WHY YOU HAVE TO GET IN THE CHUTE: REFLECTIONS ON THE INTEGRATION OF SOCIAL WORK SERVICES IN THE WESTERN COLLEGE OF VETERINARY MEDICINE

A Practicum Report

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Chapter One: Introduction

In the last week of my practicum my best friend died. His name was Nicker. Nicker was my 31 year-old quarter horse. He had been a part of my life since I was 10 years old. It was at the moment of his death that I learned exactly what my practicum was about. Nicker had always been my place of unconditional safety and love throughout my life. He had been a solid and rooted part of my place on this earth. In my grief over losing him, I tried to imagine where I would find this sense of connection again. It was in my grief for him that I came to realize why social work is so important to me and, moreover, why veterinary social work (VSW) is such an important field.

From September 9, 2014 to December 12th, 2014 I completed a master’s of social work (MSW) practicum at the Western College of Veterinary Medicine (WCVM) at the University of Saskatchewan (U of S). This practicum did not simply come my way. I chased it. The idea for a placement came about after collaboration began in July 2013 between the Western College of Veterinary Medicine (WCVM) at the University of Saskatchewan (U of S) and the Faculty of Social Work (FSW) at the University of Regina (U of R). The Veterinary Social Work Initiative Committee (VSWIC) that emerged from this collaboration focuses on bringing together social work and veterinary medicine in the provision of services to people and their animals. A key goal of the VSWIC is to create and support opportunities for social work clinical field placements. The committee is comprised of individuals from both academic programs and representatives from the Department of Sociology and the Saskatoon Health Region.

Simultaneously, I was taking a qualitative research course taught by my Academic Supervisor. I can still remember the first day of this course when she mentioned that the Veterinary Social Work Initiative was moving forward and should anyone be interested in a
potential practicum placement, to let her know. I am not sure how many times I ‘dropped by’ her office, asking whether there was any news about the potential practicum and whether I could be considered for this placement.

During the qualitative research course, students were required to complete a pilot research project. The assignment involved designing a research question, completing a literature review, interviewing two individuals, using a qualitative method to analyze the data collected, and discussing the preliminary findings. My research question focused on the attitudes of emergency shelter service providers towards the companion animals of shelter residents. Furthermore, I was interested in the perceived barriers of these service providers to accommodating companion animals within emergency housing. It was this assignment that truly sparked a fire within me to practice social work with a focus on the human-animal relationship.

This report is a reflection on and an analysis of my Master of Social Work (MSW) practicum journey. I provide an overview of my learning experiences with particular attention to my role in the creation of an organizational structure, clinical practice in this setting, my interactions with staff, students, and faculty of the WCVM, the integration of social work theory and practice, ethical considerations, and the literature as it pertains to the practicum context.

I begin with a description of the placement setting. I then discuss my primary activities during my placement. I explore the relevant literature around human-animal interactions, social work, and veterinary sciences. I also include a discussion of how my practice has been informed by theory and discuss the challenges I experienced within the practicum setting. Throughout the report, I incorporate my reflections on the ethical considerations of the practicum. Finally, I offer my recommendations for the future of the Veterinary Social Work Program.
Placement Setting

I officially began my placement on September 9, 2015 but attended a meeting of the VSWIC prior to this date. The purpose of the meeting was to meet the committee members and discuss logistics concerning my placement, such as the need for access to a computer, telephone and, importantly, office space. From the outset of my placement it was made clear by the Dean of the WCVM that social work should not only be available to clients using the Veterinary Medical Centre (VMC), but also be available for staff, students, and faculty of the WCVM. The Dean has championed the inclusion of social work from the outset of the development of the VSWIC and I believe that this contributed greatly to the success of my practicum and the success of incorporating social work in the WCVM.

My supervisory committee reflected the interdisciplinary nature of the veterinary social work initiative. Dr. Trisha Dowling, a veterinarian and faculty member, served as my Professional Associate and provided support related to the veterinary context at the WCVM. As a new initiative no existing social worker was located within the WCVM. Therefore, Doug Harder (MSW/RSW), a program manager within the Saskatoon Health Region Mental Health and Addiction Services, served as a Professional Associate and provided clinical support related to my direct practice with clients. My Academic Supervisor, Dr. Darlene Chalmers, provided a link between both the academic programs and the VSWIC, and overall practicum guidance and support during my placement at the WCVM.

The practicum was located on site at the WCVM; a physically vast building. The veterinary college has one of the largest physical footprints on the U of S campus because it incorporates all that is necessary to educate veterinarians both in general practice and specialties. This includes the Veterinary Medical Centre (VMC), an animal hospital much like a human
hospital, with access to all the essential services and equipment to offer clients emergency and specialty care for their animal companions. The animal hospital is made up of a number of different clinical teams and specialties.

The structure of the clinical teams includes: fourth year students who rotate through different areas as a part of their educational process; residents and interns who provide veterinary intervention under the supervision of clinical associates and faculty; and a capable team of veterinary technologists provide services similar to nurses in human hospitals and are in fact supervised by two registered nurse managers. The clinic itself is unique in that its scope is much larger than a private clinic. It operates 24 hours a day seven days a week. Clients have access to a number of resources including: large and small animal surgeons; oncology and cancer treatment; MRI and CT; small and large animal emergency medicine, intensive and critical care; ophthalmology; dentistry; dermatology; zoo, exotic, and wildlife medicine; pharmacy; rehabilitation; acupuncture; nutrition; preventative medicine; reproduction; lameness; an equine performance centre; disease investigation; herd health; medical imaging; and finally field service veterinarians who can attend to large animals outside of the clinic (University of Saskatchewan, n.d.). It was within these existing structures that I would be incorporating social work services.

I went into my first days of practicum with the only intent of building relationships with people and knew that the only way I would be able to provide social work interventions, was if the staff, students, and faculty of the clinic believed I was competent and useful. This is due to the fact that few in the clinic had contact with social workers within a veterinary setting. Thus, if I wished to be a part of the team I knew I would need to prove my usefulness and worth in order to also prove that the new social work service I was creating was worthwhile to the WCVM. More so, I wanted to be authentic in the way I approached my interactions with everyone at the
WCVM. Since a goal of this practicum was to better understand the setting, the potential need for ongoing social work services, and to build relationships with clinicians; my approach to program creation was guided by principles of mutual respect and positive regard. In the days that followed I met a number of veterinarians, some who were curious about me, others who queried what I could actually offer. Generally, when I was greeted with what I perceived as suspicion or uncertainty I attempted to de-personalize and differentiate. This meant that I acknowledged that I am who I am, they are who they are, all of us have the right to hold these places and my only job was to facilitate respectful interaction. Practically speaking, this involved providing information and answering questions about my social work role as best as I could. Often this also meant touting my employment history, something that is uncomfortable for me, as I do not want to come off overconfident. However, what I learned is that in this placement, which is an academic setting, people generally lead with credentials in their interactions and thus it is important to share why it is that one is qualified to take on a role.

As I was going into a new environment and organizational culture that had no previous involvement with social work, I drew on skills that I have used in the past to gain entry into new settings. Initially, the VMC Director and my Professional Associate served as gatekeepers to my entry into the college and VMC. I was connected with a nurse who on my first day provided me with a tour of the clinic and introductions to many WCVM team members. These gatekeepers also took it upon themselves to introduce me to people where I could then take the opportunity to give a brief synopsis of what I hoped to be able to provide in the clinic. I would consider this as both an education and relationship building stage. Many veterinarians and staff were not familiar with social workers or what social workers do. Thus, visibility was an important part of my initial work. Thanks to my gatekeepers, I was quickly invited to attend rounds within the VMC,
which gave me larger exposure to both the small and large animal clinics. Rounds within the
college were different and yet familiar to me. They very much parallel the rounds I had attended
in other areas of my social work career such as hospital and long term care settings. I also came
to learn that the VMC works very similarly to other hospital systems and this provided me with
some familiarity and increased my confidence to interact with the veterinarians and staff.

The more I learned about the breadth and depth of the work of the VMC, the more
parallels I discovered between the care available to animals at the VMC and the care humans
receive in a hospital setting. I realized that should social work be effectively integrated into the
clinic, then this service could experience significant growth. As is found within a typical hospital
setting in Saskatoon, social workers are found throughout the hospital providing support that is
uniquely geared towards the needs of a patient on any particular ward. Thus I became aware that
the role of social work could expand to meet these similar needs within the different areas of the
VMC. I also began to realize the enormity of the task at hand. In order to begin to incorporate
social work into the VMC, I would need to learn how referral pathways worked, how individuals
accessed these services, and where I would be the most valuable to the VMC.

**Development of the Practicum Objectives**

The development of my practicum proposal and learning objectives required creativity.
The practice of veterinary social work exists in a few North American university social work and
veterinary medicine programs but none are located in Canada. The emergence of this sub-
specialty of social work is most notably credited to the work of Dr. Elizabeth Strand at the
University of Tennessee-Knoxville (UTK). As such, the objectives I created were guided by the
established professionalized goals of service developed at UTK. The UTK program identifies
four areas of focus for VSW intervention. These include “providing support for grief and pet
loss; animal assisted interactions; the link between human-animal violence; and compassion fatigue management” (UTK, n.d.). Therefore, my learning goal, objectives, and proposed activities were developed to fit within the context of these existing spheres of VSW intervention. However, I also ensured that they reflected the Canadian context and specifically the three prairie provinces served by the WCVM.

My learning goal was to provide support to human beings in their interactions with animals. As the social work practicum placement was new for the academic programs, VSWIC, and the veterinary college, I had two main roles incorporated in my learning proposal. First, the clinical role of my practicum was to consist of the provision of clinical support services to the clients of the small and large animal clinics, as well as intervention with students, staff, and faculty. Second, a project role was to include the development of infrastructure to support a salaried social worker and future practicum placements in this setting. This would require completing an environmental scan to determine the needs within the clinic to successfully incorporate a collaborative social work initiative. My placement setting additionally required that I work from an interdisciplinary approach alongside veterinary sciences. This also included community-based services as needed to support human beings in their interactions with animals.

In order to achieve this goal I set out a number of objectives that would serve as a starting point for incorporating social work services. These objectives were as follows:

1. Examine the literature on human/animal interactions with relevance to ethical VSW practice.
2. Intervene on behalf of human beings in the context of human/animal interactions through micro, mezzo, and macro levels of practice, paying particular attention to underserved populations and populations living with oppression.
3. Develop and implement social work supports in an existing agency/host setting, where social work does not currently exist. This practice will be congruent with the Social Work and Veterinary Medicine codes of ethics, as well as relevant legislation (ex. child welfare and animal welfare legislation).

4. Provide relevant social work interventions, which may include provision of community resource information to WCVM students and faculty; referring clients to appropriate community resources; and counseling support to clients.

5. Conduct an environmental scan to further the development and implementation of VSW; developing a satisfaction survey to measure types of services provided and outcomes (clients, students and faculty).

6. Develop and demonstrate psycho-educational, mediation, advocacy and team building skills. As I developed these objectives I was conscious of how they might be in line with my own belief system as well as the tenets of social work practice that I believe to be important. This includes that I incorporate ethically based, anti-oppressive approaches to social work from a systems theory perspective. Theoretically speaking, systems theory seemed sensible as I was seeking to integrate social work into a host setting that had no prior experience with the profession. To clarify, when I refer to systems theory I am broadly referencing a theoretical model that proposes that every system has a number of parts that interact and therefore have relationships with one another (Nichols, 2009). Additionally, I am conscious that a workplace, much like any organism, has many parts that make up the whole. I am thus aware that by introducing social work into an existing organism/workplace I am essentially disrupting the existing homeostasis of that organism by adding another part (Nichols, 2009).
Similarly, when I note that I include tenets of anti-oppressive approaches into my learning objectives, I am referring to the fact that these objectives specifically make note of paying attention to groups living with oppression. As Mullaly (2002) suggests, if it is an individual’s intent to work as an advocate, then one must cultivate an awareness of the ideological thought structures that contravene social justice as part of the work. Furthermore, if one intends to change that which is unjust, one must build into their work an ideological framework that seeks to combat injustice (Mullaly, 2002). Thus when I developed my learning objectives, and included reference to populations living with oppression, I suggest that injustice exists and that as a social worker I will specifically pay attention to this injustice. Moreover, this attention will also require that I explore mechanisms to ensure that I am cognizant of multiple oppressions as it pertains to my work.

If one unpacks the objectives above, the references to anti-oppressive social work and systems theory are clearly noted. For example, objectives one and three both reference ethical social work practice as well as the laws that govern social work practice in Saskatchewan. These are all examples of systems interacting with one another. Additionally, objectives two, four, and five make reference to incorporating social work in an existing system or the ways that social work interacts with systems as a part of service provision. Furthermore, objectives two and six make reference to oppression, vulnerable, underserved populations and advocacy, making clear that social justice is a part of the underlying ideology of the practicum plan.

I was conscious that social work services would be new and therefore had to be responsive to the unique needs of the WCVM host setting. Furthermore, the work itself would be developmental and therefore needed to be broadly defined. Mainly, I did not want to begin with a narrow scope of practice that could potentially alienate the WCVM by not meeting their needs
and that also would not pigeonhole the project should social work have a different role than what was anticipated. This sensitivity was rooted in my own belief that relationships are paramount and should be mutually beneficial and respectful. Thus, it was for these reasons that the objectives were broad in nature and designed to address the needs of the WCVM as they arose.

I then considered the activities that would permit me to accomplish my objectives. The activities I decided upon were intended to be flexible and allowed for change during the practicum. They were as follows:

1. Develop and demonstrate knowledge of human and animal welfare issues

2. Synthesize literature and practicum experiences while also incorporating both theory and policy implications, into a final practicum report including the human and animal bond, disenfranchised grief, ethical considerations within the veterinary setting for social workers, research related to domestic violence and child abuse as linked to violence against animals

3. Create a resource manual for veterinarians and clients of the clinic related to a variety issues surrounding human/animal interactions and available community supports

4. Provide clinical social work services within the vet clinic that may include information and support for clients related to animal interactions such as: resources for clients who cannot afford animal care; resources for clients who experience domestic violence or are perpetrators of violence; resources related to grief—in particular disenfranchised grief associated with pet loss; mediate circumstances where the human/animal interaction is in conflict with veterinary or social work ethics (cases where animals or human counterparts may be at risk, end of life decision-making etc.); and provide resource support for students and faculty
5. Assist in the development and implementation of on-going educational seminars for veterinary students and faculty

6. Participate in the Veterinary Social Work Initiative Committee (VSWIC)

The activities I developed were based on the information I had gathered from UTK prior to my practicum. Essentially I wanted to create a list of activities that would serve as a launching point for a potential new program. Moreover the activities also needed to be broad enough in scope so as not to stifle the potential of social work in this new setting. My primary goal was to build relationships. I wanted to provide social work services but to do this I believed that I needed to be visible and available, while also being respectful that I was new, did not have pre-existing relationships, and that this was an unfamiliar service. I was not naïve enough to believe that I would simply show up and have a caseload, nor was the infrastructure in place for me to do so. I wanted to begin to build social work into the WCVM in a respectful way that honoured the existing services (both formal and informal) for meeting client needs. Furthermore, I wanted to remain open to what social work should look like within the context of this particular clinic. Thus, my activities and objectives were guided by the existing literature and practice, and remained flexible enough to meet individualized program needs.

From the first day of my practicum I embarked on a voyage of learning that has led me to believe that VSW is not only extraordinarily challenging, but that it is a reflection of all other forms of social work practice. To clarify, I have truly come to believe that many of the different skills required in the social work practice of other settings, are mirrored in the role of the veterinary social worker. For the duration of my practicum I kept a detailed journal, which included my day-to-day activities, musings, struggles, and moments of elation. I cannot emphasize enough how important this practice was to my practicum. The journal not only
provided me with clarity through reflection during my placement, but also provided a practical means of retracing my steps during program development and the writing of this report. The next section presents the activities that I engaged in throughout my practicum. These included setting up the necessary administrative processes, attending to the clinical needs of the WCVM, and facilitating presentations.
Chapter Two: Practicum Activities

Seminar Presentations

I attended and participated in my first VSW seminar on August 22. This seminar had been created by the VSWIC as a mechanism to educate the students, staff, and faculty of the WCVM on the role of a veterinary social worker. These seminars had been facilitated at the college prior to my placement, however I was included as it would be a way to meet the new house officers and interns, of the small animal clinic at the VMC. The rationale for this was two-fold. First, it served to provide useful information to those veterinarians working on the front-line about social work practice. Second, it provided an opportunity for veterinarians staffing the clinic to meet and become acquainted with me. The presentation that was given summarized the profession and the multitude of social work roles, the populations they work with, how social workers and veterinarians are connected, and a case example where social work intervention would be helpful. The case example used in the presentation involved the treatment of a 12 year-old Labrador retriever. In this case the dog arrives at the college in the care of its owners, a married man and woman. As the case evolves it is discovered that the dog has a treatable condition, but that its male owner does not wish to treat the dog and the couple leaves. Later, the female owner returns with signs suggesting domestic violence, asking the veterinarians to treat the dog but without her husband’s knowledge as he will be angry.

This case is meant to challenge the veterinarians in considering what they might do if faced with this situation. In preparation for this seminar I was to prepare information on the duty-to-report if this couple had children (who would likely be exposed to violence). I also was to provide some resources should the veterinarian need to report and be unclear as to where and how they might do so. What was most interesting to me about the conversation that ensued was
the fear that was articulated by the veterinarians that surrounded reporting and the potential that in response to a report, the couple would stop treating their pet’s ailments. This allowed for the conversation to move towards an approach that I refer to as a relational reporting. That is, attending to the necessity of reporting while also attending to the relationship with the client. Afterwards, I journalled the points that we covered that outlined this relational method. First and foremost, this included talking to the client about their concerns and the veterinarian’s need to likely report. Second, that they emphasized their need to keep the client (woman and children) and patient (animal) safe. Third, that they created a plan to keep the woman, child, and dog safe. This also led to conversations about the rationale of including social work in the WCVM. In this case example social work was identified as a mechanism to help the veterinarians identify and engage the relevant resources for clients, as many veterinarians felt that this was beyond their scope. Finally, that the situation was reported to the local crisis management organization or child and family services. This was explained as a means of protecting the relationship while also following through with the necessary reports. Thus, while explaining this process to the veterinarians, the emphasis remained on the necessity to approach clients with mutual respect, positive regard, transparency, and fairness.

What was most obvious to me while facilitating this conversation was the frequency of veterinarians encountering this situation and their discomfort in appropriately intervening. I came to understand, in the discussion that followed, that many in the room felt ill equipped to do a meaningful intervention (i.e. engage the client in conversation or report). As well, many had fear about the possibility of incorrectly assessing the situation thus bringing embarrassment to them, or assessing correctly and having the abuser in the scenario seek retribution at the VMC. This then led to further discussion about how social work intended to complement the existing
team within the VMC. Many in the room were also concerned about their access to social work services once they moved on from the VMC, or when issues occurred outside of social work business hours. Anticipating this, I had created a list of resources for the veterinarians prior to the start of my placement that were provided to them to be used if the social worker was unavailable in the hospital or when they moved on from the VMC into their own private clinic (see Appendix A).

**Development of an Administrative Structure**

In the early days of my placement, I found myself preoccupied with how I might keep appropriate notes and charts once I started seeing clients. In consultation with my practicum supervisors, I developed a client information system that would keep record of my contacts and relevant demographic information. The information collected included the species of animal that had brought the client in, the client’s presenting concerns, how the client was referred to me, the referrals to other supports that I made during the interaction, the amount of time spent with the client, the number of contacts I had, and whether my interaction was of a direct nature, consultation, or third party referral. These last three categories (direct, consultation, third party referral) indicated whether I had been directly in contact with the client, whether I had provided a consultation to the veterinary medical team, or whether I had received the referral from a third party external to the WCVM. The rationale for tracking this information is that it would later serve as a mechanism for program evaluation. However, what I discovered is that this collateral information also provided a good foundation for my initial charting notes and allowed me to gather enough information to accurately report and chart my interactions with clients. Over the duration of the practicum, this sheet became the face sheet for all of my charts providing me with
a foundation for my records and a means of gathering pertinent charting information (see Appendix B).

The WCVM uses a computer charting system called VetNet. VetNet is a platform that incorporates a digital chart and messaging system, where all health records are kept online and where users, employees of the WCVM, may text work cell phones or access individual message boards to communicate. From an access to information standpoint, this program was paramount to my initial understanding of the VMC. On it I could locate clients, find out the current medical information and interactions with their veterinarian—all important pieces of supporting clients in their interactions with the WCVM. Furthermore, I could contact veterinarians, and I could also be made aware of the types of bookings that were coming into the clinic on a daily basis, including emergencies. From a strictly charting perspective, this allowed me to print labels with contact information to be placed on the collateral information sheet, which made for clear and easy charting.

What I found helpful in creating this collateral information sheet and then by also utilizing VetNet to create labels, is that with minimal difficulty I was able to instantly create a paper charting system that is consistent with the Saskatchewan Association of Social Workers (SASW) regulatory documents. When considering how I would chart I consulted the SASW regulatory documents to ensure that from the outset, the program could operate ethically and effectively. This included first, the Canadian Association of Social Workers (CASW) Code of ethics (hereafter referred to as the Code of Ethics) (CASW, 2005) and the CASW Guidelines for Ethical Practice (hereafter referred to as the guidelines) (CASW, 2005). I then referred to the SASW Standards of practice for registered social workers in Saskatchewan (hereafter referred to as the Standards) (SASW, 2012). In keeping with these documents I ensured that charts were
kept in my office in a locked cabinet where I was the only person who had access to them. I alphabetized the charts by client last name, included the dates of the consults, my treatment notes, and the referrals I provided in each file. I also considered the ramifications of my charting as it pertained to the Guidelines.

As noted, the veterinarians utilize VetNet to house their charting. However, charting on VetNet would not be effective for me for a couple of reasons. First, it did not afford me the opportunity to chart a client interaction, as the charts in VetNet are animal specific. Thus, an owner, or in my case a client, might have multiple charts in the same system. Second, there was no place for me to chart client interactions that were staff, faculty, or student related. Also, I could not guarantee their confidentiality if I were to place their record on a system that all of their colleagues had access to. Therefore, I elected to instead create my own system of paper charts. However, this still raised the question as to how I could notify veterinarians that I had indeed followed up on their referrals for clients of the VMC. In conversation with the Director of the VMC, it was decided that I would place a one-time client communication on the VetNet file that would indicate that I had received the referral from the veterinarian and had contacted the client. This was arranged to help with client continuity and to ensure that the veterinarian knew that I had indeed followed up with his/her/their referral.

When considering who my clients would be, it was made clear to me by the Dean of the Veterinary College, as well as the veterinarians on the VSWIC, that supports be made available, if appropriate, to students of the WCVM. Initially I was quite curious about this. I have worked for the past six years for the Saskatoon Health Region and am familiar with the resources available in Saskatoon and, most notably, that students have access to free counselling services through the university. Therefore, when I was told that students would also be a part of my
caseload I was concerned about creating confusion and, quite frankly, duplicating service. After sharing these concerns with the Dean, I was assured that my role would be to provide brief support and primarily referral, which seemed sensible given my good grounding in the referral pathways and resources available in the city.

Internal Systems

During my first week I quickly became familiar with the administrative structures of my practicum placement. Importantly this included Student Services. Student Services at the WCVM oversees a number of different areas of student academics and has been primarily responsible for providing academic support services to students when in need. That is, if a student cannot fulfill their responsibilities due to personal factors outside of the college, Student Services endeavors to make arrangements, in partnership with the student, to help them be successful, even while struggling with external challenges. A clear commitment to students by the WCVM through Student Services exists. Student Services had initiated a number of initiatives to support wellness in the students of the WCVM. Some of these include giving students Wednesday afternoons off, creating a policy where faculty are not to contact students on the weekends, changing test schedules to remove some pressure, liaising with student counselling to ensure students have access to supports, and adding a mentorship program for all students. Up to the start of my placement, Student Services had not been involved in the VSWIC. What emerged during the practicum were concerns surrounding coordination of support services for students.

A difficulty that I experienced was how to work collaboratively with Student Services and address their concern that I might affect the work that had already been underway to promote a healthy culture for students within the WCVM. This meant ensuring that should a student
access veterinary social work in advance of Student Services, that I did not unintentionally usurp their role or move beyond my scope of practice. Specifically this meant that social work could not provide academic accommodation in any way should a student require it. Moreover, Students Services had their own methods of discerning the most appropriate accommodation and was concerned that social work might provide inappropriate counsel in this regard.

In considering how social work would work alongside Student Services in a collaborative way, a clear understanding was needed of how both would and could communicate with one another about the needs of students. At first, Student Services identified that they wished to be kept apprised of all referrals that social work made. This was the first point in my practicum where I struggled to explain social work and the ethical constraints of the profession. However, I was able to articulate that without informed consent of the person, in this case the student, no information could be disclosed to student services. The process that was agreed upon was that social work would vehemently try to get informed consent for the sole purpose of ensuring that student’s needs were met. As such, social work agreed to discuss with student clients the role of Student Services in providing academic support. This agreement was made with the intention that students would understand that if Student Services was not made aware of the life crises creating distress, that academic accommodation would not be provided preemptively should the student require this. Given this, what emerged early in my practicum was an initial draft of a policy for student support:

- Social work will provide support to students who ask for service.
- Social work service is meant to be short-term, referral-based and is meant to redirect students to the appropriate services. Social work is not meant to provide services already available to students through established counselling programs. As such, social work’s role is primarily
brief interaction and referral to: Student counselling for individual support; Student Services for academic support; community resources (if requested or in addition to another referral); and in crisis situations the appropriate crisis intervention.

- Social work will, as early as possible, seek informed consent from the student so as to be able to work collaboratively with Student Services and provide Student Services with the student’s presenting concern. This is to try to ensure that social work does not impede treatment pathways already established by Student Services and to ensure that social work does not contravene the Canadian Association of Social Work Code of Ethics (2005) as they pertain to confidentiality.

- Once consent is given by the student, two options exist for coordination of support with student services: 1) The student will call Student Services directly, or 2) social work will call Student Services and provide a brief summary of social work’s contact with the student. It is important to note, that where consent is given by the student, social work will follow-up with Student Services and ensure that the student has contacted them.

- Social work will provide clinical support, as needed, to Student Services to provide them with appropriate resource information for students.

- The provision of social work services is intended to be collaborative with existing departments and services within the WCVM and University of Saskatchewan. As such social work is committed to continued collaboration with Student Services so as to provide exceptional service within the WCVM.

The policy document continues to exist as a working document to best meet the early needs and concerns identified by Student Services. The document provided a good foundation for the relationship between Social Work and Student Services. I was receptive both to any preliminary
concerns while ensuring that I could work ethically respecting the autonomy and confidentiality of students seeking my services.

Client Satisfaction Feedback

In addition to creating a system of charting and policy around providing services to faculty, staff, and students, it was important to have a mechanism for feedback from the clients of the VMC. In this case, clients are defined as those individuals who have come to the VMC to access services for their animal (large or small). It was pertinent at the outset to seek feedback from clients about the effectiveness of the services that I provided. However a feedback sheet also provided an opportunity to potentially alert clients to the service if a referral did not come directly from the veterinarians and staff of the VMC. At the top of the form a brief description is included on the role of veterinary social workers within the clinic. As clients primarily received discharge notes from the clinic via email it seemed reasonable that I create an online feedback tool that could also be filled out manually (see Appendix C).

To make the survey cost effective I used Survey Monkey©, a free online survey website. I wanted the survey to be accessible and short so that respondents would not be burdened with a lengthy document. The goal was to establish whether clients had heard about the service, how they came to know about it, whether a specific concern brought them to the clinic that factored into a social work referral, and whether they found the service to be a valuable part of their animal’s care team. Once the survey was created, I met with the VMC Director and Health Records to determine how the document could be included on all discharges from the clinic. What occurred was that the document was attached to all of the discharges through computer programming. The reception areas were also provided with a folder to place any paper copies,
which I could later collect and manually enter into the online system in the event that clients elected to complete the form manually.

The outcomes of the document were not quite what I had anticipated. Of the 64 responses to the feedback survey, 83% of respondents had not met with social work, 14% did not know if they had, and 3% identified having met with the social worker. Of the 3% who saw the social worker, 100% identified that the referral came from their veterinarian. Upon review of the responses it became clear that the bulk of the respondents had attended the clinic for small animal services and these services did not require social work intervention. In speaking with the reception staff at the clinic, I learned that when an animal patient is euthanized, often the clients do not want or require a final discharge note. As grief and loss in times of euthanasia were my primary connection to small animal clients, those clients that I was likely to have had contact with were unlikely to receive the survey link or document. What was interesting is that 75% of respondents identified feeling neutral, that is they neither agreed nor disagreed, about whether “social work was a helpful part of my animal’s care team”. In asking whether social work would be helpful or unhelpful, many respondents identified how well served they felt they were by the VMC and that while social work was not a service that they had used or needed during the current visit, they would elect to use social work in the future should they need to do so. While the survey was limited in its feedback on client experiences of social work, it did provide the second course of action, which was to promote the new program. The survey continues to be an evolving tool and will be interesting to re-evaluate in the future.
Clinical Work in the Animal Hospital

Once I had sorted through some of the more administrative pieces of the placement, the clinical work began. As mentioned I went into my first days seeking only to build relationships with people, as I knew that the only way I would be able to provide social work interventions was if I was perceived as competent and useful by staff, students and clients. More so, these interactions needed to occur authentically so as to build a program built on mutual respect and positive regard. I was fortunate that the office I was given to use was centrally located directly between both the large and small animal clinics in a throughway that made for plenty of opportunity to connect with passing clinicians and medical team staff. This was paramount to making initial contact with them.

Typically I would arrive at 7:30 in the morning, peruse VetNet to see if any emergent cases that had arrived the evening before might benefit from social work intervention, and then attend to rounds. This allowed me the opportunity to learn about the inner workings of the clinic and offer service to clinicians addressing the social side of cases that had arrived in my off hours. For the first few days I settled in, attending rounds, and waffling between feeling bored and overwhelmed with possibilities. Referrals for VMC clients came much as I thought they would, through veterinarians, technicians, and reception staff. The practice of making referrals to social work, rather than me actively seeking them out, evolved over my time in the clinic as members of the team grew more accustomed to my presence. However my first case came through my Professional Associate. While on another round of being introduced throughout the clinic, I was introduced to a clinician in the small animal clinic, who then passed my information on to his resident, who then invited me to my first euthanasia in the small animal clinic. I feel it important to discuss this experience and why I believe it was a positive one.
The animal that was to be euthanized was young, had previously been seemingly healthy, and its human counterparts lived several hours outside of the city. After a barrage of tests, it was determined by the attending veterinarian that this animal was suffering from a neurological illness that was creating a rapid decline in health and increased suffering. The owners elected to humanely euthanize the animal given the poor prognosis. I attended to the family prior to the euthanasia and talked with them about their loved one, listening to their grief. When the time came I gave them the option of spending some time alone to say goodbye to their pet and returned to them just before the veterinarian was to enter. By this time I had determined I would follow my instincts in how I would provide support. I really did not want to overstay my welcome or leave the family feeling as though they were alone. As I re-entered the comfort room, a low-lit space with a couch where many euthanasias take place, I found the family nestled on the floor with their beloved pet. I sat down with them and let them know that the veterinarian would be returning shortly and asked if they were ready. I also asked whether they would prefer I stay with them or go, letting them know that in either regard I would be nearby should they need me. They asked me to stay and the resident re-entered and euthanized their animal. We all sat together and somberly said goodbye. Afterwards, there were tears and time spent stroking the animal. We talked about how the decision felt and how they planned to honour their friend. When ready, the veterinarian returned and took their animal away for cremation and a paw print memorial. The family requested this. Finally, I escorted them to the waiting room. Then something really interesting happened. One family member turned to me, teary eyed and said, “this veterinary social work thing, it’s a really good idea”.

I wish I could say that from that point forward I attended all of the euthanasias in the clinic providing equal support to every individual who was losing a companion, but
unfortunately, this was not the case. For one, it was just not feasible. The sheer number of euthanasias that are done on a daily basis would not permit for this degree of intervention from one person. However, this was also not the last euthanasia I attended, nor was it the most complex. In my time at the VMC I had attended a number of euthanasias and provided support to clients before, during the end-of-life decision-making process, and in their grief afterwards. I provided support to clients whose animal was undergoing treatment or who were unsure if they should pursue further treatment. I saw clients of the VMC whose animal did not appear to have a diagnosable illness and where, in the end, the client was potentially presenting with a mental health concern that had been projected onto their animal.

Similar to my first foray into small animal medicine, was my induction into the large animal clinic. With the same combination of happenstance, visibility within the clinic, and thoughtful connection with veterinarians, I met a large animal veterinarian and faculty member who introduced himself early in my practicum. He indicated that he could easily see the connection to small animal medicine, providing support around grief and loss, but shared his belief that there potentially could also be a significant role for social work in the large animal clinic. He shared with me the structural issues that face large animal clients. More specifically, that there are circumstances that veterinarians often feel ill equipped or lack time and resources to manage. Some of the examples he provided me were circumstances where an individual was likely to be charged under the Animal Protection Act for the mismanagement of their herd. In these circumstances a herd would be potentially malnourished, gone untreated medically or otherwise medically declined for preventable reasons.

This veterinarian explained that in his experience it was almost never malicious in nature, but could often be attributed to issues related to mental health, addictions, financial distress, or
other mitigating factors. He explained to me that quite often the circumstances were such that generally veterinarians found time did not permit or more simply veterinarians could not intervene on the social side of medicine in the ways they wish they could. He also identified cases where he was fearful for the safety of a producer after a large part of their herd needed to be culled or if enforcement agencies needed to be alerted. Mostly this was because in his own experience, farmers and producers could experience a significant amount of shame, grief, guilt, and loss when faced with the idea that their herd’s illness was untreatable or could have been prevented. These feelings coupled with financial hardship in the event that a producer experienced large loss, were in his description, factors that contributed to increased personal risk to the client. After learning about this, I asked whether he would consider including me on one such call so that I too could observe and potentially intervene.

One such case arose and I was invited to attend a small herd disease investigation in a rural location. In consultation with this veterinarian, I elected to take my own vehicle rather than travel with the team for the following reasons. First, if I was unwelcome or did not need to be at the call for the same length of time as the team attending, I wanted to have the freedom to leave. Second, and more importantly, I realized that should there need to be intervention of some kind where I needed mobility, for instance if the client needed to be transported somewhere for their own safety, I would need a vehicle to provide this service. At seven in the morning I arrived at the VMC to meet the team and follow them for several hours to the farm.

Driving into the farmyard, I was struck by how carefully and beautifully built the yard was. The infrastructure was so carefully architected that I immediately thought that the person who had taken such care in the building of the place must also reflect that in his work. After initial greetings, the veterinarian guided the team, the producer, and me into the barn to take
down a medical history. On the way to the barn, the loss the producer was experiencing was visible. There were a number of dead animals that had been either centrally located on a manure pile or left where they had died. The producer noted he did not move the losses of the prior night, leaving them where they lay, in case this information might be pertinent to the investigation.

During the history I learned that he was losing approximately 25 young animals per week. I watched the veterinarian take a long and clear history, asking questions in a way where the producer could help him build a linear timeline that explored what was occurring on the farm and what interventions had already been attempted.

After taking a medical history, the producer took us on a tour of his place. As we were walking through I could see his carefully built south-facing shelters, that all of his animals had access to fresh water, and as he explained how he came to be in his industry, his real enjoyment of what is often very hard work. We continued to tour around the place, and I noticed that there were several young animals that had ‘downed’. To clarify, when an animal ‘downs’ it refers to the fact that they are unable to rise due to a medical concern. Even to my layperson’s eye, I could tell that they were unwell. The veterinarian noted them and at the end of the tour sent the team out to pick them up so that they could be euthanized and necropsies on them could be completed.

While half of the team was picking up these ‘downed’ animals, the other half went to the barn to body score a number of the adult animals. I waited with the team who was to euthanize the animals for necropsy and learned about the use of a captive bolt technique for euthanasia. To clarify further, a penetrating captive bolt is an instrument that causes the animal to become unconscious immediately as the brain tissue is destroyed as a result of the bolt penetrating the skull (Iowa State University, 2014). Afterwards a pithing tool is inserted into the area to ensure death through exsanguination (Iowa State University, 2014).
I wondered how I would react to euthanizing the animals. Interestingly one of the team members reached out to me beforehand. She asked whether I was comfortable staying or whether I would rather not watch. I told her I wanted to stay. Truthfully, I was familiar with the process of using a captive bolt, though had never seen it in person. I determined that if I planned to work in an industry where death is one, if not, the main components, I best be knowledgeable and have firsthand experience of the appropriate euthanasia techniques. However, I was appreciative and interested in her reaction. It seemed almost like an acknowledgement that the process of death by euthanasia is not necessarily a normal human experience. Moreover, that euthanasia using the captive bolt technique might somehow be even more difficult to observe. After the bolt and pithing were done, a necropsy was performed on the animals to attempt to determine if there was anything visible on their organs or within the cavities of their bodies that could help the investigation.

I returned inside as the producer was bringing a representative part of his herd in for body scoring. Condition scoring is a process whereby the veterinarian examines the overall body condition of the animal and nutritional status of the animals (Fernandez, n. d.; Whiting, Salmon, & Wruck, 2005). Simply put, the veterinarian is seeking to determine whether the muscle and fatty tissue of the animal is within a normal range (Fernandez, n. d.). Scores range between one and five or one and nine, dependent on the species of animal scored (Fernandez, n. d.). For example, the number one would indicate that the animal is emaciated and a five or nine, again dependent on the scale being used, would indicate obesity (Fernandez, n. d., Whiting et. al., 2005). While I waited at the barn door I watched the producer bring in his herd. He moved them carefully and slowly. There was no battle of wills but instead there was an apparent respectful leadership. He moved the animals without hurry and maintained a quiet and relaxed herd.
As they came into the chutes in the barn the team readied themselves to condition score the animals. However, there was no guillotine gate to close behind the animals. As such the producer had to climb into the chute in order to push his animals forward so that they could be examined without them retreating out of the chute. It is important to note that the team I was with was primarily made up of veterinary medicine students, many who identified minimal experience working with the herd in question. As the animals filled two chutes I watched the producer manage to keep one chute quiet, so the animals could not reverse out. However while the students attempted to body score the animals in the other chute, the animals were successfully backing out to avoid their interference. It was at this point that likely one of my more significant social work interventions happened. Though I believe in the traditional view of social work, this would not seem social work oriented at all. I got in the chute and side-by-side with the producer pushed the animals forward. As I stood there side-by-side with the producer in the chutes while the veterinary students body-scored his animals, I think that it was at this moment that he looked at me for the first time. It was while I was standing in that chute next to him that he shared with me the struggle the work had been for him, how he came to be involved in small herd production, and what he was actually facing as a result of the illness sweeping his herd.

I discovered that he was experiencing a significant problem with coyotes that were coming to his land each night to collect the corpses of the dead animals that were composting on his manure pile. I realized that my interventions with large animal were going to be much more concrete responses addressing concerns in real time concerns that while not necessarily traditional generalist practice methods of social work practice, based on client self-reflection and self-actualization, these concerns were equally important. As we talked we realized that he
would be able to run electrical fencing (otherwise known as a hot wire) around his manure pile to help stop the coyotes from free-feeding. Additionally, he stated that this would help his dogs greatly in the protection of the rest of his animals and take a fair amount of weight off of his mind. Moreover, it would provide him with the time necessary to gather the funds to dig a deep cistern where he could compost any losses in the future.

I think for the sake of situating myself and for clarification, I should make clear what gave me the confidence to get in the chute. I grew up with horses. Obvious likely because of the way this entire report begins. However, I did not just grow up just learning how to ride. I grew up learning how to be with animals, how to watch them and how to help others who are working with them. When I work alongside livestock of any kind, I am conscious of those around me, and how we can safely reach our desired goal. When moving animals and caring for them, I was taught to intervene with them in a way that both gets the job done, but also ensures the safety of everyone involved. There is also something that often goes unspoken in rural circles. That is, if you are there to help, than you better darn well be helpful. Otherwise, for all intents and purposes, you are useless. I am not sure that I realized at that moment how important understanding this worldview would become in providing social work services within these same circles. Additionally, my knowledge of how to cope with pests, in this case coyotes, or how to run a hot wire proved to be necessary for me to provide a meaningful intervention. Too easily I could have fallen back on the idea that I was only there to provide a specific, narrow, social work service. This would have meant that I would have gained no entry to the inner experiences of this producer or others that I have since had the pleasure of working with. There would have been no sense connecting or sharing with me if I had not first been useful. In the end, I believe, if I had
not gotten into the chute I would have never been able to provide a successful large animal intervention.

In the times before, after, and in between my first euthanasia and small herd clinical experiences I did varied work with clients of the VMC. I provided short-term grief counseling support that was typically one to two sessions. In these sessions the focus had been to give clients an outlet for their loss where a place for the feelings associated with loss could be normalized. I also worked with individuals who were in the process of determining when they should euthanize their animal. These conversations typically centered on the individual’s view of the quality of life of the animal. I began these sessions by learning about the person, the animal, and the relationship they had with one another. Following this, I typically gather a description from the individual about the concern that is leading them to consider euthanasia. More often than not, the client has told me that they do not want the animal to suffer and that they are most concerned about doing what is right for the animal itself. Most times we talked about what the animal was like when they were their best selves that involved a detailed story about their animal’s temperament, daily activities, and recreation. We would then discuss the different ways that the client would be able to tell that the animal had changed, or what lead them to believe that the animal was unwell. From there, we would discuss how the client identified pain, illness, or discomfort in the animal. The primary focus was always based on the client’s tangible observations and intimate knowledge of their animal.

The rationale for this process was two-fold. First, it was to clearly build a picture of who the animal was when they were in good health. This allowed space within the session to learn about the relationship between the client and the animal. Second, I wanted to gain clarity around the client’s definition of quality of life. In my time working in human health and specifically
long term care, I learned that everyone has different perspectives on the quality of a life being lived. For this reason, it was imperative that when I met with clients that I learned their definition of a quality life. In learning about quality of life and end-of-life decision-making as it pertains to animals, I needed to have a document that would ground these conversations to aid in facilitating empathic and educated conversation. After some research I chose to use the “five freedoms” as the foundation for quality of life discussions. Originating in the United Kingdom in the mid 1960s, the “five freedoms” speak to an animal’s primary welfare needs (Canadian Federation of Humane Societies, n. d.). The freedoms are summarized as follows: Freedom from hunger and thirst; Freedom from discomfort; Freedom from pain, injury, or disease; Freedom to express normal behaviour; and Freedom from fear and distress (Canadian Federation of Humane Societies, n. d.). In using these “five freedoms” as my guide, the client and I would explore their knowledge of the animal and how they come to know that the animal was experiencing these freedoms. This contributed to a client process for me to follow in building a healthy animal picture and identifying any decline.

Ideally clients are in a position to have this conversation openly and with the best interest of their animal as the primary focus. However, this is not always the case. Based on my observations in my practicum, I am conscious that there are circumstances where the client’s love of their animal and anticipatory grief may impede their ability to assess the quality of life that is being lived now. This is usually apparent when the veterinarian’s perspective is in direct contradiction with the client’s view. Thus, it is extremely important to develop a clear picture of the healthy animal so that discussion with the client can occur in real terms regarding their declining animal. The healthy animal picture is critical to my work as it allows me to explore with the client what the current picture looks like. This also includes appropriately querying if
there are reports from professionals, family members, and others who are close to the animal that paint a different or contradictory picture. Furthermore, if the animal is not experiencing distress in the magnitude necessary for the owner to make the decision to euthanize, I would also be able to identify with the client what potential changes in the animal would mean that their quality of life had diminished to the point that humane euthanasia would be a honourable decision. When I refer to humane euthanasia as a honourable decision, I am referring to a decision that honours the client’s relationship and history with the animal. Thus, euthanasia moves from being the client’s fault, or evidence that the client has not done enough for the animal, to a relief for their companion and an end to suffering.

The work related to euthanasia that I was engaged in was no different than any other grief work that I have done save for one reason, that clients identified shame for the grief of their animal. Many clients shared that those around them did not understand their love of their animal or would offer platitudes for support. Many cited friends and family saying things like ‘it’s just a dog’ or ‘you’ll get another one’ seemingly diminishing the client’s experience of their grief. For this reason, many of these sessions focused on the primary loss of the animals, but also the secondary losses experienced by the client. Furthermore, in an attempt to create a safe space for the clients I met to grieve, we would discuss options in which the person could honour their relationship with their animal. Many clients chose to cremate their animal and to have a paw print made so that they would have a token of remembrance, as these are services made available at the VMC. Together we would put together a plan where clients would be able to celebrate the life of their animal without feelings of embarrassment or shame that they were doing so. Often this meant assisting the client in determining who, from their support system, might be made aware of the celebration and choosing only those people the client felt understood their grief, as
well as planning unique means of honouring their animal (e.g. spreading ashes in a particular place or buying a special urn to display ashes etc.). This provided a method of connecting with clients and normalizing grief while also managing the disenfranchisement that so many clients reported to me during my placement.

Clinical Involvement with Staff and Students

My clinical involvement within the WCVM also broadened to include meeting the needs of staff and students as requested. I am reluctant to give much information about the needs of staff and students as the community at the WCVM is small. In adhering to confidentiality I have summarized how I worked with staff and students and how I managed this in the WCVM community. Given the location of my office, the complexity of maintaining confidentiality was challenging. Fortunately, my role within the VMC was such that any time I spent providing support to staff and students could be perceived by others as providing them with consultation related to active cases. However, I had to consider the implications of dual relationships, as I would be providing a service to people who also served as colleagues. I would liken this experience to rural social work where the boundaries may not be as clear due to population size and availability of services. Service provision within urban centres often provides for greater privacy and anonymity solely based on the fact that the community is not as intimate. In rural communities, anonymity is more difficult to ascertain. Moreover, a social worker may come across clients more frequently outside of the professional relationship. For instance in a rural setting, there is potential that your client is also your mechanic, owns the grocery store, or is a member of town council. Thus, I made use of this understanding given the emerging duality of my relationships within the WCVM. It is for this reason I decided to make use of the fact that the WCVM is located in an urban centre and focus primarily on initial and brief counseling contact
with an emphasis on referral. The fact that I was both part of a smaller entity that needed support, but could refer outside of the WCVM, meant that my clinical interventions with this population were short term, and this was the overarching intent of this role with all clients. I provided intervention and referred to existing structures (employee assistance plans, student counseling, and other resources within the community). Employees (staff and faculty) sought me out on their own. They would swing by my office or email me to see if I could meet with them for a session. Students typically either emailed me or were sent my way by their faculty advisor. I would then provide an appointment time and proceed with single-session or brief counseling work.

Generally, the topics of conversation and presenting concerns of staff and students centered on work and life balance—or lack thereof. Most often they reported high levels of stress within their working environment and normalized this experience. They would typically cite “stress”, due to exams, a busy clinic, lack of sleep, perceived limited collegial support, or complex cases. Often these clients would quickly reiterate that this was normal for the clinic or university and stated that they should be able to cope with the workload. Following this, they would identify a personal concern that had surprised them, worn them down, or cropped up quite suddenly. This culminated in an inability to manage both the work or school demands and the demands surfacing in their personal lives. I observed that the staff and student clients that I saw were similar in their presenting concerns to clients I had worked within the public outpatient mental health system. Similarly many of these individuals share in their experience of not knowing how to access services through their employee assistance plans or student counseling service. Interestingly, access to resource issues is also something I have frequently come across when doing intake appointments within public mental health. I have observed that people can be fearful of making the initial phone call to access these resources. Much of what I believe my role
with staff and students involved was to provide intervention at the right time and place simply because I was accessible. I also have an additional responsibility to make counseling approachable, as many individuals indicated fear in seeing a counsellor. As such, my interventions always start by creating a relationship with all clients that is based on empathy and growth seeking.

Whether meeting with a VMC client, staff, or student, my intervention and connection was always brief. I was unclear whether social work would continue after my practicum in the clinic finished. I was hesitant to see VMC clients for any length of time as I did not want to create a relationship that I would not be able to maintain. Further to this, students and staff have other avenues of support. So while they may choose to meet with me first, my goal is always to appropriately refer them to a support person who is not only likely to be available for a lengthier period of time, but is also not serving a dual role of counselor and colleague. Typically my referrals would follow one of the following pathways: redirecting clients to pet loss support, redirecting clients to the employee family assistance plan counseling or student counseling finding resources related to a specific topic and a corresponding community support or redirecting clients to the Saskatoon Health Region Mental Health and Addiction Services Centralized Intake. Always in my interactions I assessed for client safety and intervened where crises occurred. However, these types of situations were exceptions in my clinical work. I created collateral information sheets so that I could eventually get a statistical picture of how my clinical time was spent at the WCVM. I went through my records at the end of my practicum and was able to discern important numbers. The total number of clients that I was in contact with during my practicum was 38. Of those 38 clients, approximately 75% were women and 25% were men, with no one self-identifying as ‘other’. Of the clients I saw, approximately 70% were
clients of the VMC, with staff making up approximately 20% of my clients and students the remaining 10%. The average time that I spent per session with a student was 55 minutes, compared with an average 75 minutes spent with staff. The average number of contacts that I had with these two groups during my practicum was two. For VMC clients, the average time spent in direct client contact was approximately 55 minutes and the average number of contacts was two. I also measured my time spent consulting about clients with the veterinary team. In those circumstances, the average amount of time spent was approximately 25 minutes with an average one time consult for the particular client. I chose to measure these areas specifically so as to be able to account for my clinical time.

Furthermore, I established the perimeters of what time investment I could expect in my clinical counselling interactions so that my daily scheduling was responsive to the average need of clients. Overall, my work in my practicum and especially with clients at the WCVM paralleled what I was seeing in the literature and provided support and validation for what I was experiencing and how I was practicing. In the hope of better synthesizing my experiences with clients at the WCVM with the literature, I have elected to place the review of the literature after the clinical work. The next section highlights the connections to the literature in the areas of human and animal bond, grief and loss of companion animals, end-of-life decision-making, interpersonal violence and child maltreatment, veterinarian and student stress, farm stress, and the role of social work within the veterinary setting.
Chapter Three: Literature Review

Human and Animal Bond

In reviewing the literature, it is clear that the relationship between human beings and animals has evolved over time (Walsh, 2009a). Companion animals, those animals meant to serve primarily as a means of social interaction and emotional support for their human counterpart, are now found in 72% of American homes (American Veterinary Medicine Association, 2012). Of the homes with companion animals, 63.2% consider the resident animals to be a member of the family (American Veterinary Medicine Association, 2012). Fifty-six percent of Canadian households report having a cat or dog and additionally 12% of homes have fish; 5% have birds; and that 2% have rabbits or hamsters; with the remaining 1% of homes having another type of animal (horse, lizard, guinea pig, snake, frog, turtle, ferret, or gerbil) that they consider a pet, or animal companion (Perrin, 2009). This is a significant change from early human interaction with animals that were largely goal oriented or sustenance based (Walsh, 2009a). The evolution of humans towards emotional connection with animals, has removed the emotional distance of the earlier relationships (Walsh, 2009a). Some writers suggest that this interconnected relationship between the two species was an inevitable by-product as it came from the side-by-side evolutionary experiences of humans and animals (Hanrahan, 2013; Serpell, 2010).

Research literature over the past thirty years has also begun to examine exactly how closely these relationships impact human beings at the core of connection to self and to others. Animals have moved from the abstract ‘other’ and now contribute to our feelings of connectedness within the human world (Hanrahan, 2013; Serpell, 2010). Furthermore, this relationship has become an interconnected piece of human existence and experience (Hanrahan, 2013; Perrin, 2009; Serpell, 2010). Given this, it seems pertinent that service providers consider the implications of human-animal bond in their work (Ascione, 2000a; Netting, Wilson, & New, 1987). However, while social work practice is concerned
with the human experience, it struggles to be inclusive of a seemingly abstract analysis of the bonds between animals and humans (Hanrahan, 2013). This alone provides a rationale for social workers to move into areas where animals and their owners interact with the wider world. In practice, practitioners must come to understand that the bond between human beings and their animals is as important as the bonds shared between human beings (Ascione, 2000a; Netting, Wilson, & New, 1987). The literature reports that human beings take meaning from their relationships with companion animals (Kidd & Kidd, 1994). The meaning found in these relationships is also often described as one of the only places where unconditional love and acceptance are experienced (Kidd & Kidd, 1994). The placement of social workers within a veterinary setting permits a practice window for social workers into the relationship between human beings and their companion animals. As discovered during my placement at the WCVM, social workers in this setting are able to interact with and support the human-animal bond during times of distress.

**Grief and Loss**

Grief and loss is a primary example of when distress related to the human-animal bond may be experienced. As stated previously one of my primary activities at the WCVM, and in interacting with VMC clients, was to respond to client grief. Numerous writers explore the loss of companion animals and the domain in which the relationship exists (Beck & Katcher, 2003; Beck & Meyers, 1996; Walsh, 2009a). These writers posit that the human connection to pets is as powerfully important as connection to another human being. The loss of an animal companion has been studied primarily in the context of mourning a pet due to death and the implications of this loss on the family and individuals. Research suggests that the loss experienced by an individual or family when losing an animal companion is likened to the loss experiences of those losing a human companion (Carmack, 1985; Clements, Benasutti, & Carmone, 2003; Packman, Field, Carmack, & Ronen, 2011). Carmack (1985) explains
that pets can often take on a similar positioning in the human experience to that of a child. In my experience within the practicum setting this appears to be very true. After the loss of a pet, clients would often explain to me that the animal was “like a child” to them and had been very much a part of the family. Packman et al.’s (2011) study clarifies this further by suggesting that this may be due to the fact that the human and animal relationship “constitutes an attachment bond” (p. 342). Therefore, the loss of an animal companion follows a similar process to that of an experience of human loss. Research has demonstrated that statistical grief scores mirror those who have experienced the death of a human companion (Packman et al., 2011). It is for this reason that during the practicum I worked with clients using a similar approach that I would use with anyone who has experienced a loss. Key to this practice is that I consistently normalize their grief experience.

Many VMC clients also indicated identifying shame alongside their grief. In particular this included sharing that their grief experience was not validated or understood by their support systems. Doka (2008) introduced the concept of disenfranchised grief or grief responses that are without social validation and recognition. Some characteristics of disenfranchised grief may include: the relationship, the loss, or the griever not being recognized. As such the death is disenfranchising as the way the individual grieves is not socially validated (Doka, 1999). This concept is echoed in the contacts between society at large and homeless individuals shared by homeless pet owners (Irvine, Kahl, & Smith, 2012). These individuals reported that their connections to their pets were systematically challenged by the public, who believed that animals would be better cared for by strangers than their homeless human counterpart. This was cited as leading to further feelings of disenfranchisement and disconnection from more privileged members of society (Irvine, Kahl, & Smith, 2012).

A compelling theme captured in the literature is that the loss of one’s animal should be considered as equal to the loss of a human companion. In my practicum I observed individuals’ coping
with pet loss and their perception that others viewed this experience as relatively trivial. Furthermore, the lived experiences of clients mirrored the literature in that those facing this type of loss reported that the feedback they received from those around them was that their loss should be readily mastered and that the grief experienced should be quickly remedied or even non-existent (Doka, 2008; Irvine, Kahl, & Smith, 2012). Thus, the literature supports my experience of working with individuals who felt their grief was unjustified based on the reactions of other people in their lives.

Veterinarians are on the forefront of the death of companion animals as their role often includes euthanasia. Similarly to the literature found in the social sciences, the veterinary literature in this area also speaks to the provision of grief support. Veterinary scholars cite that veterinarians are often called upon to the use communication skills, in particular the use of empathic statements, while treating a client’s animal (McCarthur & Fitzgerald, 2013; Morris, 2012; Pilgram, 2010). Furthermore, it is suggested that emotion on the part of the veterinarian can be used as a mechanism for creating a comforting space for clients when an animal is approaching death (Morris, 2012). However, it is also reported that there is a lack of training within veterinary sciences to adequately prepare veterinarians in providing social support of this nature (Pilgram, 2010). This reason provides a rationale for incorporating social workers within the veterinary setting. Veterinary social workers are able to provide support within the clinical setting ensuring clients get the benefit of therapeutic services from a professional in this area. Moreover, social workers may contribute to the veterinary team by providing additional training in the area of grief and loss so as to broaden the scope of interventions veterinarians may provide, should they choose to do so. This additional education was requested during my practicum and as such I am now providing educational seminars on grief and loss for clinicians within the VMC.
Interpersonal Violence and Child Maltreatment

First explorations of the implications of animal abuse by human beings occurred in 1961 when MacDonald, a psychiatrist, developed a triad of childhood characteristics, which included the abuse of animals as a pillar that could theoretically predict later violence as an adult (Wright & Hensley, 2003). In discussing the first seminar I participated in at the university, I identified the case example used where a veterinarian suspected interpersonal violence was occurring in the home. This case example is consistent with the literature as it is stated that where there is domestic violence or child maltreatment there is likely animal maltreatment as well. Ascione (1998) presented one of the more formative studies on the experiences of women escaping domestic violence and the impact of animal abuse on their decision to leave. In this study, of the 28 women surveyed who were currently residing within emergency housing: 71% of respondents identified that they owned a pet, 57% identified that the perpetrator of the abuse they experienced had also harmed their pet; and 18% identified that fear for their pet’s safety played a determinant role in delaying their entry into a shelter (Ascione, 1998). A second study by Flynn (2000) suggests that of 107 women surveyed within the study: 40% owned pets; 46.5% of those with pets reported that the perpetrator of the abuse they experienced had harmed those pets; and that 40% of those whose animals experienced abuse, delayed seeking shelter out of concern for their companion animals safety. Furthermore, 49% of those women with animal companions, carried on worrying about their companions safety upon entering the shelter. Thus what can be understood from the literature is that there is a clear link between interpersonal violence and animal abuse. Furthermore, if veterinarians are often at the frontline of animal abuse cases, they too may be at the front line of interpersonal violence (Ascione, 1998; Deviney, Dickert, & Lockwood, 1983; Duncan, Thomas, & Miller, 2005; Flynn, 2000; Miller & Knutson, 1997). This provides further rationale for the inclusion of social work within the veterinary setting, as social workers are trained to intervene in such
cases. Moreover, as noted in the case example involving the Labrador retriever, suspected violence, and presentation within a veterinary clinic that was discussed in the aforementioned practicum seminar, social workers can help provide resources to veterinarians who are working in isolation.

A study conducted by DeViney, Dickert, and Lockwood (1983) examined families with companion animals that were in contact with child protective services. Within these households, the study found that in approximately 60% of the households where child maltreatment was found there was concurrent abuse of companion animals (DeViney, Dickert, & Lockwood, 1983). Furthermore, within the study, childhood abuse was categorized into types of abuse whereby the authors discovered that in 80% of households where physical abuse of the child was present animal abuse was also present (DeViney, Dickert, & Lockwood, 1983). In a study conducted by Miller and Knutson (1997) beginning correlations were drawn between the exposure of adult participants to animal cruelty, as children, and their remembrances of past experiences of physical punishment within the home. More recently, Duncan, Thomas, and Miller (2005) used comparative analysis between boys identified as having a conduct disorder who had abused animals and boys with the same identified disorder who had not. It was found that boys who had abused animals also had histories of childhood maltreatment or had been witnesses to interpersonal violence as opposed to their counterparts who had not (Duncan, Thomas, & Miller, 2005). Similar correlations are found in two other studies. In the first study it was found that mothers who identified that their children had witnessed interpersonal violence were also at greater likelihood to report that their children had abused animals (Currie, 2005). The second study reported that the prevalence of animal abuse or cruelty to animals is five times higher in sexually abused children than in non-abused children (Ascione, Friedrich, Heath, & Hayashi, 2003).

Based on this type of information, human service providers have begun to work collaboratively to incorporate the human and animal relationship into their work. Within the scope of domestic
violence, Ascione, Weber and Wood (1997) studied the awareness of emergency shelters in assessing for animal abuse. Their study reports that while less than one third of shelters assess for animal abuse in their intake assessment process, over 85% of women in crisis shelters discuss animal abuse during their stay (Ascione, et. al., 1997). Ascione (2000a) furthered this inquiry and conducted qualitative research interviews with emergency shelter workers for survivors of domestic violence. It was discovered that a number of animal welfare agencies had established or were preparing to provide for the companion animals of women escaping violence for this reason (Ascione, 2000a).

Since these studies, organizations like SAF-T™ have begun the process of establishing international standards and guidelines on how to incorporate the accommodation of animal companions into emergency shelters. However this has primarily been within an American context (Phillips, 2011). Within the Canadian context a recent study examined the stories of 51 women from across homeless shelters in six urban areas (Labrecque & Walsh, 2011). This research found that only two of the six shelters were currently providing services for animal companions (Labrecque & Walsh, 2011). It was reported that one shelter provided room within the shelter for cats, dogs, fish, and birds with a second space for clients who were not able to manage with an animal in the shelter. The second shelter providing this service also ensured that kenneled space was available outdoors due to potential client fears and allergies (Labrecque & Walsh, 2011).

Within the scope of child maltreatment, a Canadian study implemented a partnership between the Humane Society (HS) and family and children services (FCS) (Zilney & Zilney, 2005). The researchers study involved the cross referencing between animal welfare officers and child and family services that included seeking referrals for families or companion animals when suspecting abuse, harm, or neglect. Several important pieces emerged from this study including the fact that the authors demonstrated that links between animal abuse and child maltreatment existed (Zilney & Zilney, 2005).
However, the authors found that FCS workers participating in the study appeared to value the maltreatment of children over the maltreatment of animals and thus “did not view the project as important or relevant and were resistant to delving into animal welfare” (Zilney & Zilney, 2005, p. 61). The recommendations of the study included that, should it be replicated, HS workers and FCS workers be cross-trained more completely. This was because it was apparent that HS workers felt beyond their depth in their ability to intervene in child maltreatment cases, while FCS workers who did not have senior managers who were committed to the project did not necessarily fully commit themselves (Zilney & Zilney, 2005).

Loar (2014) succinctly states why a social worker should be committed to and concerned with animal welfare:

Animal abuse and neglect can be indicators of abuse and neglect affecting people of all ages in the same household. The animal’s distress is often more visible and allows intervention to begin earlier, making it safer for all living beings involved. There is a need for cross-disciplinary and cross-species accountability, risk assessment and focused intervention. Asking first about the animals’ welfare lets the interviewer learn about risky behavior that jeopardizes the safety of all living things in the home, builds rapport even with hostile clients, and targets interventions to protect those at greatest risk (p. 149).

I would posit that alongside emergency shelters and child and family services, veterinary social workers have an equally important role in intervening in suspected interpersonal violence and child maltreatment. It is well documented in the literature, that veterinarians often encounter situations where they suspect domestic violence or child abuse and neglect (Green & Gullone, 2005; Michigan State University, 2008; Williams, Dale, Clarke, & Garrett, 2011). However, veterinarians also report fear of client retaliation after reporting violence, a sense that reporting human abuse is beyond their scope, or that they simply are unaware of the resources to do so (Green & Gullone, 2005; Michigan State University, 2008, Williams et. al., 2011). Thus, the incorporation of veterinary social workers...
into the field of veterinary practice creates an opportunity to provide interdisciplinary support as well as the opportunity to intervene in cases of suspected abuse.

**Veterinarian and Student Stress**

Given that the average day of a veterinarian is filled with grief, distress, death, and potential violence or suspected abuse, it is not surprising that clinicians themselves struggle to meet the demands of their work and home life. This was stated by a number of staff and student clients that I worked with during my practicum. Similar concerns and issues were cited in a study by Michigan State University (2008) as primary reasons for veterinarians experiencing empathy fatigue, also known as ‘compassion’ fatigue, and leaving the profession. Mellanby (2005) suggests that veterinarians experience stress from: irregular hours, overwhelming workloads, high expectations and demands from clients, and compassion fatigue, all while working in psychologically and physically isolating environments. Furthermore, Mellanby (2005) suggests that veterinarians experience the highest suicide rate at four times a national rate and twice as high as physicians or dentists. In another study focused on veterinary surgeons and suicide, it was determined that the most often used means of committing suicide was poisoning or the use of a firearm and that veterinary surgeons were three times more likely to die from suicide (Platt, Hawton, Simkin, & Mellanby, 2010). A third study examined contributing factors to veterinary surgeon suicide and determined contributing factors to suicidality. These included: occupational stressors-including managerial aspects; long working hours; heavy workload; poor work-life balance; difficult client relations; and performing euthanasia (Platt, 2010). Other literature points to euthanizing healthy animals as a potential catalyst for Perpetration-Induced Traumatic Stress (PITS), a condition introduced when it became clear that war veterans were more likely to experience symptoms of post-traumatic stress (Whiting & Marion, 2011). This is cited as a particular risk for veterinarians working for enforcement agencies where their work sometimes requires them to euthanize otherwise
healthy animals (Whiting & Marion, 2011). The literature is generally clear on what factors contribute to empathy fatigue and often to veterinarians exiting the profession or committing suicide (Mellanby, 2005; Platt, Hawton, Simkin, & Mellanby, 2010). Furthermore, the literature also suggests that veterinarians also lack the skills necessary to cope with these stressors as their education primarily focuses on the technical aspects of veterinary medicine and lacks training on how to cope with the impacts of these stressors (Platt, Hawton, Simkin, & Mellanby, 2010).

During my placement at the WCVM, veterinary students echoed similar accounts of a lack of work-life balance. This is also reflected in the literature albeit differently than I anticipated. In a study of veterinary student stress done by Strand, Zaparanick and Brace (2005), it was found that students did not experience significant levels of overall stress. This was similarly identified in the findings of other studies on veterinary student stress (Chapman, 1979; Kelmen, 1978). Rather, the students in the study did report higher levels of depression, time pressure, and subjective stress with female students reporting higher incidences of perceived stress than their male counterparts (Strand et. al., 2005). This same study asked students to share their best strategy for relieving stress. The highest-ranked activities cited by students in the study included: some form of exercise (47%), spending time with friends (26%), or spending time doing some other non-veterinary activity or hobby (22%) (Strand et. al., 2005).

What is clear from reading the studies on veterinary student and veterinarian stress, is that there is overwhelming information to support the need for mental health intervention with veterinarians and students as client groups. Within the WCVM a portion of my practicum included providing lectures to students and veterinarians as well as clinical support to veterinarians and those working alongside them. Within my educational material I consistently focused on the notion of self-care as paramount to promoting work-life balance. However, during my practicum two well-known practitioners’
veterinary community died by suicide. During that time the off-hand conversations that I overheard in the clinic often included conversations about suicide. If I was meeting with a veterinarian, I would most often be told about their plan if they were to attempt to die by suicide. What was most interesting about these conversations was the matter-of-fact way that these veterinarians had of describing their plan that left me to believe that suicide ideation across the profession may be relatively normative. Further study is needed to explore the perception of veterinarians of death by suicide in order to identify if this is so. However, what was of deeper significance to me is that veterinarians identified that their job required and allowed access to lethal doses of medication or firearms that would facilitate their end. It became quite clear to me that to put into place a suicide safety plan with a veterinarian would be more difficult. This is because limiting their access to their means of suicide would also mean interfering with their ability to do their work.

**Farm Stress**

As mentioned in the clinical portion of this report, the stress experienced by large animal producers was identified as an underserved area by of veterinarians’ at the WCVM. Furthermore, attending to calls related to the stress experienced by farmers has become a facet of my practicum experience. I think it is important to discern the difference between large animal services for equine clients and the services provided to producers as the feelings associated with the loss of an equine more accurately parallel the experience of losing a small animal companion than the experience of the large or small herd producer (Stull, 2013). Therefore, those people who are managing issues with an equine counterpart actually straddle both the small and large animal worlds. However, I would also argue that the practical skills required of a VSW working with this population would more accurately fall within the scope of production animals. Thus, for the purposes of this portion of the literature review the focus is on production animals.
Farm stress as a general concept has been well documented in the literature (Baker & Thamassin, 1988; Keating, 1987; Lunner-Kolstrup, Kallioniemi, Lundqvist, Kymalainen, Stallones, & Brumby, 2013; McSahne & Quirk, 2009). Writers cite financial pressure, poor psychological work environments, vulnerability to changes in weather, interest rates, debt load, multiple-roles within the home and workplace, and work demands as well as competing work and home responsibilities as contributing to the stressors experienced by the farming community (Baker & Thamassin, 1988; Keating, 1987; Lunner-Kolstrup et al., 2013; McSahne & Quirk, 2009). The reported results of these stressors include increased levels of anxiety, depression, poor coping generally, and in some cases suicide (Baker & Thamassin, 1988; Keating, 1987; Lunner-Kolstrup et al., 2013; McSahne & Quirk, 2009). These studies suggest a range of interventions which include both education and more traditional counseling support (Keating, 1987; Lunner-Kolstrup et al., 2013). However, support services are referenced as being variable based on the location of the farm and accessing these services is identified as the responsibility of the individual struggling to manage (Lunner-Kolstrup et al., 2013).

Within Saskatchewan the development and implementation of a farm stress line has allowed farmers experiencing farm related stress to access crisis intervention services (Government of Saskatchewan, 2013). However, aside from accessing available resources within home communities or contacting the farm stress line for short-term intervention there is no farm specific service available. Thus what is clear from the literature is that farm stress is indeed an issue within the scope of social work intervention, however there are few formal mechanisms of intervening with this population. Furthermore, intervention with this population is neglected in the literature as it pertains specifically to veterinary social work practice. As such, it is pertinent that the work of veterinary social work within
the WCVM continues to build upon the existing literature by documenting its involvement with this community.
Chapter Four: Integration of Theory and Practice

The literature surrounding the human-animal bond, grief and loss, end-of-life decision-making, interpersonal violence and child maltreatment, veterinarian and student stress, and farm stress provides ample rationale for social work intervention. However, in my work at the WCVM I had to be guided by my own previous work experiences in order to determine which theoretical approaches would successfully guide me in my practice. Regardless of the presenting concern and the clinical intervention, I inevitably needed a theoretical foundation. Furthermore, I am clear that if my intention is to walk alongside a client as they navigate difficulty, I must incorporate theory and practice to support my own work.

In the course of my career, prior to working within the WCVM, I have worked in areas that include mental health counseling, addictions, crisis management, case management, interpersonal violence, child maltreatment, trauma work, and working with people living with disabilities. It was in doing this work that I have learned the skills necessary to provide counselling support, as well as intervention in times of distress. Furthermore, I have gained some competency in providing access to appropriate referrals both internal and external to the agencies I am working within. This exposure to a number of different facets of social work has afforded me the opportunity to continuously reflect and change my approach to meet my client’s needs. I believe it is this flexibility that has provided me the greatest advantage in my work at the WCVM. As the client relationships and needs have varied based on the client group I was working with (staff, student, clinician, VMC client), I think it is important to make clear what these practices have been and how theory has impacted my interventions.

My belief system about the world falls within the social constructivist lens, more specifically, the critical social constructivist leaning. This philosophy seeks to critically understand the world and uses broader concepts like justice or equality (Kuma, 2007). Furthermore these concepts are then used
to deconstruct and understand social phenomenon (Kuma, 2007). The social constructivist belief
system identifies that the individuals’ reality is constructed through interaction with the world and the
relationships built therein (Creswell, 2013). Moreover, that human beings then interact with the world
based on their understanding of these social constructs and constraints (Creswell, 2013). As Green and
Thorogood (2009) note, critical constructivist frameworks have “had a vital role in questioning
common-sense assumptions about the categories we use routinely, as if they were ‘natural’ categories
rather than social ones” (p. 16). This means that when I engage in counselling work I am naturally
interested in the relationships people have with one another, the perceptions they have about
themselves and others, how they know these constructions to be true, and how this translates into the
way they walk through the world. While this lens guides my work it does have limitations. It does not
effectively consider the interaction between different occupied spaces. Within the WCVM, there are
more than just socially constructed environments to be considered. For this reason it became important
that I learn and incorporate a theoretical approach that considers not only the human experience, but
also the interaction between human beings, animals and the environment. In order to incorporate these
interactions into my theoretical understanding, I turned to the One Health perspective.

One Health is a concept that has quickly grown in the literature and to summarize all of the
facets of this concept is beyond the limits of this paper. Broadly, One Health is an interdisciplinary
concept that attempts to better address issues that cross the human-animal-environment interface. This
paradigm instead seeks to explore the way a concern impacts all three spheres, crossing boundaries and
requiring interdisciplinary approaches in order to act effectively (Hanrahan, 2014). Some prime
examples of this include “anti-biotic resistant infections and germs, foodborne illness, better
preparedness in prevention and control of zoonoses [diseases that cross between humans and animals];
interdisciplinary cooperation to achieve One Health; biomedical technology; and how veterinary
medicine benefits people and not only animals” (Hanrahan, 2014, p. 37). However, One Health is also limited in its approach, namely because its focus has been to address issues pertaining to the environment with humans being the chief beneficiary (Hanrahan, 2014). While One Health draws animals and the environment into the collective consciousness, it does not respond to the anthropocentrism of incorporating these spheres (animal and environment) as only worth addressing as they pertain to human benefit (Hanrahan, 2014). Furthermore, it relegates the animal and environmental spheres into the periphery by lacking acknowledgement of the impact of humans on other sentient beings (Hanrahan, 2014).

Social constructivism and One Health offer initial discourse into the impact that we have on the world and how the world impacts us. However, I believe that the analysis is shallow when the profession is side-tracked by only the social sphere of human experience. This is noted by Coates (2003) who writes, “social work has been largely absent from environmental discourse, and the primary thrust of social work remains anthropocentric” (p. 38). For this reason, I also chose to draw on ecological perspectives of social work to inform my epistemological position. If my social work practice is to be concerned with social transformation and justice, it means that I need to be attuned to the finer points of justice. This must then also include the environment as more than just a stage for the social sphere. I wholeheartedly believe that by incorporating the environment in a meaningful way, the profession has a greater opportunity to support a sustainable future for the health of all. Given what I know about the relationships of my clients with the animals in their lives, and their homes (or environments), it has become important to me to more adequately embrace anti-oppressive and critical approaches to the interface between human beings, animals, and the environment. This has meant incorporating social constructivism, one health, and ecological approaches into my work as a means of grounding my analysis of the world.
Grounding my analysis of my practicum more fully required attention to macro implications. I needed to incorporate a theoretical structure that would tangibly incorporate these macro processes into my practice approach, Relational-cultural therapy (RCT) provides this framework. The premise of RCT is that in order to help or heal an individual needs to be doing so in the midst of mutually empathic relationships that foster growth (Comstock, Hammer, Strentzsch, Cannon, Parsons, & Salazar, 2008). Moreover, this approach allows human service practitioners to more freely explore how issues of sex role socialization, power, dominance, subordination and marginalization impact the way clients relationally develop (Comstock et. al., 2008). According to Jordan (2000), the process of healing through relational development follows seven tenets. They are as follows:

- People grow through and toward relationship throughout the life span.
- Movement toward mutuality rather than separation characterizes mature functioning.
- The ability to participate in increasingly complex and diversified relational networks characterizes psychological growth.
- Mutual empathy and mutual empowerment are at the core of growth-fostering relationships.
- Authenticity is necessary for real engagement in growth-fostering relationships.
- When people contribute to the development of growth-fostering relationships, they grow as a result of their participation in such relationships.
- The goal of development is the realization of increased relational competence over the life span. (Jordan, 2000, p. 1007).

The principles outlined by Jordan (2000) suggest that human beings at their core innately want to connect. However, as Duffey (2011) states, disconnection is also a part of life. As such growth can also be attained through healing disconnection to reconnection and that the process of learning to distinguish between relationships that foster growth and abusive or toxic ones is also a process of building overall relational competence (Duffey, 2011).

There are eight key principles of RCT, which help to clarify this core concept (Duffey, 2011). The first, growth-fostering relationships, is the concept that “each party’s growth and the relationship itself become a priority” (Duffey, 2011, p. 226). As exchanges continue between the
party’s so expands their thoughts and feelings increasing mutual understanding (Duffey, 2011). The second principle, empathy, calls on the party’s to have clarity about emotional arousal as well as clarity about one’s own experiences and feelings as compared to another’s. However, from an RCT perspective this process must be mutual and when mutual empathy is achieved, it promotes relational healing and psychological growth (Duffey, 2011). The third concept is authenticity. Within RCT authenticity speaks to an individual’s ability to represent themselves honestly within their relationships and interactions. This can be challenging for a number of reasons, but most notably in relationships that have power differentials or where internal voices carry deeply critical messages (Duffey, 2011). These relational patterns can lead to disconnection, the fourth concept, as a means of protecting oneself from disappointment, pain, or other relationship injuries (Comstock et. al., 2008; Duffey, 2011; Jordan 2001).

The problem with disconnection however is the fifth concept, the central relational paradox (Duffey, 2011). The paradox is that while disconnection is well intentioned as a means of protecting the individual, it also keeps someone from the connection they desire (Duffey, 2011). One means of working through disconnection is the sixth concept, which is the exploration of relational images. Relational images are templates used by individuals to predict how they will be treated in the future based on their experiences from the past (Duffey, 2011). This means that one will react to situations based on past experience impacting how an individual interprets present interactions. However, in engaging in growth-fostering, authentic, mutually empathetic relationships, an individual can learn to discern between painful relational images and increase relational competence (Duffey, 2011).

The seventh concept relational resilience identifies the point where an individual is able to move “toward mutually empowering, growth-fostering connections in the face of adverse
conditions, traumatic experiences, and alienating social-cultural pressures…Resilience is the ability to connect, reconnect and/or resist disconnection” (Jordan, 2005, p. 83). Once grounded in relational resilience they reach relational competence, the eighth concept of RCT (Duffey, 2011). When relationally competent, individuals become more caring for one another and are willing to display vulnerability and authenticity rather than power-over (or disconnection-based) relational strategies (Duffey, 2011). In doing so, the individual becomes more attune to the impact they have on others as well as open to the influence of others (Duffey, 2011; Jordan, 2005). RCT counselors consider the primary source of struggle to be isolation and thus work towards reconnection as a mechanism of healing. Counselors working from this frame of reference therefore collaborate with clients to understand patterns of connection and disconnection as well as to unpack relational images and expectations (Duffey, 2011).

RCT offers concepts to explore within the counselling relationship, but is not prescriptive in that there are not specified questions to be asked or tools to be trotted out. As such, it is a guide for exploration. In my practice within my practicum I used this theory to explore the relationships clients had with themselves, their animals, and their environment. I also used it as a guiding force for my own relationship building. I am comfortable with building relationships that foster mutual growth. As I had few pre-existing relationships within the WCVM, I was free to approach my interactions with people from a place of empathy and with a goal of fostering mutual growth. The gentleness and authenticity required of this approach was central to gaining the trust and faith of colleagues in the veterinary college. I believe it removed any threatening preconceptions of what my role might be and instead allowed me to address the needs of the placement as they arose.
As the approach pertained to my direct counselling work it permitted the opportunity for me to attend to people’s relationships with each other and with their animal counterparts. This was particularly relevant in the case of producers and their connection and relationship with the land. To bolster this approach, I utilized a number of more prescriptive approaches. Some of these included systems theory, solution-focused and narrative lines of questioning, crisis intervention skills, and case management approaches. However, these tools were used interchangeably and situation specific, as a means of achieving the real goal of safe and resilient connection. Throughout this process I also connected frequently with both my Professional Associate from Mental and Addiction Services and my Academic Supervisor to seek clinical guidance that my interventions were appropriate.
Chapter 5: Achievement of Objectives and Next Steps for the Program

This practicum experience challenged me in a number of ways. I set out to integrate social work services into a series of existing structures that included the WCVM, the services available to students, and the VMC. In doing so I embraced a number of ethical, administrative, and practice challenges. In the end, I was able to provide services to students, faculty, staff, and VMC clients by seeking to relationally connect with all of these groups. Through connecting with these different client groups I was challenged to use a number of different social work skills that ranged from education and resource finding to counseling intervention and crisis management. Throughout this practicum report it is clear that for the duration of my practicum, I stuck closely to my initial goal of working in an interdisciplinary way alongside veterinary sciences providing support to human beings in their interactions with animals. Furthermore I carried out the clinical goal of the providing clinical support services to the clients of the small and large animal clinics. I also created the infrastructure that could support a salaried social worker and potentially future practicum students.

I have come to believe that veterinary social workers need to be skilled in their ability to meet client need in whatever way it manifests itself—staff, faculty, clinic client or student crisis and case management, or clinical work. More specifically, in order to be successful in this field, a broad skill base and flexibility are required of any practitioner. In exploring the literature as it pertained to my placement, I feel grounded in identifying not only those issues which are being addressed by veterinary social workers elsewhere (human-animal bond, grief and loss, interpersonal violence and child maltreatment, veterinary and student stress), but have also identified a potential new area for veterinary social work (farm stress). In considering theoretical and practice approaches to the work, I believe that a combination of social constructivist, One
Health, and ecological epistemologies with an overlay of relational-cultural theory and therapy has, for me, allowed me the freedom and flexibility to provide client-centered intervention for the clients I have encountered. Furthermore, I believe that approaching the work and the placement in this way has facilitated a growth-seeking relationship with clients and colleagues simultaneously.

Rightfully as my time began to wind down at the WCVM a number of people asked what the future plans were, identifying fear that the program would simply grind to a halt. If that does not speak to the value of the program as seen by the staff, I do not know what does. I believe that the next-steps for this program are quite simple. Keep social work visible and active, as connection is key to its continued success. At the end of my practicum I would often tell my committee that it feels as though I am riding a dragon. That at any moment the program could become vast and wild. I still believe this to be true. I think with the incorporation of a permanent structure, it would do wonders for staff, students, faculty, and clients as connection would be less uncertain. With more certainty in connection, the WCVM as a whole will be able to trust and therefore engage more fully in the social work program.

I want to end this report where I began, with the death of my beloved horse Nicker. While going through my own grief experience I have come to understand more deeply my role. In the end I discovered, how glad I am that I can manage grief and know what it is to be changed by it. How glad I am to know the depth of this type of love, so that I can respond to it in others. Finally, how hopeful I am that as time wears on there may be more veterinary social workers so that there is a greater pool of professionals who respect and understand the depth and complexity of human relationships with animals. Furthermore, that these professionals are interested in how interactions and connections with animals enrich our lives and our connections in this world. My
hope for the future is that support be available for all those who interact with animals whether they are student, staff, doctor, or client and that social work can fulfill that promise.
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Appendix A
Bookmark (left) and brochure (right) created for clients and staff of the VMC of community resources
Appendix B
Collateral Information sheet used for charting and gathering clinical statistics.

Stats Quick Sheet

Date:

CASE STICKER

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Client Gender

Male ☐ Female ☐ Other ☐

Species of Patient:

Presenting Concern:

Referrals Provided:

Amount of time spent (0000-0000):

Number of Contacts:

Type of contact:

Direct Contact ☐ Consultation ☐ 3rd Party ☐

Where:

Urban ☐ Rural ☐

Out of Province (Where):
Appendix C
Feedback tool that accompanies discharges from the VMC

Veterinary Social Work
We know how important your animal is to you. For many, pets are beloved family members, friends, and companions. The Veterinary Social Work Program is here to support you.

How we can help
- Offering emotional support during diagnostic testing, treatment, or euthanasia
- Helping you communicate your questions and concerns to your veterinary medical team
- Providing referral to community supports if needed after you leave the medical centre or after your animal’s death
- Helping you and your family work through your loss
- Supporting family members who are caring for seriously ill pets
- Counselling for issues such as abuse (animals/people) and alcohol/drug addictions

How you can reach us
- Ask a WCVM veterinarian or staff member about counselling services, call for counselling services 306-966-2852, and visit us on the VMC website: www.usask.ca/vmc (click on services).

We welcome your feedback either on the questionnaire below, which can be returned to reception, faxed to 306-966-7129, or filled out online at: https://www.surveymonkey.com/s/J7BCBP2

1. Did you meet with veterinary social work?
   - Yes ☐ No ☐ Don’t know ☐

2. If yes, how were you referred to veterinary social work?
   - Brochure/Poster ☐  Veterinarian ☐  Social Worker was in my appointment ☐  Other ☐
     (Please specify)

3. Your gender: Male ☐  Female ☐  Other ☐

4. Species of your animal:

5. What brought you to the clinic? (Presenting concern)

6. Veterinary social work was a helpful part of my animal’s care team?
   - Strongly disagree ☐  Agree ☐  Neutral ☐  Disagree ☐  Strongly agree ☐

7. Please let us know how veterinary social work was helpful/unhelpful (Additional comments):

To mail, return to:
Veterinary Medical Centre
Western College of Veterinary Medicine
52 Campus Drive
Saskatoon, SK
S7N 5B4