IMPLEMENTING A SYSTEM-WIDE TRAUMA INFORMED CARE MODEL

A Field Practicum Report

Submitted to the Faculty of Social Work

In Partial Fulfillment of the Requirements

For the Degree of

Master of Social Work

Faculty of Social Work, University of Regina

By

Marcie Dupuis

Regina, Saskatchewan

April 2020

Copyright 2020: M. Dupuis All Rights Reserved
SYSTEM-WIDE TRAUMA INFORMED CARE

Abstract

This practicum report describes my practicum experience in the Mental Health and Addictions department (MHAD) of the Saskatchewan Health Authority (SHA). In partial fulfillment of the requirements for the Master of Social Work (MSW) degree program at the University of Regina, this practicum focused on integrating trauma informed care (TIC) into social work practice within a health care system. The report outlines the theoretical underpinnings of the TIC approach and discusses both the opportunities and challenges of using TIC for system-wide transformative social work practice. It also highlights the benefits of TIC such as avoiding re-traumatization and ensuring best interest of clients, both of which require an understanding of trauma and the impact it has on patient functioning. Through a narrative approach that includes personal reflections, field journals, and stories, I discuss the TIC literature and incorporate systems theory and anti-oppressive theory specifically, in interrogating the challenges I faced in achieving my goals. Finally, in the report, I proffer recommendations to enable the Saskatoon Health Authority to alleviate the adverse effects of trauma on clients and employees by integrating TIC into all levels of staff training, as well as micro and macro practice. I argue that TIC is basically good social work and is therefore relevant to a large interdisciplinary system such as SHA seeking to put clients first by prioritizing their best interest. Trauma Informed Care enhances patient outcomes and effective community reintegration through a systems theory informed wholistic treatment that reflects the core social work code of ethics, values and principles of practice.
Acknowledgements

This journey took a village! I would like to express sincere gratitude to my family and close friends. Without them, I would not be where I am today. To my husband, Justin, thank you for always seeing the potential in me to go further in my learning and career while supporting me through it. For the many long nights, we spent discussing and editing, I am forever grateful. I started the graduate program at nine months pregnant and I would not have been able to pursue this dream without the support of my parents and my parents-in-law. Everyone made sure I had time to prepare, study, and take moments for myself. Thank you to my children who constantly inspire me to follow my dreams. Tristan, my stepson, is incredibly intelligent, curious, and has big dreams that I am confident he will follow. Bodhi, my toddler, has a big personality and is so smart and caring. They both have made this difficult journey worthwhile and have been the joy in my life. To my best friend Brittany, you have willingly jumped in to help me get through the tough days and have given me an endless amount of laughter that I will never take for granted. My village is filled with love and I am so lucky.

To my professional associate Doug Harder, thank you for taking a chance on me. I could tell in our first meeting that we had similar ideas and goals we wanted to pursue in the Saskatchewan Health Authority. Our many conversations on the complexities of the big systems in play were an essential part to my learning. Thank you for supporting me through the process.

I want to thank my academic supervisor, Funke Oba, and my committee member, Randy Johner. You were both instrumental and supportive throughout my entire degree. My newborn baby was never considered a hindrance or nuisance to either of you. Each of you challenged me in the classes you taught and also during the writing process. Your patience, encouragement, and commitment to be a part of my journey is an incredible gift I will never forget.
# Table of Contents

Abstract ................................................................................................................................................. i

Acknowledgments ................................................................................................................................. ii

Glossary of Key Terms ......................................................................................................................... v

**Chapter One: My Journey** .................................................................................................................. 1

  Introduction ........................................................................................................................................ 1

  Rational .............................................................................................................................................. 3

  Learning Objectives ........................................................................................................................... 4

**Chapter Two: Trauma Informed Care** ............................................................................................... 9

  Five Pillars of Trauma Informed Care .............................................................................................. 11

  Medical Trauma Informed Care ....................................................................................................... 13

  Complex Trauma ............................................................................................................................... 14

  Stigmatization of Mental Illness ....................................................................................................... 15

  Adverse Childhood Experiences ...................................................................................................... 16

**Chapter Three: Theoretical Framework** ......................................................................................... 18

  Systems Theory in a Social Context ................................................................................................. 19

  Anti-Oppression Theory ................................................................................................................... 20

**Chapter Four: The Practicum** ......................................................................................................... 24

  Activities .......................................................................................................................................... 24
SYSTEM-WIDE TRAUMA INFORMED CARE

Education and Presentations.................................................................27

Chapter Five: Challenges........................................................................30

Macro Social Work vs Micro Social Work..............................................31
Buzzwords.................................................................................................31
Ethical Journey..........................................................................................32
Restraints.................................................................................................34

Chapter Six: Personal Reflection..............................................................36

Self-Wellness..............................................................................................36
Role of Social Work....................................................................................37
Future Vision..............................................................................................38

Conclusion.................................................................................................40

References.................................................................................................42
Glossary of Key Terms

Trauma Informed Care - refers to a method of care that is not meant to treat symptoms of abuse or other forms of trauma but rather to provide support services in ways that are perceived as safe to those who may have experienced trauma.

Saskatchewan Health Authority - the amalgamation of all health regions but within this report refers specifically to all sub systems and units within Saskatoon.

Systems Theory - the interdisciplinary study of systems that are influenced by the environment and defined by structure and purpose.

Anti-Oppression Theory - is a lens where experience, typically power based, is understood. This theory suggests the need to understand the dynamics of power and how it divides people and places, on a hierarchy of value.
Chapter One: My Journey

Introduction

For a very long time, I have inevitably been drawn to social work. The person I am today has been created by many years of successes and sometimes challenges. My childhood has had a great impact on how I see the world and react in different situations. I have had the pleasure of being able to support many clients through difficult times during my career. I have always strived to use the privilege that I grew up with to help me create change for the people around me that have not been as lucky. My educational journey was not straight and linear but rather included several changes. These changes culminated into the diverse spectrum of knowledge put forth into my graduate degree. As part fulfillment of my Master of Social Work (MSW) program, I undertook a supervised field learning experience also known as a practicum. The setting for my practicum was the mental health and addiction unit (MHAD) at the Saskatchewan Health Authority (SHA). I focused on incorporating a Trauma Informed Care (TIC) approach in a multilayered health care system to ensure transformative interventions; avoid re-traumatization and maximize the best interest of the patient and their outcomes. In order to achieve this goal in MHAD, I was exposed to interdisciplinary practice, provided training to personnel at all levels, and engaged in a variety of activities and initiatives which have implications for micro, macro, community-based, and other systemic policies impacting patient outcomes.

Incorporating a TIC approach in a large system involves the infusion of practices into everyday policies and procedures that guide the work of staff (BC Substance Use Branch, 2013; Klinic Community Health Centre, 2008). TIC is an approach that recognizes individual history of trauma and seeks to address symptoms not as individual deficiencies but results of trauma (Hales et al., 2017). On a systemic level, TIC changes organizational culture to emphasize...
SYSTEM-WIDE TRAUMA INFORMED CARE

respect and appropriate response to the effects of trauma at all levels (Rapp & Anyikwa, 2016). TIC does not merely treat symptoms of abuse or other forms of trauma, but rather provides support services and safety to those who may have experienced trauma (Hales et al., 2017). While attempting to incorporate TIC into MHAD, there were many rewarding accomplishments, but also frustrating hurdles because the process of enacting systemic change is fraught with challenges (McKenzie & Wharf, 2016).

This report will discuss the journey of implementing systemic changes at the Saskatchewan Health Authority. It begins with an outline of the purpose, goals, and objectives of my practicum placement as well as the rationale for the location and then discusses the process of implementation of my goals within the chosen unit. An overview of the SHA and description of the MHAD is included to provide a context for the activities described in this report. This is followed by outlining how the SHA can alleviate the adverse effects of trauma on clients and employees by integrating TIC into all levels of staff training, micro, and macro practice. The literature review goes into detail about childhood trauma and how it can impact a person’s life trajectories. I outline the basics of TIC including the five pillars and the Adverse Childhood Experiences scale (ACEs) before proceeding to discuss the theoretical framework adopted for my practicum placement and this report. The theoretical framework chapter delves into how systems work or do not work together, the resulting dynamics and their effects on implementing TIC in a large organization such as the SHA. Describing the theoretical and conceptual underpinnings of the TIC approach, I examine in detail, how systems theory and anti-oppressive theory work together as a foundation for TIC. The final chapters include a narrative approach to discussing the activities, challenges, and experiences I faced during the practicum and further underscores the necessity of TIC. I highlight the difficulties of implementing change in a multi-
SYSTEM-WIDE TRAUMA INFORMED CARE

layered system, as well as the benefits of TIC which includes its adaptability to approaches already in use within the SHA, its salience for transformative practice, and alignment with the social work code of ethics and values as well as those of many other interdisciplinary professions within the SHA. In conclusion, I summarize insights from the practicum, and best practices for implementing TIC while linking and examining my own placement journey experiences with existing literature on Trauma Informed Care.

Rationale

As part of completing my graduate degree in social work, my practicum project with the SHA focused on Trauma Informed Care. The SHA has established one provincial approach to deliver health care services. Province wide, there is a commitment to using best practices and improving frontline patient care (Saskatchewan Health Authority, 2020). MHAD provides a wide range of inpatient and outpatient services to residents of Saskatchewan that follow this approach. These services and the helping strategies utilized vary based on factors such as the age of the patient and the presenting issues. Traditionally, MHAD revolves around a medical model. The medical model is “characterized by a reductionist approach that attributes illness to a single cause located within the body” (Wade & Halligan, 2017, p.995) which can create a divide between physical health and mental health. My interest in TIC began when I learned about the five pillars of TIC (The 70/30 Network, 2018). The five pillars are safety, trust, choice, collaboration, and empowerment. These pillars can be very difficult to implement, as I soon discovered. Before this practicum, I had a fair amount of experience with TIC and thought I understood how to incorporate best practices into large organizations. What I did not initially realize was that TIC in a medical setting is very different from a non-medical setting. Some values of TIC conflict with the policies and medical model of a hospital, such as looking past the
biological factors and ensuring context around medical problems is prioritized, which I will elaborate on later in the paper.

From my perspective, this practicum was innovative, cutting edge, but was also constantly changing and evolving. The initial plan was to work directly with the staff in the Mental Health Assessment Unit located in the University Hospital Emergency Room, but this later evolved into working with select employees from that unit as well as patient family advisory groups and the Saskatoon Hoarding Coalition. This plan changed because the Mental Health Assessment Unit was new and did not have the capacity to fully support a student. I was able to bring TIC knowledge and training to enhance the practice of all three units with clients. My immersion in TIC soon made me realize it has similar features that align with models and concepts my colleagues and I currently utilize such as anti-oppressive practice and Patient and Family Centered Care (PFCC). The realization that it is possible to use multiple practices such as TIC and PFCC together, afforded me a way to honour and leverage the transferable skills staff possess and thereby partly overcome some resistance to the training sessions I conducted that I discuss in greater detail later on in this paper. TIC involves a radical shift from the belief that something is wrong with the patient and reframes it by asking and discovering what has been done or what happened to the patient. My learning objectives became a roadmap during my practicum to help me stay on track in answering these questions with other professionals through insightful conversations and supervision time with my professional associate.

**Learning Objectives**

To enhance learning during the practicum, which is the field education component of the Master of Social Work Program, students are required to develop learning objectives to be attained in the field and the activities that would facilitate the achievement of the desired
outcomes. I articulated my objectives with the purpose of meeting my educational goals and contributing meaningfully to the work of my supervisor, the agency, and ultimately, the clients. Throughout the practicum, my supervisor and I reviewed these goals regularly to see how I had achieved them or how they were changing as the term went on. Some of these objectives were broader, which was helpful because as my practicum evolved, my projects and tasks remained well aligned with my overall objectives and planned outcomes. Later on, in the report I will discuss specific activities that I participated in to accomplish my learning objectives.

Below, I have detailed the goals and objectives I proposed and achieved during the practicum process.

1. *The purpose of this field practicum was to use Systems Theory to understand and articulate best practices for Trauma Informed Care within the healthcare system.* I did not fully understand the vast number of systems intertwined within the healthcare system. My supervisor and I developed many ideas for change or enhancements to current programs. Almost every conversation revolved around the system’s inability to accommodate such changes which then underscored the need for change in many of the current policies and practices. These conversations enhanced my learning significantly because although the barriers were challenging in the moment, knowing the barriers was the first step to overcoming them.

2. *To become familiar with the Mental Health Assessment Unit and the services offered to patients experiencing mental health and discover barriers to client success within the Mental Health Assessment Unit.* I had very little experience with the Mental Health Assessment Unit. Not only was it a new unit, it was also developing patient care processes during my practicum internship. This afforded me the privilege of seeing behind the scenes and learning what is involved with the planning
SYSTEM-WIDE TRAUMA INFORMED CARE

process. Being one of the first of its kind, there were no mental health emergency units in Canada at the time to learn best practices from. This meant the department had to develop new patient care processes within the broader health care system. One of the activities that took a lot of time was ensuring a cohesive link of patient care between the different disciplines. Given the multidisciplinary nature of the teams with doctors, nurses, care aids, specialists and more, there are many people with unique ideas about how policies and procedures should be completed. For example, figuring out something as simple as who would send a fax with pertinent information about a patient is complicated in a new department because roles, responsibilities, processes and procedures were still being articulated. Unfortunately, the person truly hurt by the lack of clarity is the patient.

3. To critically analyze the service delivery to mental health patients who access the Mental Health Assessment Unit and understand the impact of the Trauma Informed model.

Once I was introduced to the Mental Health Assessment Unit, I began attempting to combine my knowledge of basic TIC with learning to adapt the model within a hospital setting. Most of my questions and conversations with my supervisor were around how we could introduce the trauma informed model within this unit to enhance the patient’s experience. Frequently there was an example of how a patient’s treatment could have been more successful or impactful if staff and policies specifically focused on the five pillars of TIC: safety, trust, choice, collaboration, and empowerment (Bath, 2008). The most important pillars seem to be choice and empowerment. Mental health is an umbrella term with individuals situated along a very broad spectrum. Trying to balance the medical model with anti-oppressive frameworks could mean every patient
deserves to be seen holistically and not just by the label or stereotypes attached to their diagnosis.

Under a TIC model it is everyone’s right to know how their treatment plan works and the rationale as this creates feelings of safety and trust with their healthcare provider. Once patients know the answers to these questions, they should also have the right to accept or decline, based on principles of self-determination. The ability to make these decisions can open the lines of communication and collaboration with their healthcare provider(s) and adjusting the plan of care as needed, thus TIC assists not only the patient but also the practitioner’s effectiveness in creating the best plan for the patient. No situation for any patient is simplistic or easy, especially when mental health and addictions are involved, context is always important.

4. To gain understanding of how the Transition Team works and the contributions they make with the mental health patients leaving treatment.

While deciding on this goal for my practicum, I really did not fully understand the scope of the process for someone who is reaching out for help with mental health and addictions. The process of recounting their story begins at intake with emergency room nurses. If the nurses deem it necessary, the next step is the Mental Health Assessment Unit which includes seeing a practitioner who then coordinates and manages the plan of care followed by a discharge plan. This discharge plan requires due diligence to ensure, among other things, that patients have a safe place to go. The Transition Team is therefore the next support because they facilitate the patient’s community integration. Clients require varied levels of support, for some, it can be quite high, ranging from support to secure stable housing, connections and referrals to longer term services in the community, to avoiding the feeling of isolation that may be common upon discharge from hospital. Although the Transition Team did not use TIC-specific language or
SYSTEM-WIDE TRAUMA INFORMED CARE

values prior to my practicum, the team quickly adopted the TIC language after the training I provided. The team was also interested and inquisitive about exploring how to avoid the re-traumatization of patients. The receptiveness of this team was enhanced by their manager who advocated to begin using the TIC approach with patients.

5. As an outcome of the comprehensive search I will use the Trauma Informed Model and make policy recommendations to enhance the care of mental health patients in the Mental Health Assessment Unit.

Throughout this process, I discovered barriers to patient success such as the sheer number of interdisciplinary workers patients interact with, and lack of access to the policy administrators. It was not feasible to train all interested interdisciplinary workers within the duration of the practicum but recommendations were jointly proffered with my professional associate to address this lack of training. I met with one employee who works in the emergency department and had also been a patient there. Her story of some nurses and doctors not following all and the adverse impact on her own mental health journey in the hospital are discussed in-depth later on in this paper. After researching, I found that the official policy had some areas that followed the TIC model, but practitioners were unaware of the policy or were not held accountable for following the policy. It was therefore not adhered to in her case and so the new focus on TIC which I brought to the interdisciplinary teams and the recommendations I made were not entirely new but served to ensure current policies that align with TIC were adhered to consistently. TIC emphasizes the patient’s care as the main priority regardless of how many systems they interact with in the hospital. I interfaced with the Patient Family Advisory Committee to ensure documents used by quality control employees reflect trauma informed language, as this group of professionals recognized and helped facilitate the introduction of Trauma Informed Care.
Chapter Two: Trauma Informed Care

Trauma Informed Care does not begin when a patient arrives at the hospital. It starts with an awareness of the impact of trauma, the trauma details, and the knowledge that childhood trauma can lead to negative health outcomes as an adult (Freeman, 2017). The five pillars of TIC, as discussed in this chapter, are a guide to both individual and system-wide change. Trauma is complex, and it gets substantially more complicated when associated with mental illness because of the stigmatization around it. TIC is one way for practitioners to assist patients in their healing journey, while creating minimal re-traumatization. The definition and features of this approach will be discussed in the next section.

Trauma Informed Care (TIC) is a model that seeks to reduce, if not eliminate barriers for clients and creates a safe and accepting organization. Often, workers are set in their ways so the process of becoming trauma informed takes mindful practice. This process is not just a one-time training or workshop, but intentionally infusing this into the everyday policies and practices will make the person and organization successful (BC Mental Health and Substance Use, 2013; Klinic Community Health Centre, 2008). Successful TIC needs to be based on not only an individual, but also on an entire organization as a system, creating clinical practices that recognize complex trauma and offer clinical supervision to address the same (Menschner & Maul, 2016; Veach & Hodges-Shilling, 2018). System wide change is crucial not only for the potential client, but also for the health and wellness of the staff. The value of TIC becomes apparent when people become more knowledgeable about how complex trauma can affect the responses and behaviours of those they serve. Changing the belief that something is wrong with the patient and reframing it into discovering what led them to this point, is imperative. TIC holds the patient accountable for their actions but avoids and seeks to prevent re-traumatization
SYSTEM-WIDE TRAUMA INFORMED CARE

(Menschner & Maul, 2016). It is important to note that TIC uses a strength based therapeutic model with patients, which allows the patient to take control over their healing journey (Wissow, 2016).

Trauma can be defined in many ways and can be very complicated. The Diagnostic and Statistical Manual, fifth edition (2013), defines a traumatic stressor as a

… direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (p.274)

Traumatic stressors or complex trauma looks different for everybody and that is why it is hard to only rely on one definition of trauma. TIC is based on the assumption that everyone has dealt with some sort of trauma. The experience of trauma can have intense effects on an individual’s life (Dass-Brailsford & Myrick, 2010; Walser, 2007). The key is that the traumatic responses vary and are unique to each individual. Trauma is the response to the event, not the event itself. The main types of trauma are acute, chronic, and vicarious. “In trauma informed treatment, a person’s symptoms are understood as attempts to cope within the context of one’s life experiences” (Chandler, 2008, p.263). Chandler speaks to how the trauma informed medical team should be responding to negative behaviors and symptoms; such as addictions. In order to understand how to respond, one must first be familiar with the different types of trauma and how they can impact the patient.
Five Pillars of Trauma Informed Care

Practitioners need to recognize and come to terms with their own privilege before they are able to create the best environment for their patients. This ideal environment would be inclusive of the five pillars of TIC. Recognizing privilege is a key component in anti-oppression framework, which will be discussed in more detail below. These five pillars are values that have often been eroded in the lives of people who have been traumatized: safety, trust, choice, collaboration, and empowerment.

Trauma is marked by a loss of control. Treatment must start with creating an atmosphere of safety through predictable and respectful relationships. For an individual to heal, they must feel safe and in control. Choice, empowerment, and the ability to express how they feel and be heard are essential in recovery. (Bruce et al., 2018, p.131)

This argument is fully congruent with the five pillars of TIC. Whether it’s an accidental traumatic event such as a car accident, or an event that is planned and executed to take advantage of someone, one or more of the five pillars would have been compromised; more often it is more than one. In response to traumatic events, making sure the client feels in control over these pillars is what truly makes a difference. Isobel (2015) states that “mental health services need to realign their power dynamic to allow consumers to become not only partners in care, but empowered and self-determined individuals within that partnership” (p.276). Safety as the first pillar is significant because a person’s safety is fundamental for all these pillars. When safety is compromised, it can cause a lot of long-standing issues, typically going from one extreme of never trusting anyone to the other extreme of trusting everyone. As trauma informed providers, we need to create calm and caring environments for our clients.
SYSTEM-WIDE TRAUMA INFORMED CARE

Patients must be physically and emotionally safe (Quiros & Berger, 2015). This includes physical placements of signs, chairs, desks, etc. This could also mean being aware that some clients may not feel safe sitting with their back to others while some may prefer sitting with a clear and defined exit nearby. If a patient feels safe, they will begin to trust their practitioner and the establishment. Trust is developed through clear and consistent information provided by individual workers and the organization as a whole. When trust is broken, it can be a very sensitive time for clients.

When developing clinical relationships, healthcare providers must remember that trust often requires time to build a genuine and safe feeling space. One way to build genuine trust is to make sure the clients feel they have choices. Choice in TIC is about giving clients choices and control over their lives which leads to these important feelings of trust and safety. Often in medical TIC, the patient may not like the options, but it is about the medical team being open and honest with the patient and stating the choices as honestly as they can. By giving the patient choices, the practitioner and patient begin a collaboration to better serve the patient. Having healthy communication skills can assist in this. Communication is also key to building and maintaining healthy relationships (Müller et al., 2013). These communications can happen verbally and/or non-verbally. Non-verbal communication can come across in a variety of ways such as avoiding eye contact, standing away from others, or trying to physically escape a conversation. Crossed arms, for example, puts forward a clear message of being uncomfortable or standoffish. Body language can convey a clear message warning people to stay away. This body language can develop out of fear or insecurity and will prevent the person from having normal relationships (Müller et al., 2013).
SYSTEM-WIDE TRAUMA INFORMED CARE

Collaboration is where TIC and PFCC become one, as the two share this top value (Krumholz, 2010; Michael et al., 2019). Collaboration is about the client having a major role in their treatment plan as knowing all their options, good and bad, creates ownership of the plan. The client gains more responsibility and self-efficacy over a plan they can call their own because they have been heard and provided input into the treatment. TIC would suggest that the practitioner work with the patient to find out what they want or need but recognizing that the answer is seldom simple or clear. However, not having trauma-informed conversations, limits the patient’s opportunity to make an informed decision about their care (Corbin et al., 2011). When a client gains an ownership of their care, they leave a worker’s office or a hospital feeling empowered which is crucial for their recovery.

Medical Trauma Informed Care

There have been many studies that show how creating a trauma informed hospital or emergency room can benefit patients (Corbin et al., 2011; Dubbin, et al., 2013). The goal of many hospitals that use and value PFCC of TIC is the provision of medical care in conjunction with the patient’s cultural values, needs, and preferences (Dubbin et al., 2013; Elliott et al., 2005). Corbin and colleagues (2011) implemented an intervention called ‘Healing Hurt People’. This intervention was meant to encourage youth to learn about trauma and healthy coping mechanisms. Corbin, who is an ER physician, dealt with complaints of a lack of follow up and support once the client left the hospital, like many emergency departments. To combat these experiences, ‘Healing Hurt People’ used connection and education of trauma to help youth heal. Corbin’s program consists of four pillars including safety, managing emotions, acknowledging loss, and reconstructing a future (Corbin et al., 2011). These are similar to the five pillars of TIC. This model was based on creating connection to not only heal past trauma, but to also stop the
cycle of violence in the client’s life. Corbin (2011) concludes that “although the main focus of (hospital) care has been acute treatment of traumatic wounds, a broader public health impact can be made through secondary and tertiary prevention to stem the cycle of violence” (p.522). These secondary measures, which include relationships between the patient and practitioner, feeling of safety, and the five pillars of TIC, are the connection illustrated in that research. The feeling of safety can be threatened because of stigmatization from people both inside and outside of the healthcare system that come into contact with these patients.

Complex Trauma

Trauma can be found in many areas from acute and chronic, to vicarious. Acute trauma refers to a single incident and typically includes immediate emergency support, therapy, or medication (Kowalski et al., 2018). It is unclear why some individuals completely recover, and some develop long lasting effects of acute trauma (Kowalski et al., 2018). When an acute patient needs care, the medical team has the task of restoring the individual to their pre-crisis coping level (Moloney et al., 2018). It becomes more complicated when a patient has had multiple traumas throughout their life because it is then hard to assess where the coping levels should be. Moloney et al. (2018) believes that healing trauma begins at the acknowledgement stage (2018). There is a need to acknowledge a patient’s life experiences to deliver effective care (Menschner & Maul, 2016). TIC is a change in service delivery that recognizes complex effects of trauma throughout the patient’s life (Isobel, 2015; Menschner & Maul, 2016). Isobel (2015) also insists TIC is imperative to acute health services.

Vicarious trauma can also be referred to as compassion fatigue (Harrison & Westwood, 2009). Typically, when someone is dealing with vicarious trauma, they are on the road to being burnt out. According to Beck et al. (2014) burnout shows itself in emotional exhaustion,
cynicism, and feelings of ineffectiveness at work. “Burnout is a form of mental distress manifested in normal individuals often recognizable in negative attitudes and substandard work performance” (Beck et al., 2014, p.455). Secondary traumatic stress is witnessing trauma being inflicted on others. Secondary traumatic events happen often in hospital settings and are typically verbal or physical attacks. Being a witness, or hearing expressive details of traumatic events, can lead to Post Traumatic Stress Disorder (PTSD) symptoms (Jacobowitz et al., 2015). PTSD can be defined as a disorder that has extreme sustained anxiety over personal safety, and reactions to memories of dangerous situations which create hyper-arousal and avoidance symptoms (Stein et al., 2011). Symptoms of all types of trauma can be minimized by following TIC practices, using the five pillars of TIC, and becoming aware of one’s privilege (Klest & Birrell, 2009). Privilege is defined as an advantage that is not earned but given because of social location and ethnicity (Hernandez-Wolfe & McDowell, 2013). Through being aware of one’s privilege, it is possible to critique and improve social work practises through an anti-oppressive lens, which will be discussed in depth in chapter three (Yee et al., 2013).

Stigmatization of Mental Illness

Often the stigmatization of mental illness does not begin with mental health professionals, but with people who have little to no training in the area such as hospital security guards (Knaak et al., 2017). The stigma is also present with doctors and nurses who are looked to as experts but may have only received minimal training on mental health during school. “Psychological consequences may develop and persist long after physical wounds of traumatic injury have healed” (Kassam-Adams et al., 2005, p.131). Often these psychological issues can arise seemingly out of nowhere but are rooted in traumatic experiences from the past. This does nothing to reduce the stigmatization of mental illness because it is difficult for an outside person
to know why someone is acting out or experiencing mental problems. Often the patients themselves may not connect the old trauma to the current issues. The adverse childhood experience survey (ACEs) connects childhood trauma to poor physical and mental outcomes, poverty, and a variety of social issues (DeBoard-Lucas et al., 2013; Hales et al., 2017) and “stigma, discrimination, and marginalization are gateways to oppression” (Baffoe, 2013, p.1). Stigmatization can retraumatize individuals and hinder their ability to regain better control over their lives. This potential for re-traumatization suggests that there is much more to a traumatic event than just the event itself. For the practitioners, it is relevant and helpful to be aware of past childhood trauma. This is done by using the adverse childhood experience survey (ACEs). Asking the questions in the ACEs informs practitioners about the possibility of a trauma history.

**Adverse Childhood Experience Survey**

Adverse childhood experiences (ACE) are “acute or recurring stressors that encompass multiple forms of child maltreatment and household dysfunction” (Mersky et al., 2019, p.51). These childhood experiences have a large impact on brain development and attachment. Long-term studies show there is a strong relationship between a high number of adverse experiences and both unhealthy adult behaviors and chronic disease (Freeman, 2017). These include higher risk of autoimmune disease, heart disease, liver disease, cancer, and more (Dong et al., 2004; Dube et al., 2009; Ports et al., 2019). ACE are said to affect 20-50% of adults (Freeman, 2017; Tink et al., 2017). The ACE survey is broken down into three categories: abuse, neglect, and household dysfunction. It is done by asking ten questions; the more questions that are answered with ‘yes’, the more trauma you have experienced in childhood (The National Crittenton Foundation, 2015). There is no way as an adult to change an ACEs score, but because trauma affects everybody differently, these experiences will also affect people differently. There is a
suggestion in the research that responses to ACE can contribute to improvement in health and well-being (Larkin et al., 2014). Asking the questions in the ACEs can illuminate for physicians, psychologists, social workers, and other health professionals, the wide range of factors that could affect the patient. Studies conducted among resident physicians to determine how often they give the ACE survey to patients show that if a resident has a higher ACEs number, they are more likely to use the survey with patients (Freeman, 2017; Tink et al., 2017). The ACE survey is linked to TIC as a pivotal piece in assessing the patient. The next chapter will explore TIC within systems theory as well as anti-oppression framework.
Chapter Three: Theoretical Framework

Theories enable us to understand, interpret, explain and predict phenomena, therefore the theoretical frameworks that inform the TIC approach also provide insights into the consequences and complexities that can arise long after a traumatic event happens; “[f]or women especially from marginalized communities, such traumatic experiences are shaped by oppressive social structures and are everyday occurrences” (Quiros & Berger, 2015, p.150). Often, symptoms arising following a traumatic event turn into Post Traumatic Stress Disorder (PTSD)-like symptoms or depression/anxiety (Beck et al, 2014; Bruce et. al, 2018; Jacobowitz et al, 2015). Bruce et al. (2018) discusses a framework in which TIC actually provides an understanding of PTSD symptoms and can show institutions how to prevent future trauma for patients who have suffered previous trauma. Harner and Burgess (2011) reiterate that TIC is a theoretical framework where workers move past simply asking about past trauma and instead view their patients’ symptoms and behaviours in the light of the traumatic experiences in their lives. TIC as a framework provides an alternate lens to viewing patient or client behaviors, such as viewing negative behaviours as coping mechanisms. (Chandler, 2008; Harner & Burgess, 2011; Walser & Westrup, 2007). Services need to change to address not just the current symptoms, but also the previous underlying trauma to prevent the symptoms from recurring or at least to help the client cope better with the symptoms (Hales et al., 2017). This change can be difficult in a large system because there are many moving parts. Systems theory and anti-oppressive theory helped guide the practicum because between the managers, practitioners, and patients it is very difficult to create large systematic change. Every person has their own experiences which shape the way they practice. Negative practices are embedded in systems and through anti-oppression theory, one can critique and adjust accordingly (Rosenie & Carmela, 2013). Both frameworks (systems
theory and anti-oppressive theory) worked together to shape the hands-on learning that occurred during the practicum placement.

**Systems Theory in a Social Context**

Preventing re-traumatization means changing the current system. Systems are not quick to change and “often slow in adopting major innovations in social policy, and new policies are prompted by initiatives that originate through the advocacy efforts of policy networks” (McKenzie & Wharf, 2016, p.50). As McKenzie and Wharf (2016) state, systems do not like to disrupt the social flow. They like to bring in as much money as possible while not upsetting the majority of the people. The downside to this is that there are issues the system could, and should, fix, but instead problems often are ignored.

A trauma informed approach mimics many of the priorities of Patient and Family Centered Care (PFCC). Wissow (2016) argues that an integrated trauma informed system is patient centered and goes beyond traditional healthcare services. “PFCC is an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships” (Bass, 2012, p.534). PFCC is supposed to balance the medical team, the patient and the family for ideal satisfaction outcomes (Bass, 2012). This is congruent with TIC and the five pillars. One of the biggest differences between TIC and PFCC is the special attention given to mitigating the future impacts of trauma on the patient. Trauma informed systems emphasize individual choices that are collaborative and minimize re-traumatization (Chandler, 2008). Using TIC and PFCC frameworks in large systems such as healthcare regions is difficult because there are a multitude of differences in the people served from rural to urban. “A system consists of components and their relations with each other (organization or structure). Particularly important are a system’s environment as well as the key processes, dynamics, and mechanisms that make it
work” (Pickel, 2007, p.394). The complex systems work simultaneously to produce positive or negative results (Pickel, 2007). With so many employees, patients, managers, and smaller systems to work with, it is challenging to enact change (Rosenie & Carmela, 2013); “systems are intimately attached to people. Systems don’t change if people don’t change. People don’t change if they don’t feel something. To create genuine change must be targeted towards the ‘people’ level” (Moreland-Capuia, 2019, p.5). As mentioned in Chapter Two, a crucial part in changing the larger system at hand, is to train everyone, from the frontline workers, to the managers, to the cleaners. Being able to provide TIC knowledge to everyone within the system will ensure the system begins to align its values, as knowledge is power. The more knowledge a person has about a systemic problem, the more likely they are to feel compassion towards it. Staff training on the complexity of trauma as well as personal biases and cultural awareness may minimize the ongoing re-traumatization (Harris & Fallot, 2001; Savage, 2007; Quiros & Berger, 2015). Moreland-Capuia (2019) argues that the TIC approaches create more safety for employees and patients which ensures a high likelihood of healing. Both research and practice suggest that trauma informed systems must adopt comprehensive approaches that take into consideration all of the operations of the agency (Greene & Blundo, 1999; Lester, 2018; Quiros & Berger, 2015). Not only does this apply to the larger systems, but Thompson-Lastad et al. (2017) implore clinicians to specifically look at patients’ lives in the context of the trauma they’ve experienced to mitigate the future re-traumatization.

**Anti-Oppression Theory**

“Anti-oppression frameworks of practice are being increasingly advocated for in efforts to address racism and oppression embedded in mental health and social services” (Corneau & Stergiopoulos, 2012, p.263). By advocating for this framework, social workers, researchers, etc.
are recognising power imbalances: When systems attempt to avoid disrupting the social flow, they often end up oppressing those that are at the bottom of the social hierarchy (Corneau & Stergiopoulos, 2012). Young (2004) discusses the different types of oppression in the book *Five Faces of Oppression*. She begins by discussing exploitation: “[E]xploitation creates a system that perpetuates class differences” (Young, 2004, p.2). Internalized oppression creates a culture of silence within a group. When people feel powerless, they tend not to speak up because they feel their words will not matter. Marginalized communities can begin to feel naturally inferior and dehumanized (Young, 2004). Dominelli (2008) defines oppression as a “system of domination that denies individuals dignity, human rights, social resources, and power” (p.10). Anti-oppressive social work practice is something that will continue to challenge and motivate social workers. Oppression is not something that can be fixed by one person, or ten; it is about understanding privilege and the knowledge of how disadvantaged people became who they are. It is about building relationships and “analyzing oppressive conditions, to reclaim group identity, and to change social and psychological patterns associated with oppression” (Mullaly & Mullaly, 2009, p.223).

Oppression is multilayered due to its many forms and how it affects each person differently. Marginalization, violence, and cultural imperialism are just a few of the forms that Young (2004) describes. Marginalization confines a specific group of people to a certain physical place and considerably lower social standing within society. There may not be nearby or available essential services or basic resources. McGibbon (2008) states,

The threat of oppression, and oppression itself, has a persistent impact on mental and physical health, and these two aspects of stress do not happen in isolation. Rather, they
SYSTEM-WIDE TRAUMA INFORMED CARE

happen together to produce a powerful synergy that is ultimately inscribed on the bodies and minds of oppressed people. (p.35)

McGibbon (2008) argues that although oppression is not always at the forefront of the issue at hand, it is always in the background. When somebody is oppressed, they live with it daily, they have grown up living it, and it has become the norm. The worst threat of oppression is the oppressed not even realizing or caring that they are oppressed but just living life as is.

An anti-oppressive framework can be used to critique and improve social work practises (Yee et al., 2013). Often negative practices are embedded into organizations’ policies (Prescott et al., 2008). Yee et al. (2013) argue that an application of anti-oppressive approaches can enhance system-wide change. McKenzie and Wharf (2016) state that systems are slow to change and that changing the cultural flow is a large undertaking and challenging. “An anti-oppressive framework that incorporates both a process for organizational change and a logic model that integrates progressive values and goals may be used to transform oppressive practices into those that promote more equitable outcomes” (Yee et al., 2013, p.482). This framework focuses on both the process and the outcome. Empowering users by reducing the negative effects of hierarchy in individual relationships is key (Dominelli, 2002). The outcome may not always be ideal, but through an anti-oppressive framework, an organization is meant to document all incidences and continue to demonstrate measurable activities so one can figure out what works and what does not in similar situations (Yee et al., 2013). It is extremely important when using an anti-oppressive framework while working with clients that there is inclusion, engagement, and support in every phase of service delivery (Corneau & Stergiopoulos, 2012). Similar to the five pillars of TIC, empowerment of service users is monumental in their healing journey.
SYSTEM-WIDE TRAUMA INFORMED CARE

On a macro level, anti-oppressive policies are mutually beneficial for everyone. Being accepted for who you are and receiving support where needed in any aspect of life is important. When one part of a community is diminished to bring another up, it does not truly help either group. It can actually give the privileged group a false sense of entitlement or a feeling that they are better than the ‘other’ group. This act of giving privilege to some groups over other groups prompted me to focus on making policies more anti-oppressive while also training group members in TIC procedures. The following chapter will focus more directly on the practicum and how TIC was implemented to enact change in the SHA.
Activities

As discussed earlier, my learning objectives were used as a guide during my practicum. All of the activities that I engaged in were centered around the learning that I sought during my proposal. During my practicum, I worked on a variety of committees and groups. My role was to bring a TIC perspective to group members but also to the policy documentation. I worked with people from the Family Advisory Committee to create a feedback form on their experiences at the Mental Health Assessment Unit. This feedback form was generated to address specific questions in a trauma informed manner to ensure there was no re-traumatization during the feedback interview. There was a lot of discussion around who would do the interview, how long it would be, and when it would be administered. I also worked with a group on creating a video called ‘Understanding Suicide’. This group was comprised of a psychiatrist, two current patients, my supervisor, the training nurse for SHA, and I. The interviews incorporated into the video were completed prior to my joining this group but I worked with the film producer to pull out the most relevant themes. These themes were then discussed with the Patient Family Advisory Committee and agreed on. These themes were important to be included in an updated training for Emergency Room nurses.

I attended the Violent Threat Risk Assessment training (VTRA) for schools during my practicum. From this training, I applied the information I learned to the TIC systems that I had been working with at the SHA. The Violent Threat Risk Assessment training discussed four different types of systems: naturally open, naturally closed, traumatically open, and traumatically closed (North American Center for Threat Assessment and Trauma Resources, 2018). These four systems provide a different view on TIC and classifies the systems that are traumatizing to
SYSTEM-WIDE TRAUMA INFORMED CARE

clients. The ‘naturally open’ system is ideal in TIC, as it promotes leadership which is open with information and there is an acceptance that everyone is different and will respond differently (North American Center for Threat Assessment and Trauma Resources, 2018). This is in contrast to the ‘traumatically open’ system where the fractured system runs off previous traumatic events. The hierarchy is uncertain as information sharing is the same for all levels regardless of if they are part of the administration team or workers. ‘Naturally closed’ systems have no complicated trauma history and the information sharing flows down, but the management is often kept in the dark. The ‘traumatically closed’ system has multiple unresolved trauma and most people are considered ‘outsiders’ as the system is very private (North American Center for Threat Assessment and Trauma Resources, 2018). Conflict is not dealt with in person and is easily passed over to continue the status quo (Violent Threat Risk Assessment Training, personal communication, October 16th, 2018).

It is interesting to examine how the SHA fits into these systems. There are parts of the SHA that have had large traumatic events, which changed how they operate business. One example is the Irene and Leslie Dube Centre for Mental Health in Saskatoon. This mental health facility had an unprecedented amount of violent client outbursts where staff got injured within a short time frame. These incidents evoked changes to procedures to include stronger security guard presence and stricter rules. I would place this mental health facility in the ‘traumatically open’ system where it responds to previous traumatic events. This can lead to reactive practices that go against TIC pillars. Extra security presence can be triggering for many people and can escalate them further (Hall et al., 2016). However, to keep staff safe, that is the route that management decided to take.
I worked with the Saskatoon Inter-Agency Hoarding Committee (SIAHC), which included Saskatoon City Police, Mental Health and Addiction managers, Saskatoon Fire Department, Public Health, Child and Family Services, and Animal Control. This committee had a goal of streamlining their services to better assist the community. My role was to help with this and to work on the Protocol & Research Manual. During the streamlining of this committee’s services, a complex hoarding case arose. We discovered which tactics worked and did not work to improve the collaboration going forward. Hoarding Disorder is considered a co-occurring disorder as it is associated with other mental health diagnoses ninety-two percent of the time (Frost, 2014). Hoarding behaviour arises from biological, psychological, and social determinants (Frost, 2014). The recidivism rate is unbelievably high with hoarding cases (Boss, 2006). When looking at hoarding from a TIC lens, it becomes clear that the patient has gone through some complex trauma. An ACE survey would be important to complete with the hoarding clients to show practitioners best practices in understanding the client’s history of childhood traumatic experience and how to provide meaningful service to clients suffering from hoarding disorder. There are currently no studies that show the relation between hoarding and ACE. While the SIAHC dealt with the complex hoarding case, many flaws in the intervention process came to light such as multiple organizations having the same legal jurisdictions. By having all the same legal jurisdictions, it was unclear what each role was which resulted in a lack of collaboration and unorganized chaos. The revised manual was simpler, used trauma informed language, and was a realistic process for front line professionals, such as law enforcement, to follow. The procedures and roles of each organization were made clear so that going forward there could be coordination. This committee needed training on TIC language to be able to incorporate it into the manual.
SYSTEM-WIDE TRAUMA INFORMED CARE

Knowledge and empathy surrounding mental health and addictions, or intergenerational trauma, is extremely important as these traits can help to de-escalate situations. I experienced multiple incidents highlighting the lack of mental health education provided to security guards. The scheduling system for security guards presented a hurdle for this education. Guards were not able to stay in specific buildings or units based on interest or to develop expertise. This means someone who has never been around a person going through mental health psychosis could become the security guard in the Mental Health Assessment Unit or the Irene and Leslie Dube Centre. People, like security guards, who have not had experience with these patient groups did not understand how to safely de-escalate them but rather employed physical restraint as the first response. Training on mental health and TIC for security guards was discussed in depth but was not accomplished before the end of my practicum.

Education and Presentations

To create an enabling or empowering environment for the client, there is immense value in becoming trained in TIC and having continual conversations and training on the topic. A one-time training session does not allow time for processing and thoughtful application of the values. The TIC approach gives an alternate lens for the behaviors shown by clients. There needs to be a cultural shift in staff and management to ensure the actual transition to TIC (Chandler, 2008). Supporting organizational change must be a continuous process to ensure everything is being reinforced. Veach and Hodges-Shilling (2018) describe TIC clinical supervision as “supervision that seeks to enhance the knowledge and skills of practitioners in understanding the complexity, dynamics, and potential behavioral manifestations of trauma” (p.90). Veach and Hodges-Shilling (2018) continue to focus on the supervision approaches, arguing that they must be relational and must ensure the modeling of healthy relationships and trauma informed practice. As discussed
SYSTEM-WIDE TRAUMA INFORMED CARE

previously, the successful application of TIC must happen with every employee and be reflected in the policies across and within varied interacting systems. Isobel (2015) refers to changing the culture that informs the way clinical practices have always been done by having formal rule reviews to ensure consistency among medical staff. Practicing TIC can enhance medical professionals’ knowledge about trauma and the idea of avoiding re-traumatization (Hall et al., 2016). Hoysted et al. (2017) state that “TIC should be seen as an essential component of education programmes in emergency nursing and medical training” (p.867). There is an abundance of research verifying why TIC is necessary and how proper staff training and policies make a difference in the lives of patients (Chandler, 2008; Corbin et al., 2011; Hall et al., 2016; Veach & Hodges-Shilling, 2018).

During my practicum, I witnessed firsthand where frameworks like TIC could substantially benefit clients. I experienced many instances lacking a trauma framework and it was evident how ongoing trauma was negatively affecting people in many different ways. Without that framework, I felt that the system was re-traumatizing clients. Gaining trust and using collaboration to enhance the clients’ lives is crucial. If a client feels uncomfortable in the space or feels they are not important or are being discriminated against, they may choose to not seek help the next time. An example of this could be as simple as the intake process and forms. If a client does not have a high reading level and cannot focus for long periods of time to fill out forms, they can be turned away from receiving service. In that instance it would be ideal to be able to offer to have a worker fill out the forms with the client. Should the client choose to not give their information and the agency decide that they need the information to continue service, the trauma informed model would suggest that the agency ensure they give recommendations to places that do not need the same strict regulations.
During this practicum I had the privilege of working with different teams in Mental Health and Addictions, affording me the opportunity to present on both trauma and TIC. Through these presentations, I was able to receive feedback from the frontline workers on how TIC works, or does not work, in their daily activities. Many of the workers were implementing core components of TIC already, but seeing it backed by research and well articulated procedures solidified it even more. A social worker who puts the client first and truly helps them in their situation already does a lot of TIC work without even knowing it, but it is important to be methodical and conscious of how the model of practice affects the patient. It is important to have a systemic understanding of client’s past trauma while also understanding that, as their social worker, we do not need to know the actual details of that trauma to help them in the moment. It is essential when working with people who have experienced trauma and also currently dealing with a lot in order to help them gain strategies to get through the tough times. Often, the support work is short term, so may not be an ideal time to open deep traumatic roots but offering coping skills can empower people to heal.

I educated many individual employees that were interested in TIC as well as the Transition Team. An interesting part of these conversations I led were the discussions focusing on coworkers and why certain coworkers reacted to certain situations questionably. It was a lightbulb moment for people watching the presentation to think about not just their clients having gone through traumatic events but also their coworkers. Often, the difficult behaviors involved with trauma can be seen in coworkers who are defensive, love to gossip, talk down to others, and are generally oppositional (Moloney, B. et al., 2018). By using a TIC approach with coworkers, it’s possible to break down barriers and create a calmer space. Using a TIC approach is ideal, but, as I came to realise, it comes with its own barriers.
Chapter Five: Challenges

As I discussed in the introduction, I came into this practicum with a fair amount of experience with TIC and the best practices for large organizations. What I didn’t realize was that TIC in a medical setting is very different from a non-medical setting. This was my first large challenge at the beginning of my practicum. TIC Five Pillars often go against the processes followed of being in a medical setting. This means the practitioner needs to intentionally look at the differences and why the processes in the medical setting are there. Questioning the way it has always been done is a huge part of being the best possible practitioner for the clients. Thankfully my professional associate was someone with whom I felt comfortable questioning the system. This helped me gain an understanding that would have been impossible otherwise. Throughout the challenges that I describe here, my learning increased substantially as a social worker and student.

As earlier observed, one common issue throughout my practicum was the lack of training for security guards working in the mental health section of the hospital. Knowledge and empathy surrounding mental health and addictions, or intergenerational trauma are extremely important. These traits help to de-escalate situations. The Irene and Leslie Dube Centre was also going through a time of increased security for practitioners’ safety so there was also a surplus of security guards. For a lot of patients, security guards bring on a feeling of anxiety (Pich, J., 2014). Their authority can be intimidating. A lack of training in TIC for security guards creates a disconnect between the two parties. Security guards must understand the important emphasis on compassion, empathy, and a willingness to help and be open. It was challenging to become aware of a large barrier to implementing TIC but not be able to do anything about it.
SYSTEM-WIDE TRAUMA INFORMED CARE

Macro Social Work and Micro Social Work

Another challenging part of TIC and this practicum is that it did not neatly fit into a category of macro or micro social work. Micro social work focuses on direct patient care while macro social work may interact with patients but ultimately it seeks to change policy (Austin et al., 2016). This practicum involved training frontline workers on TIC while also working on manuals covering various topics to ensure up to date and relevant trauma informed language was utilized. TIC requires both macro and micro changes to truly enhance a patient's outcome such as changes to the intake process as well as the policy and procedures that are followed. With both macro and micro changes, there can be significant improvements in a patient’s healing journey (Rapp & Anyikwa, 2016). However, these improvements may not be fully realised if the system stays stagnant in old ideas and is hesitant to adopt new ways of practicing health care.

Buzzwords

Often, I felt as if the TIC model was treated like just another new training which employees had to endure. People become so accustomed to the constant rolling out of new theories and models of care that they stop investing in them. This lack of investment happens when there is no systematic follow through (Lester, 2018). This makes new theoretical frameworks another chore with minimal support for adopting the new frameworks. TIC needs investment from all practitioners from top to bottom. If managers in the SHA do not feel they have full accountability to be trauma informed, they will not be, and it will fall from there. Although it is still beneficial for individual staff members to take it upon themselves to work in a trauma informed way, there must be a commitment for the physical environment to follow the five pillars of TIC. If not, the physical environment can add to the re-traumatization of the client (Klinic Community Health Center, 2008).
Something that became clear during my placement is the number of ‘buzzwords’ that are casually thrown around. There is a set of buzzwords for every reasoning and approach in the SHA so much so that when I talked to people about TIC, they seemed to become uninterested. It seemed that this was just another one- or two-hour training workshop they were forced to take. Although they agreed with the philosophies, it was not going to actually change their everyday practice. Realizing this early on, I quickly learned to catch their interest with some of the unique concepts and values of TIC instead of the terminology. I also adjusted my tactic by doing research into PFCC and was surprised to see that many of the philosophies aligned with TIC. The SHA has attempted to change its policies and workplace culture to be Patient and Family Centered focused (PFCC). Many of the employees know the framework of PFCC is not leaving anytime soon so by incorporating the similarities and pointing out that TIC and PFCC are not polar opposites, I was able to get more people on board. TIC does not have to become another buzzword if the system itself has people advocating for change and better care for its clients. PFCC strives to be a whole person approach that considers a patient’s needs and preferences (Krumholz, 2019; Michael et al., 2019). Through a system like PFCC or TIC, a patient knows that the medical decisions made are truly owned by them (Krumholz, 2019). This is logical because every patient has their own unique health journey, complete with their own variables and circumstances.

**Ethical Journey**

The biggest thing I have learned about social work ethics is that nothing is just simple when working with vulnerable populations. There will be grey areas, multiple variables, models and outcomes to any situation. Every situation is dependent on more specific information to make the best decision. This is a difficult concept to manage because it’s much easier to be the
SYSTEM-WIDE TRAUMA INFORMED CARE

expert determining the outcome one way or another. As humans we all have varied experiences of past trauma and it is unrealistic to generalize issues without room for contextualized understandings and interventions. Understanding that this is where TIC came from helped me professionally knowing that all I can do is make the most informed decision for that moment. Areas in which I need to grow are very clear to myself. Many times throughout my life I have taken on too much and wanted to do it all. Time management skills and prioritization are two areas that will help me. All my experiences, good and bad, have helped me grow into the person I am today. I am constantly growing and changing and will continue to do so.

The Code of Ethics from the Canadian Association of Social Workers (2005), value number two is “Pursuit of Social Justice” (p.5). The quest for equity is paramount and will be fought for throughout my career. Just because we work for the system, does not mean we stop fighting against the system. This is powerful to me because sometimes the system is wrong. My personal privilege affords me the opportunity to attempt to enact change in our big and complicated social systems. My privileges are many, such as being Caucasian, middle class, having English as my first language, being able to go to schools that were safe and excelled not only in academics but also in the arts and athletics, and many more. I use these daily in my professional work and ethical decisions. With time comes knowledge and with knowledge comes change. Nothing will change unless someone starts that change with equity in mind; “[s]ocial workers advocate for fair and equitable access to public services and benefits” (Canadian Association of Social Workers, 2005). Social workers are meant to challenge the system to create change that positively impacts disadvantaged people, which can extend into eliminating or cutting down on certain practices or procedures that may not be as effective as previously thought, such as restraints.
SYSTEM-WIDE TRAUMA INFORMED CARE

Restraints

Throughout this practicum, the issue of restraints arose many times with medical staff and security guards. This intrigued my research on restraints within TIC but also research of SHA restraints policies; “[r]estraints are physical interventions used to contain patients’ aggressive behavior” (Azeem et al., 2017, p.170). Within trauma informed systems, restraints are acceptable, but there must be very clear guidelines around how and why. Preventative training and conflict training along with treatment plan partnerships go a long way in reducing the number of times restraints should be used. The use of safety plans, comfort rooms, and de-escalation approaches are key to avoiding the use of physical restraints (Azeem et al., 2017). There are reduction tools medical practitioners can provide which are outlined in the research as well as the SHA policy book. In one study, using trauma informed tactics specifically has reduced the number of times restraints had to be used (Sarofin et al., 2012). To place trauma and safety first, agencies need to incorporate the knowledge, skills, and strategies of evidence-based practice in TIC (Quiros & Berger, 2015).

A large ethical dilemma I experienced during my practicum was the use of restraints. In the typical TIC model, restraints would be viewed as restrictive or a violation of the client’s rights. In a medical setting, restraints are used often and perceived as necessary for the safety of everyone involved. They range from sedation medication, being locked in a ‘safe’ room, to being locked to the bed (Sarofin et al., 2012). My dilemma was, how can we ethically say we are being trauma informed while restraining people? I learned quickly that the lack of collaboration and lack of empowerment can be big factors. As I alluded to earlier, I met with an employee of the SHA about this topic and she shared a personal story of when she needed to be restrained. In her situation, she was put in a safe room. Staff were unaware that she was claustrophobic, and
everything escalated from there. Looking back on her situation now, this woman wanted to be talked to before she was put into the safe room. Alternatively, the medical staff could have spoken with the support person who assisted her in seeking help. The support person could have advised the staff of more appropriate interventions. This patient’s personal experience of working in the Emergency Room suggested to her that security officers, nurses, and other professions often use restraints without following procedures. After I met with her, I went back to the policies and procedures of the SHA and discovered forms and rules around the use of restraints which were not being utilized properly. Ideally, procedures should be simple, and user friendly if the goal is higher level of compliance. Additionally, there should be consistent follow-up with patients’ charts to ensure all the correct documents are being used. Ethically, it was hard for me to see how the rules on paper translated to real life and the lack of compliance and consistency. This added to my desire to create systemic change for the patients’ best interest.
Chapter Six: Personal Reflection

As discussed earlier, my privilege has impacted my practice immensely. In my professional experience, I have always gone back and forth between focusing my attention on improving the system or working directly with clients. I have critically assessed my current and previous managers. I have studied the areas in which they excelled and have also kept mindful notes of what areas I felt have potential for improvement. On the whole, my employment has empowered me, and I am forever grateful. The ability to create change is important to me as I go forward. This lead me back to the dilemma of needing both macro and micro processes to create real change. During this practicum, I had the opportunity to learn from my Professional Associate who is in a managerial role with the SHA. I was also able to participate in board meetings of committees currently making changes to policies and procedures within the SHA. It was interesting to see firsthand how many obstacles there are when trying to enact change. I appreciate the practicum process for the experience and knowledge I have gained. It is also an essential steppingstone in reaching my future goals. This practicum began with creating TIC models for clients of the SHA. Beyond clients of the SHA, I felt purpose in teaching TIC to members of the SHA. I am proud of my self-development. To be able to say one is trauma informed means frequently learning best practices, practicing constant reflection, and creating constant change since the client’s needs and wants are not static but rather change constantly. I am confident many SHA staff have a new understanding and appreciation for TIC because of the countless presentations and group meetings I was a part of.

Self-Wellness

This practicum was very busy. While working full time and having a young family, I was exhausted. I found that taking time for myself wasn’t enough to cope with events that were
SYSTEM-WIDE TRAUMA INFORMED CARE

happening. When this practicum shifted from client TIC to co-worker and self-development TIC, I looked at critical moments of current traumatic work events. I really looked at what triggered me, what didn’t, and why. So often, as social workers we are told to do self-care! Take a bath! Get your nails done! Or whatever else you might enjoy. What is not taught is how to deal with extremely difficult moments at your workplace so that they don't get pushed down and ignored to the point of burnout. During my TIC journey, I learned to self-assess and know my triggers so that I can handle them appropriately. Often these triggers come from childhood so although I cannot change them, I learned I can be aware and keep myself mentally well while doing difficult work around suicide, homelessness, assault, and addiction. Making it okay to know one’s own personal trauma and what areas can cause mental distress to oneself, especially as a social worker, was a big part of the TIC educational presentations that I did during my practicum.

Role of Social Work

The role of social work is vital in a medical setting but there are often so many circumstances at play when a person goes to the hospital. From the presenting problem or symptom, creating a discharge plan, to knowing and implementing the plan, there can be deep systemic related issues that could re-traumatize the client, if missed by other practitioners. TIC is therefore not just a social work role; it is a humane and human role. Utilizing the five pillars can be essential in connecting and building relationships with clients quickly and authentically. The mental wellness of patients are linked to their physical wellness and vice versa; yet, in hospitals, the primary purpose is to look at the physical ailment which often obscures the why, especially when that client is labelled as a ‘drug seeker’, ‘frequent flyer’, or ‘attention-seeking’. These
SYSTEM-WIDE TRAUMA INFORMED CARE

labels are used in many settings, and it’s atrocious how often we, as a society, look down upon people struggling with mental wellness.

In critically thinking about how I will incorporate TIC and anti-oppressive practice into my personal career, I think the right place to start would be to ask questions, to challenge the status quo, and to always meet the client where they are at with an open mind. Mullaly and Mullaly (2010) gives very good advice near the end of his book for personal practice. Three things that he suggests doing as an anti-oppressive social worker are as follows: to always be aware that the oppressed person must be the agent of their own change, to manage the superior gap by promoting empowerment, and to always be critically reflective in practice. These were very real guidelines that I felt I could incorporate not just into my work, but also into my daily life. To be critically reflective is to be fully aware of my privilege and use it to promote equity and justice, which is something I’ll continue to do in my future as a social worker.

Future Vision

Many social workers talk about the goal being to ‘work themselves out of a job’. The reality is that some of the major issues that we deal with will never be eradicated. One of my favorite parts about being a social worker is that the scope of work is so large that there is always something to learn or begin doing. This does not mean that one person can, or should, do it all but means that the work could focus more on trauma informed preventative measures and include more culture informed work. As far as my future vision for TIC, my hope is that practitioners from many different disciplines become aware of these best practices, utilize them, and just keep learning. TIC is not a session you can take for an hour and then be an expert. In today’s busy world, this is much easier said than done. The vision I have for myself is continual growth as a person and practitioner. I hope I am able to assess my own burnout capacity and
balance that with helping my clients in the best way possible. I am confident I can take the skills learned in this practicum and carry them forward to help my future career with clients and the system as a whole for the betterment of all.
Conclusion

Completing my graduate degree taught me a lot about myself as an individual in society and as a social worker. It is not just about working with people but also about how to navigate the systems to better serve the patients. My privilege and beliefs that I discussed earlier have made me who I am, but I have the ability to use that privilege to help those I serve as, my purpose in embarking upon this field practicum was to gain first-hand experience in how to make change in a large system. To achieve this purpose, I explored the Trauma Informed Care approach and during my placement at SHA I was exposed to barriers that can hinder systemic change. The placement gave me the opportunity of working with multiple groups of employees and partners to the SHA. The experience was everything I could have wanted. The knowledge of TIC and the skills I gained in the process of attempting to implement it into the multilayered system of the SHA was incomparable to anything else. I was able to educate peers on TIC, using interactive methods and tools such as role plays, real time simulations and demonstrations of TIC. When the discussions in these training sessions shifted from patient pathology to employees critically reflecting on the effects of trauma on their own lives and their reactions to clients’ trauma, was invaluable. This is where the frameworks of systems theory and anti-oppression theory intersected and came full circle.

Trauma is very complex and being self-aware regardless of one’s place in the system can not only promote anti-oppressive practice but is also necessary for if practitioners are to avoid re-traumatizing patients and work with them in the best way possible. There are many grey areas in mental health, therefore, there is no one way to do this, as the responses must be contextualized, recognizing patient trauma and informed by it. This concept can be difficult for practitioners entrenched in the medical model, therefore implementation of TIC requires time and enduring
commitment from the top and across all levels in the system. It is a wholistic approach, not a quick fix, which is why it is important that the system support the managers and employees alike as they attempt to utilize patient-centered models of care all through the system. The activities I proposed in introducing Trauma Informed Care to change the SHA system during my practicum were ambitious. Even though I was not able to complete them all, it was a good start to sensitize multi-disciplinary practitioners to the five pillars of TIC, its promise for mutual benefits to the SHA and the vast amount of meaningful learning I achieved through the process. Overall, I could not be more grateful for the learning, the reflectivity, the self awareness of my own privilege and the appreciation of the complexities of system level organizational change that I am taking into my future career
SYSTEM-WIDE TRAUMA INFORMED CARE

References


SYSTEM-WIDE TRAUMA INFORMED CARE


SYSTEM-WIDE TRAUMA INFORMED CARE


SYSTEM-WIDE TRAUMA INFORMED CARE


SYSTEM-WIDE TRAUMA INFORMED CARE


SYSTEM-WIDE TRAUMA INFORMED CARE


SYSTEM-WIDE TRAUMA INFORMED CARE


SYSTEM-WIDE TRAUMA INFORMED CARE


SYSTEM-WIDE TRAUMA INFORMED CARE


