gatchel & Rollings, 2008).

The assessment phase is divided into four steps: (1) identification of the critical behaviours; (2) the determination of whether critical behaviours are excesses or deficits; (3) the evaluation of critical behaviours for frequency, intensity or duration; and (4) if deficits, attempt to increase behaviours or if excess, attempt to decrease the frequency, duration, or intensity of behaviours (Gatchel & Rollings, 2008). During the reconceptualization phase, maladaptive thoughts are challenged and questioned, including examining their irrationality (Gatchel & Rollings, 2008). The skills acquisition phase involves the clinician teaching the ability to prevent falling into a pattern of automatic thoughts and how to implement strategies for daily obstacles (Gatchel & Rollings, 2008). During the skills consolidation and application training phase, the consolidation of gains and summary of work completed occurs (Dagenais & Haldeman, 2012). Homework is provided to clients to reinforce the skills acquired (Dagenais & Haldeman, 2012). The final phase, post-treatment assessment and follow-up, encompasses discussions regarding

the future while exploring how an individual will cope once treatment is completed (Dagenais & Haldeman, 2012).

CBT has demonstrated effectiveness for multiple mental health diagnosis in adults, including: anxiety disorders, depression, body dysmorphic disorder, eating disorders, chronic low back pain, personality disorders, schizophrenia, substance use disorders, and psychosis (Driessen & Hollon, 2010; Gatchel & Rollings, 2008; Gutiérrez et al., 2009; Harrison, Fernández de la Cruz, Enander, Radua, & Mataix-Cols, 2016; McHugh, Hearon, & Otto, 2010; Murphy, Straebler, Cooper, & Fairburn, 2010; Otte, 2011; Rathod, Phiri, & Kingdon, 2010; Robinson et al., 2010). Additional research demonstrated success with children and adolescents, including children between the ages of three to six years suffering from post-traumatic stress disorder (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). Adaptation of CBT techniques and processes is required when working with anxious children and adolescents (Oar, McLellan, & Rapee, 2017). Examples of adaptations include the implementation of technology, rewards, and interactive activities resulting in increased child engagement and motivation (Oar et al., 2017). Depending on the cognitive capacity of children and adolescents, cognitive techniques will require simplification with the use of concrete examples to increase overall understanding (Oar et al., 2017).

CBT can be delivered in group format or individual clinical sessions (Wergeland et al., 2014). A typical CBT program would consist of 6 to 18 sessions lasting an hour each (National Institute for Health and Care Excellence, 2008). The National Health Service (NHS), a publicly-funded healthcare system in the United Kingdom, provides a comprehensive explanation regarding the components of the clinical sessions. I selected the NHS due to its distinguished history regarding the public healthcare sector and an overall wealth of information for

researchers. During the clinical sessions, the individual and his or her therapist will separate the problems into components, such as thoughts, physical feelings, and actions (NHS, n.d.). In CBT, an individual's problems are divided into components which are: situations, thoughts, emotions, physical feelings, and actions (NHS, n.d.). These five areas are correlated and interconnected with effects on each component (NHS, n.d.). The process of analyzing unrealistic or unhelpful components includes examining the effects on the individual (NHS, n.d.). In subsequent sessions, the therapist then assists the individual in changing unhelpful thoughts and behaviours with the expectation that clients practice their newly learned skills (NHS, n.d.). Each following session would be scheduled between one to three weeks afterward (National Institute for Health and Care Excellence, 2008). Booster sessions may accompany the treatment regimen at various stages of the process, for example, after one or three months of clinical intervention (National Institute for Health and Care Excellence, 2008). This provides the therapist with the opportunity to observe the application of CBT skills in the daily lives of patients (Dagenais & Haldeman, 2012). Despite the effectiveness of CBT, multiple criticisms of the treatment modality have been identified. For example, researchers criticized the efficacy of CBT in clinical studies due to the modality not being a blinded experiment. The withholding of information which may influence clients to engage in experimental biases is referred to as a blinded experiment. During this type of experiment, blinding can be imposed on any participant, including researchers and subjects (Berger, 2013). From a research perspective, CBT is not a blinded experiment meaning that subjects or therapists in psychotherapy studies are aware of the type of therapeutic intervention utilized (Berger, 2013).

Prior to examining the implementation of CBT in a correctional institution, the setting must be described while identifying barriers to effective social work interventions. The following

paragraph will expand on these items prior to examining incarcerated individuals with mental health challenges.

### **Criminal Justice Setting in Canada and Barriers to Effective Social Work Interventions**

In this section, I discuss the barriers to effective social work interventions that occur in the criminal justice setting and incarcerated individuals with mental health problems. These barriers include inmate codes of behaviour and authorization to conduct research. Explanations of these barriers are discussed in relation to social work interventions in corrections. The primary barriers result from the inmate codes of behavior producing counteractive belief systems for the incarcerated, while the complexity of the authorization parameters complicates the overall process of conducting research in Correctional Service of Canada facilities.

The criminal justice setting exhibits unique barriers to effective social work interventions. These challenges have evolved due to need and necessity, resulting in prisoners adapting to their environment (Ricciardelli, 2014). Such barriers include the development and use of inmate codes of behaviour that produce counteractive belief systems for the incarcerated (Ricciardelli, 2014). Theoretically, inmates' adjustment to incarceration has been proposed as a reason for the development of inmate codes. Although some tenets of the code are consistent among institutions, other adaptations exist depending on a variety of factors, including the individuals incarcerated. Historical adherence to the code ordered prisoners to reject the rules of the administration (Ricciardelli, 2014; Wellford, 1967). Current research established the inmate code in Ontario penitentiaries which include the following five primary tenets:

- (1) "never rat on a con" and don't get friendly with the staff;
- (2) be dependable (not loyal);
- (3) follow daily behaviour rules or else;
- (4) I won't see you, don't see me, and shut up already;
- and (5) be fearless or at least act tough. (Ricciardelli, 2014)

Normative cultural environments and informal guidelines were dictated by prison codes defining how a prisoner should act, including what behaviours were acceptable and expected and which ones were not (Ricciardelli, 2014). Included in prisoner challenges was the establishment and assertion of masculinity in Canadian penitentiaries (Ricciardelli, 2014). Social interactions are determined by hegemonic masculinities with the enforcement of a hierarchy among prisoners where domination and power are asserted via psychological, physical, and material means (Ricciardelli, 2014). Another possible barrier that may pose a significant risk to effective treatment effectiveness includes challenges associated with access to the correctional system and settings. As described by previous researchers, “attempts to secure access to a Canadian federal correctional institution was a long, arduous, and extremely frustrating experience,” which ultimately resulted in failure (Norman, 2017). Gaining access to a Correctional Service of Canada (CSC) institution requires gaining approval and support from various committees and individuals from within the organization.

Norman (2018) described the process of obtaining authorization to conduct research in CSC facilities. This included the requirement of submitting an application that describes the ethical protections, scope, and overall justification included in the research project. Once submitted, the application is reviewed by a variety of individuals and committees (Norman, 2017). Approval is authorized by the research committee at a regional or national level (Norman, 2017). When accepting or declining research proposals, CSC utilizes eight criteria prior to providing a decision (Norman, 2017). The research committee considers the quality of the research, the researcher’s qualifications, and the project’s adherence to ethical and legal frameworks (Norman, 2017). The remaining four criteria address the impact of the research on CSC or its institutions (Norman, 2017). They are as follows: the contribution to the achievement

of the mission and the priorities of the Correctional Service of Canada; level of disruption to the implementation of correctional objectives from an operational perspective; anticipated benefit to corrections, and value for money (Norman, 2017). Researchers are ultimately required to design projects which provide contributions to the organization's operational priorities, budgetary operations of individual prisons, minimal cost to the organization, and day-to-day activities (Norman, 2017). The broad spectrum of criteria provides the CSC the opportunity to decline research proposals for any reason (Norman, 2017).

### **Incarcerated Individuals with Mental Health Problems**

In Canada, approximately 250,000 adult admissions to correctional facilities occur, with approximately 8,000 which are in federal custody and 14,000 youth admissions per year (Fazel & Baillargeon, 2011). On average, approximately 40,000 individuals are in correctional facilities per day (Perrault, 2014a, 2014b). Increased mortality from all causes upon release and high rates of suicide within prisons have been documented in various countries around the world (Fazel & Baillargeon, 2011; Larney & Farrell, 2017). Despite the shortcomings in treatment and aftercare which contribute to adverse outcomes, the contribution of prisons to illness is presently unknown (Fazel & Baillargeon, 2011).

Multiple factors in prisons contribute to negative effects on mental health, including: lack of privacy, lack of meaningful activity, overcrowding, isolation from social networks, various forms of violence, overcrowding, enforced solitude, inadequate health services including mental health services, and insecurity about future prospects (Fazel & Baillargeon, 2011; Larney & Farrell, 2017; Morgan, Van Horn, MacLean, Hunter, & Bauer, 2019). Access to health services in correctional settings presents significant barriers to care and unique health challenges (Scallan, Lancaster, & Kouyoumdjian, 2019). The increased risk of suicide in prisons and the detriments

to prisoners' social determinants of health is a common manifestation of the cumulative effects of these factors (Fazel & Baillargeon, 2011). Globally, suicide rates are significantly higher in prisoner populations compared with non-incarcerated people in the surrounding community (Larney & Farrell, 2017). In 24 countries worldwide, 3,906 prison suicides occurred between 2011 and 2014, with 203 (7%) suicides in women and 2607 (93%) suicides in men (Fazel, Ramesh, & Hawton, 2017). Juveniles and women prisoners aged 55 years or older experience higher rates of many disorders than other prisoners (Fazel & Baillargeon, 2011; Fazel & Danes, 2002). In Canada, during a ten-year span ranging from 2001/2002 to 2010/2011, 17.4% of 530 offenders died by suicide, totaling 92 deaths (Office of the Correctional Investigator, 2019). The Office of the Correctional Investigator estimates that the suicide rate for federally incarcerated offenders is 70 per 100,000 in comparison to 2009 Canadian statistics indicating 11.5 suicides per 100,000 in the general population (Office of the Correctional Investigator, 2019). Initiatives and contributions to improving the health of prisoners via the reduction of infectious and chronic diseases, other causes of premature mortality, reduction of violence, suicide, and counteracting the recidivism are required. Individual-level risk assessments and interventions are unlikely to produce significant change regarding decreasing suicide rates in prison (Larney & Farrell, 2017). A systemic approach implementing the promotion of a humane environment that promotes safety and well-being of all individuals incarcerated, including increased purposeful activity, avoidance of unnecessarily punitive actions, peer-based programs, and support for prisoners experiencing psychological distress could yield greater positive outcomes for correctional facilities (Larney & Farrell, 2017). Recent research findings have suggested that the recidivism costs of former inmates with mental illness(es) were three times higher than the costs of former inmates without mental illness (Ostermann & Matejkowski, 2013). Effective interventions to reduce the incidence

of suicide in prison would be to dramatically reduce the incarceration of individuals with severe mental illness while ensuring the improvement of access to psychiatric care and social welfare systems (Fazel et al., 2017; Horton, Wright, & Dyer, 2014; Larney & Farrell, 2017).

### **The Role of Social Workers in Criminal Justice Settings**

Throughout the 20th century, social workers in criminal justice settings have completed such tasks as: risk assessments, mental health, and substance abuse counseling, pre-sentence reports, group therapy, community outreach, employment, and social service advocacy (Brownell & Roberts, 2008). Forensic social work is an integrated practice specialization at the intersection of the law or legal system (Maschi, Leibowitz, & Bryan, 2017). Traditionally, social workers employed in criminal justice settings often assess new arrivals to the prison, develop and implement support plans and treatment plans for inmates, provide individual therapy, lead psychosocial educational support groups, monitor the progress and compliance of inmates in treatment, and provide referrals to various health services (Matejkowski et al., 2014; Sheehan, 2012). In this setting, social workers in criminal justice facilities engage in documentation about the progress and treatment of assigned inmates to comply with regulatory bodies.

In multiple prison systems, a battery of psychological tests and interviews with treatment professionals and social workers are employed upon the initial inmate assessment (Matejkowski et al., 2014). These methods are employed to determine the presence of acute and chronic conditions. Acute conditions include suicide ideations, depression, psychosis, and anxiety, while chronic conditions account for severe and persistent mental illness, substance abuse, as well as historical and current manifestations of trauma (Matejkowski et al., 2014). Throughout the assessment phase, the social worker is responsible for determining the inmate's eligibility for services and treatment with a goal of ultimate inmate discharge (Matejkowski et al., 2014).

Social workers are increasingly expected to understand linkages between family systems and psychological disorder behaviours while balancing community and individual needs (Sheehan, 2016). Discharge planning is a significantly challenging task. In the United States, 1,600 prisoners per day are released from federal and state prisons into the community (Travis, Solomon, & Waul, 2001). Research in the United States has revealed that parole supervision results in a decrease in new arrest charges by 30% while controlling for mental health problems (Ostermann & Matejkowski, 2012). Alternatively, for individuals with mental health problems, the likelihood of experiencing a new arrest during release status increased by 20% (Ostermann & Matejkowski, 2012).

Ethical challenges and value dilemmas frequently affect social workers employed in a prison environment (Toi, 2015). As a profession, social work no longer has a major presence in the criminal justice field (Gibelman & Schervish, 1996). Most social work education does not include explicit courses or programs relating to criminal justice (Reamer, 2008). Social work students seldom embark on their professional education with the ultimate objective of working within corrections (Reamer, 2008). Workshops, professional conferences, or continuing education seminars rarely focus on issues affecting and involving criminal justice (Reamer, 2008). With the limitation of social work in the criminal justice system, relatively little scholarship about criminal justice issues is authored by social workers (Reamer, 2008). Social workers employed in corrections reported complex needs and significant vulnerability of forensic clients which requires specialized knowledge of individual functioning and other systems to effectively engage in service provision (Sheehan, 2012). Previously, prisons were no longer associated with rehabilitation and instead focused on punishment and control (Tripodi, 2014). This type of environment limited the ability to promote individuals' rights and protect

their confidentiality. The growing number of inmates who present with special needs has complicated competent performance of the social work practitioner (Matejkowski et al., 2014). Such an environment makes it difficult to protect the confidentiality or promote individuals' rights (Matejkowski et al., 2014). In the criminal justice system—an industry often defined by frequent crises, demanding, clear, and unique challenges in the prison environment could benefit from social work expertise.

### **Social Work Work Practice with Groups in Criminal Justice Settings**

Aspects of group models developed by other professions are utilized in social work, ensuring our foundational values and methods of being social workers who work with groups (Bergart, 2015). Social work's professionalizing process, in relation to social work with groups, distinguishes statements between skills, knowledge, and values, engages in the clarifying of our values, identifies what the worker does, engages in the building of knowledge via research and the conceptualization of our societal mission (Papell, 2015). Previous and current social work principles include the professional purposes, ultimate involvement in activities, and the dialectical integration of concern for the individual and the societal reality (Papell, 2015). Three individual models were utilized for group practice during the 1960s—social goals, remedial, and reciprocal—all which accounted for the socially directed aspect of group work, the individual focus aspect of group work, and an estimate to unite the whole while using concepts such as “mutual aid,” “group context,” and “interaction”(Papell & Rothman, 2014). The primary source of growth and assistance for social workers was relationships with each other (Knight & Gitterman, 2017). In the 1970s, newer and elaborated group practice models emerged, with a variety of theoretical identities and shifts in the types of settings for which group services were used (Bergart, 2015; Papell, 2015). The advancement of social group work resulted in the three

models no longer representing what occurred in social work with groups (Papell, 2015). The mainstream model emerged from the interplay of four constructs: the worker with the group, the activities of the group, the group, and the member in the group (Papell, 2015). As social group work continued to evolve, a fifth construct was included which encompassing the group setting. In the current education of social work group practice, the setting has evolved to include the integration of didactic, experiential learning through authentic group experience, experiential learning through structured roleplays, task groups, and role-playing treatment groups (Warkentin, 2017).

Social work practice with groups can be more effective than individual treatment due to the availability of additional resources and support outside of the facilitator via multiple participant helpers (Corey, Corey, & Corey, 2010; Goldfield, Epstein, Kilanowski, Paluch, & Kogut-Bossler, 2001; Lee, 2018; Petrocelli, 2002; Rose, 2009; Toseland & Rivas, 2012; Yalom & Leszcz, 2005). From a fiscal perspective, groups can be more cost-effective due to the number of participants serviced simultaneously (Corey et al., 2010; Goldfield et al., 2001; Lee, 2018; Petrocelli, 2002; Toseland & Rivas, 2012). Individual problem-solving groups may be less effective than task groups due to the incorporation of stakeholders' investments and diverse perspectives (Lee, 2018; Levi, 2014; Toseland & Rivas, 2012). In my experience, individuals have felt more comfortable divulging and sharing private information during individual clinical sessions. It should be noted, however, that I have limited experience in providing social work with groups and therefore should not be considered an expert.

Limited research is available regarding social work practice with groups in the criminal justice setting. The limited vocational interest in forensics, including the limited education

available related to forensic social workers, has resulted in little scholarship on criminal justice issues which are authored by social workers (Reamer, 2008).

### **Social Work Clinical Supervision**

Clinical social work supervision is an important component of clinical social work training and professional practice, as it provides an opportunity for individualized professional growth (O'Neill & Mar Farina, 2018). A positive space for transformative learning, social work clinical supervision provides an authentic exchange between the supervisor and supervisee while enhancing clinical care for individuals, couples, and families (O'Neill & Mar Farina, 2018). The supervisory relationship parallels the therapeutic relationship between clients and the supervisor (Morrissey, 2001; O'Neill & Mar Farina, 2018). The development of supervisory activities, linked to effective building of a strong supervisory working alliance, results in the reduction of negative effects of stressful work environments which exist in the social service field (Edmunds, Beidas, & Kendall, 2013; Strickler, Valenti, & Mihalo, 2018). Included activities are comprised of adopting an informed consent process which describes frequency and purpose of supervision, outlined best practices for the documentation of supervision sessions, specificities of minimal requirements for supervision based on job categories, establishment of qualifications, and supervisory preparation and the development of procedures for assessing quality supervision (Hoge et al., 2014).

A component of social work education is intended to prepare competent and effective practitioners utilizing academic courses and field education (Kourgiantakis, Sewell, & Bogo, 2018). The field instructor-student relationship is defined as the mediation of important learning processes and teaching which shapes the extent of the student's holistic competence (Homonoff, 2008; Kourgiantakis et al., 2018; Miehl, Everett, Segal, & du Bois, 2013). The collaborative use

of knowledge and conceptual frameworks is required as learning processes which intend to understand client dynamics and the planning of effective interventions (Fortune, McCarthy, & Abramson, 2001; Kourgiantakis et al., 2018). The use of self is addressed through developing self-awareness and emotional regulation (Kourgiantakis et al., 2018). The facilitation of increased self-awareness and emotional regulation of the student is obtained via the field instructors' observation of students' practice, debriefing on client interactions, providing recurring constructive and positive feedback, and guiding students' reflections (Davys & Beddoe, 2015; Kourgiantakis et al., 2018; Maidment, 2010; Saltzburg, Greene, & Drew, 2010). The development and teaching of the use of self are particularly valuable for supervisors to impart to students throughout the course of their field experience (Solo, 2018). A foundational principle of the social work profession entails the complexity and nuance which is required to teach and apply the use of self constructively in practice (Solo, 2018). Awareness of countertransference, tolerance, and self-knowledge are essential on a personal and professional level, as the trainee must be aware of how the dynamics of the dyad impact the therapeutic work (Edwards & Bess, 1998; Solo, 2018). Clinical social work supervision is an important component of clinical social work training and professional practice, as it provides an opportunity for individualized professional growth (O'Neill & Mar Farina, 2018). A positive space for transformative learning, social work clinical supervision provides an authentic exchange between the supervisor and supervisee while enhancing clinical care for individuals, couples, and families (O'Neill & Mar Farina, 2018). The supervisory relationship parallels the therapeutic relationship between clients and the supervisee (O'Neill & Mar Farina, 2018). The development of supervisory activities linked to the effective building of a strong supervisory

working alliance can result in the reduction of negative effects of stressful work environments which exist in the social service field (Edmunds et al., 2013; Strickler et al., 2018).

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### **Interdisciplinary Health Care**

Health care systems are challenged worldwide due to continued and rising mental disorders (Markon, Bamvita, Chiochio, & Fleury, 2017). A current reform includes strengthening primary mental health care, including increased use of interdisciplinary team approaches. Mental health care professionals in various settings are increasingly required to work on interdisciplinary teams (Markon et al., 2017). The provision of health care in

correctional facilities is unique and challenging, often presenting with extraordinary circumstances which undermine the success of interventions (Costa & Lusk, 2017).

The benefits of interprofessional collaboration include features associated with increased collaboration, such as: organizational support, knowledge sharing, mutual trust, professional diversity, participation in decision-making, knowledge integration, affective commitment toward the team and belief in the benefits of interdisciplinary collaboration (Kebe, Chiocchio, Bamvita, & Fleury, 2019). These effective team qualities are suggested as mechanisms for improving interprofessional collaboration. With the implementation of interprofessional collaboration, the promotion of problem-solving in health care teams associated with the reduction of tensions occurs, while also increasing work satisfaction and motivation among professionals (Kebe et al., 2019). Health team members who consider themselves effective and high performing could take more initiative to improve patient care (Markon et al., 2017; Strasser et al., 2005; Temkin-Greener, Gross, Kunitz, & Mukamel, 2004)

A health care standard which improves patient outcomes is called collaborative practice—the maximization of resources and mutual work of all health care providers (Costa & Lusk, 2017). As defined by the World Health Organization (2020), collaborative practice is a health care strategy which creates shared objectives to achieve better patient outcomes through the mutual work of health care providers (Costa & Lusk, 2017). Collaborative practice is dependent on interdisciplinary communication, thus requiring training for health care participants in effective communication (Costa & Lusk, 2017). The completion of this training is imperative for success. Considering the effects of communication failures—including disruption of treatment, higher project expenditures, and preventable injuries—sufficient communication is required among health care providers (Costa & Lusk, 2017).

### **Discharge Planning in Criminal Justice Settings**

Research has indicated that effective discharge planning and reintegration support for people leaving corrections results in reduced recidivism, increased public safety, and reduced homelessness (Harrison, 2001; Petersilia, 2001a, 2001b; Travis & Petersilia, 2001). In Canada, inmates often cycle through correctional facilities to homelessness, resulting in re-offending and subsequent periods of incarceration (Bahen, 2016). Canadian studies illustrate a significant risk of homelessness upon release (Bahen, 2016). Previously released incarcerated individuals receive limited assistance about support upon release (Bahen, 2016). Navigating essential services and community organizations also presented challenges for individuals releasing from prisons. Numerous U.S.-based studies articulate the crucial importance of transitional support services to ensure successful reintegration of the individual (Metraux & Culhane, 2004; Petersilia, 2003).

According to guidelines established by Corrections Canada, the clinical discharge planner is responsible in developing discharge/integration plans, for example, a mental health assessment for clinical discharge, which include referrals and ongoing communication with the community in various areas such as: housing, identification, community support, cultural needs, and additional needs addressing areas relating to social determinants of health (CSC, 2020a). The clinical discharge planner is additionally responsible for communicating information to the inmate's parole officer for strategic release planning decisions pertaining to their case management responsibilities. Setting up necessary appointments, medication follow-ups, and providing brief interventions for offenders are additional responsibilities assigned to the clinical discharge planner (CSC, 2020a). When complex cases arise, the clinical discharge planner is utilized to navigate external and internal systems to ensure the most successful discharge process

is completed (CSC, 2020b). The responsibility of clinical discharge planning in Corrections Canada has been assigned to clinical social workers. According to Corrections Canada, social workers “help offenders reintegrate into the community by arranging community services for those with mental and physical health needs” (CSC, 2020c). Social workers “advocate and coordinate for the continuity of health care services for offenders as they return to the community” (CSC, 2020c).

In the next chapter, I discuss the advanced practicum environment, the agreement with the agency, learning objectives, theoretical lens, and a discussion of reflexivity prior to concluding the section. I offer a broad overview of my intentions behind pursuing an advanced practicum, and how the experience nurtured personal growth and clinical skillsets.

## **Chapter 2—Placement Description and Learning Objectives**

In accordance with the partial requirements of the Laurentian University Master of Social Work program, I completed the advanced practicum (SWRK 6024) from January 6, 2020 to March 31, 2020. The practicum was completed at the RTC, HIIC unit with Corrections Canada at Bath Institution. Within this Chapter, I describe the practicum environment, including agreements made with the organization and pertinent details of the experience such as supervision received, my learning objectives, the theoretical lens which guided my learning, and the critical role of reflective and reflexive practice.

### **Description of the Advanced Practicum Environment**

The advanced practicum occurred with the CSC at the Bath Institution, RTC, in the HIIC unit, located in Bath, Ontario. This facility was for offenders who have been sentenced to a period greater than two years and met medium security levels (CSC, 2020). For example, to meet the threshold for a medium security prison an individual will have to meet established criteria such as their behaviour, participation in correctional programming, and other requirements deemed confidential. The HIIC unit at the Bath RTC specializes in providing interdisciplinary mental health services to incarcerated males experiencing mental health challenges and deterioration. The interdisciplinary team consisted of: a clinical social worker, psychologist, occupational therapist, two behavioral science technicians, a mental health nurse, and a chief of the RTC. Each member of the interdisciplinary team was responsible for providing interventions in relation to their scope of practice. The advanced practicum provided the opportunity to focus on the development of my clinical social work skills in a forensic environment. In this application, forensic was defined as an individual with a mental health disorder coming into

contact with law enforcement (Bettridge & Barbaree, 2006). This term is the forensic mental health system (Bettridge & Barbaree, 2006).

### **Agreements with the Organization**

Ms. Suzanne Lacelle, Field Coordinator for Laurentian University, provided the appropriate forms to Corrections Canada administration. As per agency requirements, the mandatory processes included digital fingerprinting, criminal reference checks, and security clearance prior to beginning my advanced practicum. Within the first two weeks of the practicum, I attended the New Employee Orientation Program to learn of the fundamental legislation, behaviours, and manipulation of the criminal population, interventions for crisis situations, hostage negotiation procedures/processes, general mental health education, indigenous awareness, and organizational practices. This provided significant information regarding how the organization functions and the expectations placed upon public servants for the population of Canada. During my placement, I had access to extremely sensitive and classified materials, including access to high-profile cases. As I was afforded the same privileges as employees of the organization, I was cognizant of the sensitivity surrounding issues of confidentiality. I ensured additional caution when adhering to regulations, responsibilities, and ethics which were expected of organizational staff members.

### **Social Work Work Supervision**

The clinical supervision component of the advanced practicum was completed by Annah MacDonald, MSW, a clinical social worker employed with the CSC. She has been employed by Corrections Canada for nearly five years while completing her studies. Ms. MacDonald presently works at Bath the Institution, at the RTC, in the HIIC unit. The intention of the supervision component involved meeting Ms. MacDonald for an official session once weekly; however, we

spoke daily regarding individual cases, observations, opportunities for reflexivity, how to approach future sessions, and clinical wonderings. This ongoing form of supervision was invaluable, especially from a frontline perspective, as I continued to grow my clinical skills and work in a correctional environment. Additional informal supervision was a daily occurrence, involving all members of the interdisciplinary team. We would consult on individual cases, provide clinical opinions, share judgement, and create interventions for complex clientele.

Dr. Leigh MacEwan in Laurentian University's School of Social Work was my designated first reader, and Dr. Nancy Lightfoot in Laurentian University's School of Rural and Northern Health, was my second reader during the completion of my advanced practicum. Throughout the practicum, we maintained connection via email and telephone. Due to my practicum being located in Bath, Ontario, this mode of supervision was most appropriate. The readers provided supervision as required, oversaw the progress of the thesis component, ensured that learning goals and objectives were being attained while ensuring that the practicum environment was conducive to regulations stated by Laurentian University.

During the practicum, I received a substantial opportunities of professional development through Corrections Canada. Training opportunities such as individual coursework, teleconferencing, workshops, evidence-based training, and online courses assisted in developing my social work practice within correctional settings. I completed an online certificate program regarding co-occurring disorders—mental health and addictions. This training was imperative in my understanding and ability to engage in effective interventions with clients who fit the criteria of co-occurring disorders. Additionally, the organization paid for my attendance at a six-week online dialectical behavior therapy certificate program. I was also appointed a STRENGTH champion, which required the completion of a certificate program and champion training

concerning the STRENGTH resilience model. This program was commissioned by the Government of Canada and created specifically for Corrections Canada. I became responsible for implementing the model into the workplace and provide this training to my colleagues. The training of new employees, called the New Employees Orientation Program, was essential in learning and understanding the fundamentals of employment within the correctional system. Finally, my supervisor would frequently provide homework and assignments for completion to enhance my learning outcomes.

### **Training Plan**

The purpose of the advanced practicum was to increase my knowledge in the application of CBT in social work practice. The implementation of cognitive-behavioural therapy in a correctional facility differed from traditional psychology-based frameworks, as it focuses on how individuals develop cognitive functioning and learn through acting on their environment (McLeod, 2017). Through the lens of CBT, my advanced practicum assisted me in understanding and developing this framework for my social work practice in corrections. For this advanced practicum, five learning outcomes were established:

1. The use of CBT model in clinical corrections practice.
2. Social work work group practice in corrections.
3. Social work work clinical supervision in the correctional system.
4. Learning the responsibilities of clinical social workers as members of an interdisciplinary team in the correctional system.
5. Discharge planning in the correctional system.

These five learning goals spanned a significant amount of experiences while completing my advanced practicum. The independent scheduling of these tasks, the expectation of

completion and implementation towards obtaining the established learning goals were fundamental in my growth as a clinical social worker. The identified goals were new learning opportunities for me, resulting in the acquisition of specialized skills, such as complex clinical discharge planning and community connections with external organizations. The established learning goals were achieved and completed through the required advanced practicum hours.

### **Summary**

As a result of the practicum, I became well integrated into the correctional system. Balancing mental health service provision and operational demands became daily expectations, working with the operations department to ensure the delivery of mental health services to clients incarcerated in the medium-security prison. The operations unit, often working in conjunction with health services to ensure the health and safety of everyone, was managed effectively without incident. The time of my placement coincided with significant shifts in legislation and policy, including the integration of special intervention units, and the abolishment of administrative segregation. This meant that health services and program staff members had greater access to individuals requiring interventions—focusing on a rehabilitative approach. This afforded me unexpected opportunities to observe institutional change processes, while becoming involved in the process of implementation. The process of observation and reflection in conjunction with my direct clinical experience in a rich learning environment provided insight into my own philosophy as a social worker.

Upon reflection of these goals after completing the placement, I believe I surpassed the established goals, learning and engaging in opportunities beyond the expectations of the practicum. Knowledge sources were abundant and variant in perspectives which provided a greater, enhanced clinical experience in the correctional environment. The next chapter focuses

on a discussion of the advanced practicum, outcomes of proposed learning goals, critical analysis, and a review of reflexivity.

### **Chapter 3—Discussion**

In this chapter, I discuss the significance of my findings with my experiences in my MSW advanced practicum with consideration of previously known information found in the literature review. These findings of my experience will be discussed relative to clinical social work in a federal correctional facility. I will discuss the responsibilities of clinical social workers in the correctional system, including the use of CBT, social work group practice, supervision, discharge planning, and reflexivity.

#### **The Responsibilities of Clinical Social Workers as a Member of an Interdisciplinary Team in the Correctional System**

My role as a clinical social worker in federal correctional services included a detailed listing of responsibilities, including the provision of professional advice, specialized consultation, and training to staff members regarding individuals with mental health diagnoses, the development, coordination and implementation of community reintegration, the provision of direct assessment, therapeutic/counseling intervention provision, crisis intervention, advocacy, and support services to offenders with mental disorders (CSC, 2020). As a clinical social worker, I was also responsible for completing clinical discharge planning. In my advanced practicum, I was a member of an interdisciplinary team. I worked alongside other professional practitioners, such as occupational therapists, psychologists, behaviour science technicians, mental health nurses, medical nurses, psychiatrists, medical doctors, correctional officers, parole officers, and administration assistants. Each member provided crucial services to the overall functioning of the department.

With regard to my learning within the interdisciplinary environment, I was fortunate to meet such specialized professionals providing services to incarcerated individuals. I learnt the

importance of clinical diversity based on occupation. This promoted the interdisciplinary division of labour with people maintaining their caseload and referring their clients to other professionals for specialized services. When working with these professionals, I learnt a significant amount of knowledge pertaining to various specialties. The experience provided my personal growth in behaviourism, physical and occupational therapy, medical terminology and processes, psychiatric interventions, and more. This knowledge increased my general understanding of mental health disorders, various interventions, and interventions effective for various disorders. Initially, it was overwhelming to participate in clinical sessions. Being the individual responsible for the well-being of a client is a stressful experience. Members of my team understood the reality of being the responsible person for a human being, and I was able to speak freely regarding the reality of my situation. When I watched the intercommunication between these identified professionals, it developed my skills as a clinical practitioner. I learned how and when to interact with members of the interdisciplinary team.

Being the assigned clinician, it was imperative that my clients were being monitored and provided with the appropriate care required. It required flexibility to adapt to unknown interventions through dialogue. An important lesson learned from Annah MacDonald was the reality of time constraints and the ability to be prepared for unknown situations. Occasionally, this meant working through a mock group session 30 minutes prior to it starting. Another example includes dashing from one client to another with little time to prepare between sessions. Again, this required significant flexibility. Basic communication skills were reinforced and accelerated to complex communication styles. I learnt the importance of communication between all members of the interdisciplinary team to ensure all individuals are aware of current case updates.

Within the correction environment, acronyms are utilized in reports and conversations to accelerate the sharing of information and remove redundancies. This includes health services with professionals discussing their caseloads utilizing advanced vocabulary in congruence with their specialization. It was easy to become lost in conversations if an individual was not aware of the terms utilized in verbal or written reports. Working in the correctional environment demonstrated a required need for advanced language skills and the flexibility to learn these statements. For example, when first attending morning meetings, topics of conversation changed rapidly with limited opportunity to ask for clarification. I relied on my team members and supervisor to provide guidance in learning new terms, acronyms, and previously unlearned clinical language. This process allowed me to continue growing as an individual while providing advancement regarding my clinical skill set. By the end of the placement, my repertoire of clinical terms had increased significantly. In hindsight, the experience of the advanced practicum resulted in a greater understanding of psychological and/or psychiatric disorders, their assessment, and treatment.

The greater learning experience occurred when attempting to find myself within the interdisciplinary team—finding a place among the team as a regulated professional with different experiences and expertise. The interdisciplinary team members were a breadth of knowledge, resounding support, and excellent educators in the manner in which they provided support. Beginning my advanced practicum, I relied heavily on their knowledge and wisdom pertaining to corrections, mental health interventions, diagnosis, policies, protocols, and generally all aspects of learning. Without the members of the interdisciplinary team, my learning experience would have been less rich and insightful. Their collaborative natures demonstrated how an effective interdisciplinary team should function successfully. Members of the team made an active

opportunity to welcome myself to the interdisciplinary group. I slowly began to realize that finding my place within the working environment would occur naturally throughout the process of my placement. Initially awkward as a student in a professional institution, I slowly gained confidence and comfort in my role as a clinical social worker. I settled with the team and forged professional relationships which will last the duration of my social work career. The members of RTC at Bath Institution enabled me to be vulnerable without judgement or comment. They accepted me as a member of their professional family with the underlying goal of providing education and growth edges during the duration of my advanced practicum.

Throughout the initial period of the advanced practicum, I struggled with being a social worker in a correctional environment. I determined that I knew how to be a social worker, just not a social worker in corrections. Community standards differed from within the walls of a federal institution. My previous roles did not include significant protocols, security screening, and complex processes. I began to develop an appreciation for the complexity of the correctional environment. I learned to appreciate my previous freedom when working with clients in the community. Within the institution, disruptions and changes of routines frequently occur which affects overall service delivery. Despite this, I learned how to communicate effectively, compromise with personnel, and establish action plans based on the presented situation(s). The realization of power structures within the criminal justice system, including my individual power over incarcerated persons, provided a stark reminder to engage in reflexivity frequently to ascertain if decisions made were in the best interest of our clientele. It provided opportunities to examine areas in which power beheld my decisions, requiring adaptation and flexibility within the provision of mental health services in corrections.

## **My Use of Cognitive Behavioural Therapy in Social Work Work Practice in Clinical Corrections**

During the initial stages of this advanced practicum, the established theoretical underpinning consisted of the psychosocial framework. Early interest in this model was due to the lack of research into modern-day applications of the framework, especially in consideration of the proposed environment. Despite the questions of my advanced practicum supervisor, who was particularly concerned about the lack of social work supervision in a psychosocial framework, I thought my revitalization of the framework could assist individuals from a psychosocial perspective by engaging and altering an individual's environment. Despite this initial proposal, the application of the psychosocial framework in a federal penitentiary was going to be unsuccessful. Individuals were able to be changed. However, control over their environments was limited. It became my understanding that this rendered the model useless within the correctional system.

When beginning my placement, it became apparent that the treatment of choice among practitioners in the correctional system was CBT. This was prudent for the organization—it possessed significant studies indicating successful validity and reliability—therefore, guaranteeing outcomes for individuals diagnosed with mental health disorders (Hofmann et al., 2012). This model is easy to implement and is effective for teaching clientele (Hofmann et al., 2012). Finally, from a budgetary perspective, this treatment modality allows for the provision of group interventions, resulting in a greater number of individuals served (Hofmann et al., 2012). With this methodology, I learned how to adapt my presentation of the material based on the individuals with whom I worked.

Throughout my advanced practicum, I registered in a CBT certification program from Achology Limited, created by Kain Ramsay. The program was a practitioner certification course and available via Udemy. This was a prudent endeavor, as it facilitated in-depth learning into the theorems, methodologies, and the method of service delivery. The program provided additional information relating to the application of CBT with various populations of mental health disorders, such as psychosis, schizophrenia, depression, and anxiety. The program was self-paced and completed via distance education through an institution. I looked forward to the ability to apply portions of my newly discovered skillsets with a forensic population. Unfortunately, I did not have the opportunity to complete the program due to finding the resource throughout the practicum and the length of the program. The course had significant hours of video, articles, and worksheets which exceeded the duration of the practicum. After completion of the practicum, the CBT practitioner course will be completed as I continue my journey of independent learning.

When the advanced practicum began, I was responsible for a caseload of clients ranging between five to eight people—all individuals presently with the RTC at Bath Institution. The work was rather independent, with each clinician scheduling his or her own appointments and developing treatment plans in congruence with client needs. The number of individuals on each caseload varied, with distribution based on specialty, professional roles, complexity of cases, and group facilitation responsibilities. Individual sessions could be carried out in the Government Inside (GI) building, (where RTC is situated), or on the unit. Group sessions always took place in the GI building. The number and persons on my clinical roster experienced some changes, with new additions replacing others who had moved to various institutions. Many individuals on my caseload had been patients of the RTC for multiple years. My individual clinical sessions varied throughout the week. As the advanced practicum continued, I realized significant flexibility was

required in the position of clinical social worker. Routines changed frequently, and security obligations resulted in units being inaccessible, especially during the pandemic.

Initially, I was able to schedule each client into a consistent interview slot, either on a weekly or bi-weekly basis, depending on need. I was available to my assigned caseload for any suicide and/or self-harm interventions or emergencies from Monday to Friday, from 0800 to 1600. Towards the end of the placement, the clients assigned to my caseload were monitored daily, checked on once weekly with access to nursing staff members and mental health provision in crisis situations. The crucial learning began with the research of evidenced-based methodologies. In this case, it meant reviewing the CBT modality. Preparation was then required prior to the clinical session occurring. I learnt effective time management skills and was able to organize my schedule appropriately. Individual clinical sessions then occurred. After completing detailed assessments, individualized treatment plans were written for the clients. They were shared with the client, revised if needed, and signed-off as an agreement of therapeutic goals indicating how to achieve them throughout the course of treatment.

Multiple opportunities to utilize CBT existed within the correction environment. Our clients experienced various disorders; however, the treatment remained without deviation. CBT demonstrated efficacy with clientele regardless of whether the treated disorder varied. For example, a client with depression easily navigated the underpinnings of CBT which assisted in elevating his mood. Another individual with literacy challenges was able to learn the concepts of CBT through discussion during our clinical sessions. This resulted in his ability to apply the techniques of CBT, challenge his distorted thoughts, and reduce his overall symptoms.

The tools I provided led to the organization of specific CBT session materials into a comprehensive workbook. Free online resources were utilized to formulate this workbook,

primarily from the website therapistaid.com. Examples of worksheets included: Core Beliefs Info Sheet, Cognitive Restructuring: Socratic Questions, Behavioural Experiment, and Thought & Behaviours: Costs and Benefits. The workbook included various sections. Each workbook was personalized to the individual; for example, a person with an anxiety disorder would have tailored explanations related to anxiety, its causes, and worksheets made specifically for treatment. The workbooks shared some commonalities, including the explanation of CBT principles such as core beliefs, cognitive distortions, and erroneous beliefs. The workbooks allowed for individual study and within our sessions.

I provided these workbooks to my clients to support their use of newly acquired skills and independence in addressing their mental health needs. These needs included relief from symptoms of anxiety, depression, and psychosis. Individuals often experience cognitive distortions which can cause an individual to experience physiological and psychological distress. The intensity of the program, the particular worksheets utilized, and the manner of presenting information to the clients varied between my assigned clientele.

With the use of CBT during individual clinical sessions, clients were able to work through their challenges and struggles while addressing their cognitive distortions. They were able to guide themselves successfully through the process of addressing and correcting cognitive distortions. For example, a client with schizophrenia struggled with auditory hallucinations, specifically voices that were taunting, yelling, and speaking to him. We utilized worksheets, such as the challenging thoughts worksheet, to question these cognitive distortions and reframe thinking. The client was able to utilize the worksheet by questioning the validity of the thought, if the thought held weight against counter-opinions, if others would agree with the cognitive distortion, and the listing of arguments for and against. The worksheets were simple enough to

encourage and promote individual learning and practice, as skill acquisition requires practice.

The client was able to continue utilizing his workbook and exercises when experiencing thoughts of paranoia. Although the workbook was effective for literate clients, individuals with low cognitive functioning would require significant assistance and program adaptation.

In my advanced practicum, I thought that CBT was a successful modality for the treatment of multiple mental health disorders. In the correctional environment, it was flexible enough for all individuals to participate, ultimately improving their mental health symptoms while learning specialized skillsets. Learning skillsets begins with the underlying theory and principles of CBT, that our thoughts, behaviours, and emotions are connected. Individuals learn about core beliefs, thinking errors, and cognitive distortions. The individual is then taught mechanisms to examine these errors and distortions through skills such as cognitive restructuring, psychoeducation, practice exercises, and challenging negative thoughts. Participants receiving this treatment modality are expected to practice their skillsets regularly to formulate routine. This is completed in clinical intervention sessions and independently to foster the ability to utilize the stages of CBT intervention to correct erroneous thinking patterns and reduce distress. Due to the versatility of CBT, the basic tenants are easily explained and applied in clinical practice. Throughout the course of individual clinical sessions, clients were taught how to identify their erroneous thoughts, acknowledge their distortions, examine their core beliefs, and implement their learned skills to decrease distressing thoughts. My recently purchased training assisted greatly in the provision and practical application of learned skills necessary for the treatment of mental health disorders.

### **Social Work Work Group Practice in Corrections**

One of my established goals for completion during the advanced practicum included experience in social work group practice. Although I possessed experience regarding group practice, it was limited and external to a federal penitentiary. The ultimate goal was not only participating in social work group practice in corrections but in the creation of group sessions, co-facilitating structured programming, and supervising open groups. In the next sections, I discuss the groups in which I was involved.

The HIIC unit at Bath Institution operates as a well-functioning machine. Established open and closed groups are designated days and hours in which they occur. The groups I was responsible for included yoga and music—both open groups, meaning individuals could join or recuse themselves from the group at any time. The yoga group required the use of technological resources, including a SMARTboard, computer, and DVDs. I was considered the facilitator of this group, however, was not modelling the yoga positions. This was a security decision, as some yoga poses can be revealing or tempting for the male offenders attending. To ensure limited incidents and the health and safety of all involved, the yoga programs were led by an instructor on a DVD movie disc. Unfortunately, there was limited interest from incarcerated individuals. We attempted altering the times, from Tuesday mornings between 9:00 am and 9:30 am to induce participation, as some clients expressed interested but lamented having to attend in the early mornings. Despite the changes and attempts at client engagement, the yoga group continued to be unsuccessful. It was removed and subsequently replaced with a walking and reminiscing group. Unfortunately, due to COVID-19, safety precautions were required, resulting in the provision of group sessions being canceled for an undetermined amount of time.

When initially assigned the task of facilitating a yoga class for our clients, I was taken aback by the request. Unfortunately, I have never attempted yoga or have the qualifications to teach it. I never suspected, as a clinical social worker, that I would be facilitating a yoga group. However, I accepted and began organizing the group. Clients who were assigned to the RTC were notified of the program, which initially garnered support. Clients appeared interested in attending and requested information regarding the newly created recreational group. In the first session, I attended the unit where our clients reside and collected individuals who wished to participate. The initial session consisted of four individuals. We returned to the GI building, where the HIIC team was located. In the downstairs office area, group rooms were available for use. The DVD was started, and the individuals began their yoga session. I silently supervised to ensure the individuals engaged appropriately and from a security standpoint. A second staff member was present, due to security requirements and a portable alarm button assigned to each individual and registered to our locations.

These were the additional components of an advanced practicum most social work students have the opportunity to experience. The session lasted a total of 30 minutes, with the clients assisting in cleaning the area prior to leaving. This was, unfortunately, the last time I would have participants at the yoga group. Despite attempts to have individuals participate, they would make statements such as “I don’t bend that way, miss” to keep from attending. My previous group members were no longer interested in attending. Each week, I would prepare the yoga setting, insert the DVD, and attempt to garner participants for that morning. Unfortunately, our members continued to decline. This group was voluntary; therefore, individuals had the ability to participate or decline. After its lack of participation, an attempt to schedule sessions in

the afternoon occurred. I attempted to garner support from individuals; however, they continued to politely decline.

Instead, a walking and reminiscing group was exchanged and scheduled to begin during the warmer months. Unfortunately, this group never materialized during my advanced practicum due to the restrictions relating to COVID-19. The walking and reminiscing group targeted physical health and socialization—important for the well-being of our clientele. The group would have occurred once to twice weekly for approximately 30 to 60 minutes in length. During the group, an E. Adams, occupational therapist and I would have engaged the clients in reminiscing. Group reminiscence therapy is a structured and brief intervention where participants share past personal events with peers (Gaggioli et al., 2014). Group reminiscence therapy has demonstrated effectiveness for improving well-being and reducing depressive symptoms among institutionalized older adults (Gaggioli et al., 2014). Within the population of RTC at Bath Institution, many clients are older and were identified as potentially benefitting from this type of intervention.

My advanced practicum was more than 50% completed when the COVID (coronavirus disease)-19 pandemic began affecting the world. Within institutions, it meant a constantly evolving response to emerging details. Corrections Canada implemented safety precautions and promoted social and physical distancing, while providing personal protective equipment and sanitizer to staff members. Additional personnel were hired, and our routines changed drastically. Extra precautions were required, as the department remained an essential service. Interactions with clients consisted of screening questionnaires, hand hygiene routines, and physical distancing. Eventually, client interactions were reduced to an as-needed basis except for critical services such as the need for a mental health professional to complete suicide and self-

harm assessments and interventions. I found the experience stressful with built-up tension. The environment and support available ensured I was able to continue despite worries of contracting COVID-19. Corrections Canada had a significant amount of supportive services to ensure the mental health and well-being of their employees. The interdisciplinary team I worked with ensured we kept a positive and safe work environment. We began drawing a mural in our lunchroom utilizing various sharpie markers, with each person contributing an image throughout the week. This allowed the interdisciplinary team and myself to experience some repose and creative outlet throughout the duration of the pandemic. The moments of serenity from the arts-based activity provided helped me throughout stressful days. My role changed significantly when the pandemic began. The unit where clients of the RTC were housed modified routines as safety directives and to prevent cases of COVID-19. I went from seeing my clients weekly for 1:1 clinical sessions to completing weekly mental health check-ins. Restrictions regarding access were imposed, resulting in specific timeslots where clients could be seen. Eventually, I was restricted to meeting with my clients for one hour each morning and three hours each afternoon. Critical services were provided to clients which included clinical discharge planning. All groups and potential groups were postponed per directives from Corrections Canada. I was still required to complete treatment plans, clinical discharge assessments, and clinical services on a limited basis. The clients were affected by the change in services. Their consistency of standardized appointments suddenly changed. For a significant portion of my caseload, the clients required primarily supportive contacts due to infrequent instability regarding their mental health functioning. Limiting interactions with clients removed precious clinical time to address mental health challenges. Fortunately, the clients were still able to access the mental health team when

required. Throughout the COVID-19 epidemic, the clients demonstrated a significant resiliency and flexibility to adapt to ever-changing conditions.

With regard to a music group, this garnered interest from a select group of individuals. The group consisted of individuals receiving treatment with the HIIC unit with the RTC at Bath Institution and individuals from the Moderate Intensity Intermediate Care (MIIC) unit at Bath Institution. Clients who required less intense mental health interventions and primarily required supportive contacts categorize the criteria for the MIIC. A staff member from each department was present at the music group with the MIIC staff members rotating schedules. I was assigned this group and attended weekly. During the group session, I was responsible for the supervision of the clients, engagement, and encouraging participation. Over time, the role grew to include a supporting network of individuals who laughed and celebrated each other's successes. Each week, I went to the living/housing units for our clients and obtained members from RTC and clients from the MIIC unit. We then walked from the living quarters to the music room for our weekly performance. The group took place on the grounds of the medium-security prison in a trailer converted into rooms and office spaces.

Our clientele consisted of the same individuals from both treatment units. The group itself consisted of musicians from the general prison population playing for our clientele. Opportunities to play an instrument (e.g., a complete drum set, shakers, and guitars) were available. However, we primarily sang along with the musicians. Personally, I have never been trained nor utilized music as a form of therapeutic growth; however, this experience provided valuable insight about the effectiveness of music on an individual's mental health, for example, a mix of chords and notes igniting a passion for rock and roll, in days prior to incarceration. Stories were occasionally shared, providing a perspective in the life of an incarcerated person. It

removed the requirement to dwell on negative subjects, even for a small period, providing individuals with an opportunity to relax and enjoy some normalcy. I watched as individuals lost themselves in the music. We sang together often, laughing at silly antics and lauding the musicians for their performances. The music ranged from current pop hits to classic rock and roll – whichever songs were approved by the MIIC mental health team. Clients from the general population who were skilled in music performed weekly for members of RTC and the MIIC units. The intimacy of the group creating a trusted environment and included a small amount of clients. From my experience, individuals enjoyed this form of therapeutic intervention. During the pandemic, previous group members would stop me – stating they missed attending the music group. They shared their excitement for the possibility of groups being re-established once restrictions are lifted.

Lin et al. (2011) indicated that clinical studies provide evidence that music therapy is an effective alternative treatment for autism, schizophrenia, dementia, depression, agitation, anxiety, substance misuse, and sleeplessness. It is unknown if music therapy can replace other effective treatment modalities (Lin et al., 2011). During our group sessions, it is my thought that relationships formed with genuine concern regarding the well-being of each member. I thought that the music group created an almost closed group of incarcerated persons who became friends and a support system for one another. This is similar to mutual aid group work, what Hyde (2013) said, “is to encourage the collective resourcefulness and creativity of the group and minimize the need for professional intervention” (p. 44).

If an individual was not present at the weekly group session, someone would send for their peers and even attend their unit to determine the person’s whereabouts. Witnessing these acts demonstrated to me the importance of the music group in bringing individuals who shared a

common interest together. It also provided a significant stimulus for thought regarding the reality of crime, punishment, and justice. From my perspective the humanity extended by these individuals described as criminals provided a lived-experience regarding the complexities of criminal behaviour. The music group provided the opportunity for individuals to share their experiences, their memories, and their suffering in a safe and comforting manner. Towards the end of my advanced practicum, this group ended due to precautions surrounding COVID-19 and regulations established by the government for frontline staff members. This included students as well.

The social skills group was created by Annah MacDonald and a behaviour sciences technologist named V. McGonegal and targeted as a closed group for the learning of social skills. The closed-group status meant that individuals were recommended to the program either voluntarily or via their assigned clinician and were assessed for appropriateness to the program. Once this was established, individuals were interviewed and asked if they were interested in participating. This involved a commitment of multiple weeks and months from the participants. This group required two facilitators, with one typically leading and the other providing support and tending to the dynamics of the room. On multiple occasions, I was able to facilitate and co-facilitate the social skills group. As an advanced practicum requirement, I assisted and corroborated with fellow interdisciplinary members regarding the session contents, interactive activities, and the format of the individual units. The social skills group typically met on Thursday afternoons with a study session during the morning of a particular weekday that would change depending on schedule, crisis, or meetings.

I was a co-facilitator for this closed group. The group demonstrated a structure and cohesion formed out of planning and investment from the clinicians providing the services.

Unlike unstructured groups, structured groups included designed progression of the individual sessions (Kratcoski, 2017). The initial step involved determining the identification of the facilitators, how many total sessions would occur, and the review of pertinent workbooks prior to the process of interviewing candidates for the program. When I began my placement, these steps were already completed. I had the opportunity to review the material which comprised the group sessions. The content was derived from two different sources which focused on social skills training. The two main facilitators had then created chapters based on the desired group sessions and established an outline. Each week, the facilitators would meet and discuss that day's session.

When I was responsible for co-facilitating, this group became my responsibility. The other facilitator and I would meet and create the agenda for the session. It typically began with an emotion word describing how they felt, a review of the previous week's homework, and an explanation of the session contents prior to proceeding to the psychoeducation component. The sessions typically included at least one activity to practice the newly learned skills. For example, playing games associated with the session topic for the opportunity to obtain certificates of achievement. Upon conclusion, we assigned homework for the upcoming week which entailed the daily practice of new skills. The facilitation component was a shared process, with each facilitator naturally taking turns. I thought that the transition from facilitator to myself appeared seamless, presenting the material as a defined and organized unit.

The value system informing social work with groups was hailed as the "ultimate value of social work" by Northen and Kurland (2001), suggesting, "human beings have opportunities to realize their potential for living which are socially desirable and personally satisfying" (p. 15). Humanistic values were highlighted as integral to social work practice with groups. These values include "individuals are of inherent worth; people are mutually responsible for each other and

people have the fundamental right to experience mental health brought about by social and political conditions that support their fulfillment” (Glassman & Kates, 1990, p. 14). Over time, an interpersonal atmosphere developed among members, reflecting the emotional elements of the group (Soboroff, 2012). It was interesting to watch a diverse population of incarcerated persons with the same diagnosis present themselves with vulnerability, albeit slow to progress. The group? allowed for new skill development, the practice of previously learnt skills, and the provision of upcoming skills to be learned. Throughout the weeks of this group, I watched as the members positively transformed. Individuals characterized as possessing a flat affect due to the diagnosis of a severe mental health disorder were suddenly emoting, verbally responding appropriately, and engaging in appropriate non-verbal and verbal communication skills. According to Soboroff (2012), watching the development of group identity and cohesion demonstrated shared identities and a sense of closeness. It was challenging to realize that a task so simple, such as responding appropriately with assertiveness to an individual, required such determination and work from the clientele. We achieved participation by the inclusion of games, awarding certificates, friendly competitions, and the expectation of general exercise participation. Participants in group sessions typically benefit from interaction with other group members (Kratcoski, 2017). The structure of the sessions included weekly homework requiring all participants to practice their new skills at least once per day. The experience provided learning opportunities in structuring group sessions, creating a timeline for programs, and presenting the program to participants.

Nearing the end of my placement, I proposed the creation of a pain management group for individuals with co-morbidities who experienced continuous pain. The program, called the Mental Health Pain Management group, was a manual already created by staff members

employed within another federal institution. Group sessions were intended to occur for 8 to 12 sessions with the primary goals of increasing knowledge regarding chronic pain management and for the improvement of the general wellness of the individual. The Mental Health Pain Management group includes a compendium of discussion materials, skill-building exercises, handouts, and questionnaires with a foundation of CBT, acceptance, and mindfulness approaches to chronic pain treatment. This would have been a closed group focusing on individuals who meet the criteria. Individuals would have the option of participating or not, however, if interested, would require attending the sessions and focusing on the content provided. The group would have been facilitated by myself and the occupational therapist on the HIIC team at Bath Institution. The manual recommends that the group be held once or twice weekly with participant numbers ranging from between four to eight persons. Two facilitators are recommended for the application of this program. The training for this program would have been completed by a registered occupational therapist from another federal institution in the Ontario region. However, this did not occur due to restrictions relating to COVID-19. Despite this, the program manual was provided to us for review and discussion among ourselves.

With regard to the required credentials, the expectation would dictate that a registered or supervised mental health professional delivered the program. The self-learning of a pain management program seemed to be a daunting task to me. I was not trained in this intervention and worried about implementation. The Ontario College of Social Workers and Social Service Workers (OCSWSSW) discussed the requirements for “a social worker or social service worker . . . shall have and maintain competence in the provision of a social work or social service work service to a client” (OCSWSSW, 2020). Ultimately, if I were to engage in the provision of a pain

management program without the appropriate training and competence, I would be in breach of the social work Code of Ethics and Standards.

Due to COVID-19, the pain management group was placed on hold for the protection and safety of personnel and inmates alike. Regardless, it would involve obtaining training from another federal institution that had experience delivering this program. The organization has decided to continue providing pain management group services once the institution has returned to a normal routine. Throughout this experience, it was assuring to have my ideas valued and acknowledged, knowing that the program you hoped to implement would still be utilized with patients of the HIIC unit in the future.

### **Social Work Clinical Supervision in the Correctional System**

When initially seeking an advanced placement supervisor, the most available professional was a psychologist employed with the Millhaven Institution, RTC, HIIC unit. The psychologist was eager to provide clinical supervision during the advanced practicum. However, a clinical social worker would have not only been an ideal candidate for supervisor, but also necessary for an advanced practicum. An unexpected opportunity arose, and I was able to secure Annah MacDonald, a clinical social worker for the Bath Institution, RTC, High-Intensity and Intermediate Care Unit. The opportunity resulted in the provision of highly personalized, contextually rich, and generous growth edges in a social work practice context.

The specifics of clinical supervision included scheduled weekly meetings that lasted from one to two hours in length. We initially decided on Monday afternoons; however, due to the sometimes-chaotic requirements of our clientele and schedule, we required flexibility for our meetings. The positive mental health functioning of our clientele and the provision of services were essential, especially during the COVID-19 pandemic. The topics of supervision varied each

week; however, these were standard topics of conversation such as identified issues, client caseload review, self-reflection, and the ability to engage in reflexive practice.

Our clinical supervision sessions were brutally honest and candid, while examining various experiences throughout the week. For example, during our first clinical supervision session, I confessed my lack of confidence in my supervisor, citing her age and limited experience. I was the first student she had supervised since completing her MSW with an undergraduate degree in psychology. I was completing my MSW with a background which includes a Bachelor of Social Work and Psychology degree so I pondered what I could possibly learn from this individual. I was also older and had been employed in the social services sector for well over a decade. I had amassed significant experience in various organizations. My supervisor worked primarily for corrections, providing a specialization in her professional career. Initially, this subject was the focus of my journaling until we met for our first clinical supervision meeting. My supervisor was patient and understanding of my concerns, while we examined the underlying reasoning related to my thoughts. After much discussion, I came to realize multiple erroneous beliefs which were affecting my perspective of the situation. My supervisor held a wealth of knowledge in an area of specialty that I had only recently considered a viable career option. She was experienced, knowledgeable, and with skillsets different from my own. I realized my opinions reflected the biases of ageism and elitism. Together, we explored these erroneous beliefs which laid the foundation of our clinical supervision sessions.

Throughout supervision, themes connected to my social work practice emerged and re-occurred. The discussion of boundaries and my function as a clinical social worker as an individual and within the correctional system became ongoing conversations. Sometimes, the topic of assignments throughout the advanced practicum experience arose.

A recurring theme included social, emotional, psychological, and physical boundaries meant to provide protection to both the health care professional and client while providing patient-centered care (Porter-O'Grady & Malloch, 2003). Altering my perceived boundaries from the field of disability and children's mental health services required guidance, support, and learning opportunities. When working with this type of population, boundaries are significantly different than those established in the correctional system. When I was working with children and persons with disabilities, often, I engaged in hands-on activities, making our proximity closer. Physical distancing differed, as various therapeutic interventions required closer proximity to each other. Emotional and social boundaries were also different. The manner in which children and persons with disabilities are treated in comparison to incarcerated individuals varies greatly. In my opinion, society demonstrates greater compassion for vulnerable groups such as children and persons with disabilities. Incarcerated individuals have an unfortunate stigma which expands into the development of boundaries. In the correctional environment, my idea of boundaries changed dramatically. I never realized the intensity of boundaries in the correctional environment. Topics of conversation I would consider rapport building would be considered by my fellow interdisciplinary team members as a concern of boundaries being breached. For example, a client who stated he enjoyed our sessions was seen as crossing boundaries while I just viewed the comment as an indication of successful rapport building. It was challenging navigating the differing opinions, especially when they were counter-intuitive to my professional practice ideologies. When I attended the New Employee Orientation Program, they discussed the importance of boundaries with offenders while providing significant examples. This included differences in severity when working with offenders. Some individuals did not see a problem with sharing innocuous information, while some staff members refused to

share any details of their lives with offenders. The range varied, with individuals electing to implement their understanding of boundaries. Even after the advanced practicum, I still question and reflect daily regarding boundaries, perceived boundaries, and their effect on the client-social worker relationship. Did I experience greater outcomes due to my differing approach regarding boundaries? Was the expected severity of boundaries impeding the possibility of obtaining significant treatment advancement? These questions continue to permeate my mind, even after the advanced practicum.

The interdisciplinary team provided significant learning experiences, examples, and case studies regarding the successful application of boundaries. In a casual group learning scenario with members of the interdisciplinary team, roleplays occurred to practice interactions with offenders utilizing assertiveness in contrast with aggressive mechanisms of communication. The process of establishing clear, definitive, and rigid boundaries formulated immediately upon providing services to clients. For example, a client who was always stopping me when completing other duties would take a significant portion of my intervention times to discuss matters which affected his person. This client was not assigned to my caseload and was seeking information which was not within my purview. Despite previous attempts to dislodge myself from the conversation, the client would continue speaking and drawing my attention to the components of his conversation. After completing some boundary exercises and reading material about boundaries, I was able to establish a professional boundary with this individual. When he approached, I reminded this individual that another clinician was assigned to his case and provided redirection. The information was professional, to-the-point, and effective. The client thanked me for the information and stated he would wait to speak with his assigned clinician. For the remainder of the advanced practicum, the individual did not approach me or interrupt the

completion of my duties. The enforcement of boundaries had an immediate effect and promoted accessing the appropriate individual relating to the individuals' concern(s).

The benefits of establishing boundaries had demonstrated effectiveness in providing structure to the therapeutic process and establishing a productive yet professional relationship throughout the provision of clinical services. The individual sessions consisted of clear expectations and direction. For example, I would notify the clients of their responsibilities when engaging in clinical sessions, the expectations for participation and regulations to adhere to. This included being respectful of staff members, even when experiencing challenging experiences and/or emotions. The clients were presented this information via a non-scripted conversation, explaining the importance of maintaining professional boundaries. It resulted in reduced anxiety in patients, reinforced stability, and greater treatment outcomes. With predictable routines and enforcement of rulesets, clients were able to concentrate on treatment goals, thus, improving their overall mental health while reducing negative symptoms.

The benefits of establishing my professional boundaries demonstrated effectiveness in providing structure to the therapeutic process and established a productive yet professional relationship throughout the provision of clinical services. It resulted in reduced anxiety in patients, reinforced stability, and greater treatment outcomes. With predictable routines and enforcement of rulesets, clients seemed able to concentrate on treatment goals, thus, improving their overall mental health while reducing negative symptoms. As a social work student, I learned the effectiveness and importance of establishing clear, definitive boundaries with clients to ensure an appropriate professional relationship and establishing a code of conduct.

A final assignment was provided by Annah MacDonald that requested a concrete explanation of myself as a social worker and a social worker in corrections. The review of

completed journaling—written throughout the course of the advanced practicum—demonstrated the ongoing nature of personal and professional development. Various stages of understanding and learning occurred with initial thoughts of competence in the provision of social work services within a correctional environment. This thinking was reinforced by previous employment and experiences in the community. The realization of the significant differences between social work provision in the community and social work provision within a federal penitentiary quickly provided the stark reality of the practicum environment. Significant requirements, such as the responsibility to the public for safety, the provision of humane treatment to the incarcerated, and the overall rehabilitation of prisoners were balanced in tandem through a complexity of directives, legislation, and regulations. In my experience, providing mental health services within an institution required flexibility, the ability to work with various portions of a complex system, and significant patience to navigate the relationships required for the benefit of the offenders. Quickly, I realized the depth of my inexperience and limited knowledge regarding clinical social work in federal corrections. Despite the initial feeling of surety regarding clinical social work, the advanced practicum resulted in beginning anew, seemingly reliving initiation into the workforce after graduation.

Imposter syndrome became a significant conversation piece of our supervision meetings with the initial stages of clinical service provision timidly presented. Imposter syndrome is a psychological pattern in which one doubts his or her accomplishments with a persistent internalized fear of being exposed as a fraud (Langford & Clance, 1993). Although not a psychological disorder, imposter syndrome is considered a phenomenon which occurs in an individual. According to Sakulku & Alexander (2011), the first scale to measure characteristics of imposter phenomenon distinguished it by the following six dimensions: the imposter cycle,

the need to be special or the best, characteristics of superman/superwoman, fear of failure, denial of ability, and discounting praise, and feeling fear and guilt about success. With the new practice environment, I felt increasingly inefficient. Other members of the interdisciplinary team discussed their experiences with Imposter Syndrome. I questioned my clinical abilities, knowledge, and general capabilities while in the role of a clinical social worker. After sessions with clients, I would feel useless due to the limited progress made by the individual. It was through our supervision sessions where I learned the reality of imposter syndrome and its effects on myself as a social worker and human being.

Throughout the course of the advanced practicum, I began examining myself as a social worker, including myself as a social worker in corrections. As a structural social worker and rights advocate, learning the rigidity and complexities of the federal justice system provided significant challenges regarding my personal mandate. I referred to it as a conflict of values, whereas my personal values conflicted with the overall mandate, practices, or direction of the government agency. Simple notions, such as the provision of therapeutic tools, have a structured protocol for the adherence of all persons.

Accessing clients became challenging due to security and organizational requirements, removing precious opportunities to engage in clinical interventions with clientele. As a regulated professional, I was responsible for adhering to the rulesets of an employee within the organization. Timelines for interventions existed based on the Integrated Mental Health Guidelines, the document which provided all the protocols for mental health staff members. When security incidents occurred, I found myself and my schedule completely interrupted. I would intend to meet with clients only to be notified that the unit was locked down. This process occurred throughout the placement, requiring great flexibility. Prior to the placement experience,

I had a tendency towards rigidity; however, completing my advanced practicum within a federal institution resulted in significant growth relating to my ability for flexibility. The change of routines—sometimes on a moment's notice—resulted in me requiring greater patience and the ability to change my pre-planned activities. Adhering to the guidelines was initially daunting; however, the members of the interdisciplinary team were invaluable assets to my learning. Eventually, being flexible became part of my professional identity. Within the correctional environment, the security of staff members and incarcerated persons is of the utmost priority. The balancing of security with therapeutic interventions meant finding a compromise regarding service delivery and safety. We were provided with daily information from Operations regarding security challenges and updates for the institution. I would typically learn of the unit closure from Operations, the correctional manager, or the chief of mental health services regarding changes to the routines or access to clients. Occasionally, this would interfere with pre-planned routines, clinical sessions, or scheduled conferences. It required significant flexibility to adapt to these changes, including asking for permission to complete a clinical interaction based on correctional officers. This process was initially frustrating for myself. I worked in previous environments where I had unlimited access to my clientele and could interject with clinical sessions whenever required. The processes of working with another department, scheduling required interventions, completing suicide and self-harm assessments, and maintaining professional requirements were challenging. For example, attempting to complete a self-harm assessment when a unit is locked down requires additional steps, permission from correctional officers and coordination of action regarding meeting with the incarcerated individual. This could entail security transportation of individuals for a clinical session or supervision from correctional officers. Throughout the advanced practicum process, it became apparent that

greater patience was required when navigating a complex system such as corrections. It also required continual planning of alternative tasks to complete should a scheduled appointment be delayed or cancelled. Additionally, scheduling with fellow mental health practitioners due to limited interview spaces on the units occurred frequently. The situation was not ideal for the delivery of mental health services, however, satisfied security concerns while abiding by clinical frameworks.

### **Discharge Planning in the Correctional System**

Throughout the advanced practicum, I was assigned two clinical discharge files for completion. This entailed meeting with the clients to explain confidentiality, breadth of services available, and to confirm the provision of clinical discharge services. Once the required documentation and consents were completed, the assessment sessions began—examining 22 social determinants of health and the intensity of required services. The protocol for completion of the clinical discharge assessment is two months from the initial start date. Unfortunately, I often obtained clinical discharge referrals with limited notice, resulting in rushed services and tight deadlines. After information was collected, an in-depth assessment was completed. This involved researching services, organizations, nonprofit organizations, employment services, and more within communities of destination. These reports were very complex and involved—providing information regarding the completion of referrals, how to access the identified services, and an organized discharge plan to be utilized prior to the offender's discharge. The report intends to pair the needs of the individual with services/goods upon release from federal incarceration.

The two clinical discharge files varied significantly. The first discharge file involved the deportation of an offender upon release. The second file was a general release into a community

within the country. The opportunity to complete both types of clinical discharge planning provided a breadth of experience and saturation of knowledge.

The clinical discharge planning process includes outstanding legal complications such as deportation involves complex systems and the involvement of government agencies for completion. When an individual is scheduled for deportation, the clinical discharge assessment must contain information to obtain services in the country of origin. This includes international telephone contacts, scouring the Internet, and completing a detailed arrangement of services and tasks for completion. If completed appropriately, the individual receiving clinical discharge services will have a thorough document which includes the names, addresses, telephone numbers, and instructions on how to access the required/requested good/service. The clinical social worker is responsible for organizing all services possible. However, due to extreme circumstances, not all suggested items identified on a discharge plan can be completed. For example, if an individual required assistance from Ontario Works, they would need to present at a local office upon release with the appropriate paperwork. A clinical social worker can provide information to access the nearest Ontario Works office. However, accessing and completing the task is reliant upon the individual.

The process of completing a clinical discharge assessment report for the deportation file took a total of five working days. This meant limiting my clinical interventions, not completing additional duties, and solely focusing on the research and development of the clinical discharge assessment. Due to the complexity of the deportation, three options were required per identified social determinants of health. The general discharge plan still required concentration and effort. However, only one engineered discharge plan was required. This resulted in faster service delivery and less research required. Regardless of discharge planning complexity, the clients and

clinical social workers reviewed the finalized report for accuracy and agreement. Once the report was signed, the clinical social workers began the process of contacting services, completing referrals, and other tasks as outlined in the clinical discharge assessment report. If completed effectively, discharge planning reduces recidivism, increases public safety, and results in a reduction of homelessness. This is an important process for the successful transition of incarcerated persons to the community.

The secondary report, completed nearing the end of my placement, was of an offender being released to a city in the Province of Ontario. This clinical discharge assessment report was not as complex as the deportation file, as legal challenges and the requirement to engage with other countries and their representatives did not exist. The client was met on multiple occasions to complete the discharge planning process, from the initial session to our final session, where the client received a detailed review of the discharge plan. The individual was provided an opportunity to review the discharge assessment to comment and remove services he was not interested in pursuing. For example, this individual had a history of substance abuse, including the current use of illicit substances, however, did not wish to seek assistance or support for his addiction. The items identified on the clinical discharge assessment report which included substance recovery organizations, were immediately removed from the program. It reinforced that individuals must have autonomy in electing when or if they engage in appropriate services. In this case, the client was extremely vocal about his decision regarding substance recovery organizations. The remainder of the clinical discharge assessment report was centered on the individual's city of release and included all required information to access services.

### **A Discussion of Reflexivity**

Being reflexive involves examining our involvement in creating social or professional structures counter to individual values (Bolton, 2014). It involves becoming aware of the limits of our knowledge, how behaviour affects organizational practices, and why such practices might result in the marginalization of groups or the exclusion of individuals (Bolton, 2014). Reflexivity involves thinking from within experiences to focus attention upon an individual's actions, thoughts, values, identity, feelings, and their effect upon other individuals, situations, and professional and social structures (Bolton, 2014). Reflexive thinking requires a distanced view from personal belief and value systems for the purpose of understanding themselves and their relationship to the world (Bolton, 2014). To ensure I engaged in reflexive practice, I utilized the through-the-mirror model of writing—designed to illuminate and explore my experiences instead of creating them. The daily reflexive and reflective writing occurred to question my biases and skirt beyond the boundaries of comfort. Engaging in through-the-mirror writing provided greater insight and experience in the realm of social work.

The criminal justice system is complex and often demonstrates the challenges of ethical and humane treatment. The incarceration process for an individual includes the removal of a plurality of their fundamental human rights. This renders the criminal justice system in a precarious situation, establishing and implementing the breach of rights out of a requirement for justice. Incarcerated individuals are uniquely complex because they are perpetrators of crimes yet victims of circumstance. The roles of social workers in the criminal justice system are also complex. Social workers are expected to advocate on behalf of their clients which can often result in conflict. It is almost inevitable for social workers to experience resistance when advocating for people with restricted rights—inevitably interacting with the oppressor.

Navigating the correctional organization while advocating presents a myriad of challenges. It involved learning where and how to advocate within a system which is responsible for oppressing people's rights. I struggled with this concept, viewing and preferring rehabilitation of criminals. The strict regimented routine and structure of the prison environment were initially challenging. I struggled with the required balance between security and mental health. Occasionally, this would result in a need to advocate for allowances of mental health service provision when denied access from a security perspective.

### **Summary**

Throughout the advanced practicum, I achieved the goals established in the initial learning plan. This meant ensuring to engage in all components which comprised the training plan while completing the required 450 advanced practicum hours. This chapter highlighted how I nurtured my learning process through the development of my clinical practice in a correctional facility as a clinical social worker. The implementation of CBT with clients attending the Regional Treatment Centre—HIIC—at Bath Institution was discussed regarding efficacy. I began exploring the process of reflexive practice using the research to dissect themes, observations, and questions regarding the advanced practicum experience. I learned that a limited number of social workers sought careers in forensics, therefore, limiting the number of resources, supervision, and research available. The next chapter addresses the conclusion and how the analysis presents implications for social work practice.

### **Chapter 4—Conclusion**

To fulfill partial requirements for the Laurentian University, Master of Social Work program, I completed the advanced practicum (SWRK 6024) from January 6, 2020 to March 31, 2020. The practicum was completed at the RTC, HIIC unit with Corrections Canada at Bath Institution. My goal was to experience the role of a clinical social worker within a federal institution. This included experiencing social work group practice, social work clinical supervision, discharge planning in the correctional system, and the application of CBT while learning the responsibilities of a clinical social worker.

My placement consisted of direct and indirect services with clients within the RTC. Direct services included crisis intervention, clinical assessment, and therapeutic interventions. Indirect services included required forms, paperwork, completion of treatment plans, and overall documentation relating to clinical practice. As the designated student clinical social worker, there is a responsibility to oversee the mental health functioning of one's clients. This information is frequently assessed with information shared between members of the interdisciplinary team. Additionally, the organization provided multiple opportunities for ongoing learning and development.

Through the use of reflexivity, reflective practice, supervision, and peer support, I was able to enrich the lessons and experiences within my practicum placement. The self-awareness and insight, coupled with strong clinical experiences and professional development, permitted me to attain and exceed the learning goals I set for myself. This chapter illustrated how my knowledge and skills scaffolded throughout the time of my placement and resulted in a rich learning experience. Through my clinical experiences and peer discussions, I began to discern elements of my personal approach to psychotherapy. This chapter further elaborates on

reflections and descriptions of the process I undertook to acknowledge and develop my therapeutic approach. The chapter also examines reflections of my practicum experience regarding the compatibility of CBT in corrections. Finally, I discuss the implications for social work practice.

The implementation of CBT within a correctional setting provided significant positive results. When conducting individual clinical sessions, the methodology demonstrated its adaptability. I found the implementation of the CBT model with clientele was simple and easy to comprehend. Clients with low cognitive functioning were able to engage in CBT without alteration of the initial program. This meant that individuals with low cognitive functioning were able to apply CBT-related exercises, including challenging their thoughts, to participate in the intervention. CBT provided significant support for individuals suffering from cognitive distortions and taught them effective mechanisms for challenging their beliefs. For some individuals, the intervention changed how they viewed their illness and symptoms. The implementation of CBT in a group setting was not possible, as a dialectical behaviour therapy group had just finished prior to the commencement of my advanced practicum. This was a goal I did not achieve throughout the advanced practicum.

Social work group practice in corrections consisted of facilitating open and closed groups, ranging from a music group, to yoga, and to social skills for individuals. Upon beginning my advanced practicum, these groups were already established. It was my responsibility to supervise and/or deliver the groups and to engage the clientele. Unfortunately, the yoga group was unsuccessful due to limited interest and lack of participants; however, the music group and social skills group functioned on a weekly basis. As discussed, the yoga group only garnered interest during our initial session. All sessions afterwards did not successfully gain the interest of

individuals. I initially felt that this was my failing and that lack of participation would be viewed as inefficient program delivery by my supervisor. As the interdisciplinary team discussed the lack of interest, we decided to change the program to a walking and reminiscing group. Although we agreed on its implementation, the walking and reminiscing group was not facilitated due to organizational changes related to COVID-19. The music group ran successfully every week, with my responsibility to facilitate with a member from another mental health department. Initially, I could not understand the reasoning for having a music group. Eventually, I began to realize the importance of the music group to our clientele and the need for continuity of that group. It allowed them to personally engage with the music, selecting songs and singing wildly. During these instances, even clients who were more reserved engaged in the group activity. The social skills group demonstrated remarkable ability regarding overall client change. It was interesting to watch the growth of individuals attending.

While facilitating and supervising the group practice in corrections, I was provided greater experience in the correctional environment, practicing appropriate boundaries while delivering required services. These open- and closed-group sessions provided the opportunity to view differences between structured and unstructured groups. During closed-group sessions, I would sometimes need to remind clients of inappropriate comments, statements, or behaviours. This was accomplished by reviewing the session agenda, including the expected rules within the established group. I learned that creating an agenda with clear, concise instructions immediately notified participants of their expectations while attending all sessions. The rules were typically written on the whiteboard, serving as a reminder to individuals of their responsibilities regarding behavioural comportment. During open group sessions, boundaries varied. With the music group, we were all participants despite my role of supervision. I engaged with the clientele, the

band members, and sang along to the music. This group was more relaxed, and although it held minor structures, such as the date and time, the remainder of the session included bonding with participants through music and its affiliations to life events. Watching and listening individuals recount stories of lost loves, the mistakes they made, and overall hope of forgiveness added additional substance to this group. We celebrated when a member was released. With boundaries, it was important to provide clear direction and interject immediately when boundaries were being breached. I engaged in this behaviour to ensure that clients and staff members were aware of expectations prior to any incidents occurring. Although I felt uncomfortable with the installation of boundaries, it was a required skill to learn, acquiesce, and practice throughout my advanced practicum.

My social work clinical supervision in the correctional system presented various struggles. Learning how to operate within a medium-security prison and a RTC was challenging. The rules, regulations, security protocols, and overall procedures differ greatly from external institutions/organizations. When I was employed with organizations whose services focused on children and persons with disabilities, the process did not include complex security detail. There was never a requirement for security parameters, unlike that of the correctional system. Simple safety protocols existed, such as personal alarm devices when working independently with a client. However, the correctional environment employs significant security protocols. Rulesets were implemented to ensure the health and safety of staff members and those incarcerated. Although each organization has policies, procedures, and safety provisions, the difference in intensity varied greatly. Supervision provided the opportunity to learn the underlying mechanisms of this structured forensic unit, including how to navigate and provide services to our clientele.

Additionally, individual cases were discussed in detail, including the comportment of behaviour and direction on clinical practices. Thankfully, a great amount of time was dedicated to self-reflection and reflexivity. These processes differ greatly, as reflexivity is an “attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process” (Cohen & Crabtree, 2006). Alternatively, self-reflection is the process in which individuals grow their understanding of who they are, their values, behaviours, and their underlying reasons (self-reflection, n.d.). Assignments were provided, including the opportunity to reflect on myself as a social worker and as a social worker in corrections. This was paramount to my learning. As I discussed earlier, I would often question myself as a social worker and claimed imposter syndrome quite frequently (Langford & Clance, 1993). The process of completing my advanced practicum within a forensic environment provided significant growth regarding my clinical experience.

I had the opportunity to gain significant knowledge regarding interventions due to the diversity of the interdisciplinary team and their various skillsets. It provided me with an overall understanding of different variations of interventions. For example, our occupational therapist would engage her clients while incorporating physical activities. The behaviour science technicians provided manualized therapies. Each member of the interdisciplinary team shared his or her interventions through psychoeducation between peers. Often, we had conversations relating to our clients, their challenges, and different interventions. This promoted cross-learning between disciplines. I was able to apply aspects learned from the different interventions utilized. For instance, the proposed walking and reminiscing group was created via peer dialogue with the occupational therapist. The ability to implement my learned interventions with incarcerated

individuals assisted in developing my clinical abilities. All these factors contributed to significant growth regarding my clinical experience.

Throughout the advanced practicum, my clinical skills improved. It was important that my foundational clinical skills were cemented, as the environment requires an individual who is aware of evidence-based methodologies and how to apply them. My background in the field of mental health and disability provided significant experience prior to commencing my advanced practicum. I was required to determine appropriate treatments for clients after the completion of the assessment and the writing of a treatment plan. Strategies and the provision of therapeutic interventions required my ingenuity, flexibility, and a concrete understanding of evidence-based interventions. A new practitioner, in my opinion, would struggle in this environment due to the complexities of the role and the considerations for security. Over time, my ability to adapt to the environment quickly was successful in the delivery of treatment. My clinical skills improved with constant use, adapting programs, and tailoring sessions to the individual. My knowledge base increased based on interactions with the interdisciplinary team members, resulting in the learning of new techniques, approaches, and interventions previously unknown to me. I was also fortunate to practice my clinical skills with clients who were willing to participate in receiving therapeutic interventions from me. The process engrained that learning is fluid and continues to evolve over time resulting in new learning opportunities with the ability to expand my practice.

The role of a clinical social worker with Corrections Canada consists of significant responsibilities regarding their position. With this role comes the expectation of being an expert discharge planner due to the nature of social work education and specialties regarding micro, meso, and macro organizations. In the RTC, I was responsible for an assigned caseload of clients which varied with intakes and discharges. I was also responsible for completing therapeutic

interventions, managing their assignments, completing documentation per organizational /certification body expectations, creating treatment plans, facilitation of group services, and supervision of students. There are many other duties associated with the role of clinical social worker, resulting in a demanding caseload with tight deadlines due to legislative requirements. Working within this role has resulted in my greater ability to engage in time management, organizational practices, and structuring tasks in order of importance.

The discharge planning process in the correctional system is complex, with clinical social workers completing the assessment and creation of a stabilized plan post-release. The services are necessary if the criminal justice system would like to decrease the likelihood of recidivism and increase overall rehabilitation in the community. Learning how to complete the clinical discharge assessment was a significant opportunity with a single report totaling 37.5 hours of work, including the assessment, client interactions, research, and data collection for the discharge planning process. This required focus and determination to complete the assessment, including the organization of the document. As my advanced practicum ended, two clinical discharge planning reports were completed. These were provided to the clients for review and will be provided to the assigned clinical social worker for completion of discharge planning stages required prior to release.

Completing the advanced practicum with Corrections Canada was an unexpected yet incredible opportunity. When initially planning my professional future, forensic social work was not an area of interest. After an unexpected opportunity, I was able to engage in a new aspect of social work, expand my knowledge, and acquire new skills. It also solidified my newfound interest in forensic social work. Working with the range and diversity of my clientele, I watched them develop skills to improve the symptoms associated with their diagnoses. Individuals

continued making progress by utilizing techniques, strategies, and the basic underpinnings of CBT, including but not limited to identifying core beliefs and how they affect an individual, identifying cognitive distortions, and the reframing of erroneous beliefs. These individuals demonstrated great effort in being the best selves they could. Unfortunately, there were occasions where they were a detriment to themselves or simply unable to participate in treatment due to not being emotionally prepared to address their various illnesses and symptoms.

The advanced practicum would not have been a success without the members of the interdisciplinary team. I thought that the individuals employed with the RTC were inspiring in their dedication, abilities, and experience working with individuals suffering from mental health illnesses. Each day, I was privileged to work with educated, qualified, and professional practitioners who provided ongoing learning experiences. These professionals were available for a case consultation, supervision, or reviewing documentation on a continual basis. When my supervisor was unavailable, another member of the interdisciplinary team interjected to assist. They provided tasks, opinions, and clinical observations to improve my practice and learn the regulations of the correctional system. I was openly invited to participate in interventions, case conferences, and supervision to promote a positive learning environment filled with opportunity. The experience of working with an interdisciplinary team demonstrated the benefits of various professionals providing care to a team of individuals with significant mental health disorders to me. If future social work students are interested in completing their Advanced Practicum with Corrections Canada, the possibilities for research and growth are unsurmountable. The ability to engage in significant, client-based change are only a few of the inherent benefits of completing a placement with the organization. Prior to engaging in a practicum within a federal correctional institution, I would recommend interested social work students to coordinate an opportunity to

visit and tour the groups to determine level of comfort prior to engaging in the practicum experience. I would also encourage obtaining required documentation and screening checks – such as completing fingerprinting, obtaining a police verification report, and providing education documentation – to ensure prompt commencement of placement once approved by the institution and post-secondary professors and departments.

### **Future Research**

Significant research opportunities exist in relation to themes extracted based on the advanced practicum. Limited social work research within federal penitentiaries decries healthy opportunities for researchers interested in forensic social work. The almost unthinkable variables provide significant research opportunities which could provide additional resources regarding social work practice within a forensic environment. This caveat of untouched research data could provide improvements regarding the provision of mental health care delivery to incarcerated individuals in federal institutions while improving communication between staff members. Social workers have a significant opportunity to engage in shaping the correctional system through the observation, collection, and assessment of data within the correctional environment.

### **Implications for Social Work Practice**

Throughout my advanced practicum, CBT was the preferred methodology for working professionals employed with the correctional service at the Regional Treatment Centre—Bath Institution. CBT is a functional model which has provided significant improvement for patients. It can be delivered in group or individual format (Dogaheh, Mohammadkhani, & Dolatshahi, 2011). This provides organizations the ability to maintain the needs of their clientele while engaging in fiscal responsibility (Morrison, 2001). While beginning my placement, I realized that my previous learning of CBT was an asset to the placement environment. It provided the

opportunity to jump-start my placement experiences without requiring completion of training regarding the CBT model. Although CBT has demonstrated clinical effectiveness, I agree with Westbrook and Kirk (2005) in the application of other interventions dependent on client needs. For example, a client who took an interest in drawing as a method of coping worked exceptionally well with arts-based interventions. Another client who had already developed excellent coping strategies benefitted from a narrative therapy approach. Person-centered therapy resulted in the development of my clients' self-actualizing tendency (Rogers, 1957, 1966). This included an internalized proclivity toward fulfillment and growth via therapist genuineness, acceptance, and an empathic understanding (Rogers, 1957, 1966).

Clinical social workers complete various tasks in the criminal justice system, including risk assessments, mental health, and substance abuse counselling, pre-sentence reports, group therapy, community outreach, employment, and social service advocacy (Brownell & Roberts, 2002). As a profession, clinical social work does not have a major presence in the criminal justice system, with limited associated social work education, lack of professional courses, and/or programs or specializations in forensic social work available (Reamer, 2004). Social work students seldom elect a career as a clinical social worker in corrections, resulting in few scholarly articles or other research published about criminal justice issues authored by social workers (Reamer, 2004). Having experienced completing an Advanced Practicum with corrections, I would recommend the field to any social worker looking to create revolutionary change from a micro perspective. I never considered clinical social work in corrections as a viable career option due to the naturally oppressive environment. Social workers employed in corrections reported complex needs and significant vulnerability of forensic clients which requires specialized

knowledge of individual functioning and other systems to effectively engage in service provision (Sheehan, 2012).

The specialty for clinical social workers within the federal correctional system, at least in the Ontario region, is clinical discharge planning services. Initially, I was confused regarding the specialization of social workers within the correctional environment. Discharge planning was never a specific course I took or studied, nor was it a specialty I had associated with the profession. If social work students were interested in corrections, I would suggest investigating the process of completing discharge planning and the complexities involved in the process. I was fortunate to have excellent guidance and frames of reference, including previous employment experiences. My supervisor, Annah MacDonald, was instrumental in my learning regarding the clinical discharge assessment and subsequent report. She provided blank templates, example templates, a manual which detailed the process, supervision in clinical discharge planning appointments, and one-to-one instruction regarding the completion of the process. Her dedication to teaching and enhancing my social work skills was truly appreciated. I grew as a social worker through the creation and management of clinical discharge assessment reports and facilitating reintegration plans for offenders leaving the institution.

Discharge planning is an essential function to ensure successful reintegration support for individuals being released from the correctional system (Valera, Brotzman, Wilson, & Reid, 2017). Clinical social workers within the federal correctional system are required to complete complex discharge planning for clients before release from incarceration. Evidence has demonstrated that discharge planning is effective in reducing recidivism, increasing public safety, and decreasing homelessness (Harrison, 2001; Petersilia, 2001a, 2001b; Travis & Petersilia, 2001). In my federal correctional experience, discharge planning typically commenced

at least one year from release, especially if the release situation was complex. This provides the clinical social worker time to complete the required stages, complete external referrals, submit information on behalf of clients, and organize services prior to discharge. Unfortunately, not all cases are referred in a timely fashion due to uncontrollable circumstances, resulting in rushed reports and inadequate preparation of discharge supports. This affects the positive implications of accommodation being provided upon release, impacting employment, social well-being, and health outcomes (Bahen, 2016). In my opinion, social workers aiming to complete clinical work in corrections have the opportunity to enhance the experience of the incarcerated and implement significant policies and/or procedures for the betterment of the serviced population.

Throughout the advanced practicum experience, I worked alongside an interdisciplinary team of professionals who specialized in various areas. This relationship was important to the provision of professional services to clientele. It ensured all clients obtained the services they required throughout the period of their incarceration. Interdisciplinary health care has significant benefits, including features associated with increased collaboration. This includes organizational support, knowledge sharing, mutual trust, professional diversity, participation in decision-making, knowledge integration, affective commitment toward the team, and belief in the benefits of interdisciplinary collaboration (Kebe et al., 2019). The correctional environment is rigid and subject to a significant number of rulesets, guidelines, and directives (Johnson, Rocheleau, & Martin, 2017). Interdisciplinary health care is required in complex systems, such as a correctional environment, to ensure patients have access to the most consistent and organized services possible. Each member of the interdisciplinary team is responsible for duties as assigned by their job descriptions and, if applicable, regulatory bodies. This format of service delivery to patients is streamlined and provides for a team approach.

As previously stated, clinical social work supervision is an important component to clinical social work training and professional practice, as it provides an opportunity for individualized professional growth with a positive space for transformative learning, authentic exchanges, and enhanced clinical care for individuals (O'Neill & Mar Farina, 2018). The supervision component of my advanced practicum was intimate and highlighted obtained skills and attributes, such as increased flexibility, reflexivity, and individual growth. In my opinion, a successful social worker engages in clinical supervision throughout the course of his or her career. This would provide ongoing growth and support throughout a social worker's clinical practice (Ketner, Cooper-Bolinsky, & VanCleave, 2017).

Limited research is available regarding social work practice with groups in the criminal justice setting. No research relating to the social work with groups in the RTC has been researched. The limited vocational interest in forensics, including the limited education available related to forensic social workers, has resulted in little scholarship on criminal justice issues which are authored by social workers (Reamer, 2008). Social work groups were a fiscally responsible mechanism for employers to utilize and achieve targets while providing evidenced-based methodologies to clientele (Morrison, 2001).

There is an undeniable and inevitable conflict regarding the rehabilitation and health of the inmates between social work practice and the correctional system (Young, 2015). The required authoritarian nature of imprisonment, coupled with the overall holistic approach of social work, including the promotion of individual freedoms, has resulted in conflict between system structures (Young, 2015). I was not prepared for the requirement of including various departments, personnel, and clients to curb individual divide while promoting shared goals and outcomes. This, coupled with operating within the confines of institutionalization, is a complex

component of clinical social work unknown to practitioners. The limited education and research relating to social work in corrections—including the lack of clinical social work specializations—create a cyclical underrepresentation in this field. In my opinion, the lack of educational specialty in post-secondary institutions relating to criminal justice and criminology results in little knowledge in this field. Social workers without an interest or connection to the criminal justice system may not realize the importance of the profession entering the field of corrections. Accordingly, I believe the unknown territory of corrections for social workers results in limited numbers applying and working within the system. In my opinion, the lack of social workers in corrections has resulted in the organization having a compartmentalized perspective of social work, including what the profession entails.

### **Summary**

A predominant, recurring theme throughout the advanced practicum included the reflection of myself as a social worker and as a social worker within the correctional system. The use of reflexivity and reflection are crucial components to the practice of social work. Since discovering the social work world, I believed my ideologies were fixed. I had identified paradigms, perspectives, and radical approaches which nestled into my view as a social worker. I feel this has not changed significantly. I still believe myself to be a structural social worker and will always advocate for changes regarding the oppression of persons. Examining myself as a social worker within corrections was a challenging ordeal. My underlying paradigms, values, and ethics have not necessarily changed; however, the environment has led to changes in myself as a social worker. Within the correctional environment, I questioned myself often. My decisions were made with less confidence, and I struggled with implementing protocols which were counter-intuitive to my core beliefs.

The projected learning goals for the advanced practicum were achieved during the 450 hours of supervised practice. The tasks outlined required some adaptation to account for changes in the correctional environment. After significant self-reflection, I realized the fortunate opportunity I was provided. The members of the interdisciplinary team were invaluable assets to the completion of this advanced practicum. Through their knowledge and experience, they assisted my growth not only as a social worker but as a human being. I relied heavily on their judgement and expertise during the course of my learning. My supervisor, Annah MacDonald, provided all social work-based learning experiences. Annah MacDonald was instrumental throughout the practicum process, and I will forever have gratitude for her willingness to participate in my educational goals and growth. The value of participating in an advanced practicum is undeniable. For me, this provided the opportunity to experience the process of being a clinical social worker in a correctional environment with the support of qualified professionals.

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