THE CRITICAL SHIFT TO TRAUMA-INFORMED CARE FOR PRENATAL AND CHILDBIRTH SERVICES IN SASKATOON

A Field Practicum Report
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Abstract

Within Saskatoon, Canada, and globally, there continues to be oppressive practices that contribute to women being afraid to access prenatal and childbirth related services, especially those who use substances while pregnant. Women who use substances while pregnant are often made to feel shame, inadequacy, and are given few options regarding their care. To break this cycle, our health care system needs to better understand the unique needs of women who use substances while pregnant, such as barriers to childcare and transportation, and be mindful of the interconnectedness of structural, interpersonal, and intergenerational violence. Our health care system needs to take a trauma-informed approach to reduce risks of re-traumatization and postnatal post-traumatic stress disorder (PTSD). A quality improvement project was completed to better understand how health services and providers could improve and become more trauma-informed when working with women who use substances while pregnant. Four themes emerged from the quality improvement project which were: education on methadone, fears of child apprehension and judgement, feeling defeated and loss of hope, and missed opportunities. Some of the positive experiences the women from the project experienced were highlighted. Gaps in services will also be discussed thus reinforcing the need for our healthcare system to take a trauma-informed care approach for women who use substances while pregnant.
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Introduction

As a social worker, I have had the opportunity to work in a variety of mental health and addictions settings. Part of my experience includes working as a HIV (Human Immunodeficiency Virus) case manager for 18 months. As a case manager, I worked primarily with individuals who had substance use issues, were struggling to manage their HIV, and had multiple unmet social and health needs impacting their lives. I also worked with women who were labelled as having ‘high risk’ pregnancies. Being labelled as ‘high risk’ meant they were using substances and not managing their HIV to the standards set by health care providers, or they were using substances intravenously and at risk of becoming HIV positive. I noticed significant health inequities and negative stigma attached to clients that I worked with while being a HIV case manager, especially for women who were labelled as ‘high risk’. There was often a lack of acknowledgement among health care providers regarding social factors that were influencing the women’s substance use, such as unsafe environments, poverty, mental health issues, lack of positive social supports, trauma histories, and ongoing trauma. I have witnessed health care providers inform women that they would not be able to keep their baby prior to child welfare services becoming involved. Because of these experiences, I am left wondering whether health care providers, along with the negative stigma society has placed on women who receive this ‘high risk’ label, is one of the major reasons women in Canada, and even globally, continue to hide their pregnancies and access care later in their pregnancies. I had asked some the women I worked with why they did not access care sooner. They often stated that they felt ashamed, guilty, fearful that their baby would be apprehended, or that they have had poor experiences in the past with health care providers or child welfare workers. It is not uncommon for women to use substances while pregnant. Walker, Al-Sahab, Islam, and Tamim (2011) noted that, in a
study from 2005 to 2006 with 5882 mothers, 10.8% of women drank alcohol and 1% used illicit substances during pregnancy. Instead of health care providers shaming women for their substance use during pregnancy, health and social services supports need to take a trauma-informed care approach to improve access to, experiences with, and outcome of prenatal-and childbirth-related services in Saskatoon.

Women with childhood maltreatment histories are more likely to experience PTSD--like symptoms during pregnancy than women who have not (Seng, Low, Sperlich, Ronis, & Liberzon, 2009). Grekin and O’Hara (2014) found that, “…postnatal PTSD was overall more common among women with a past history of exposure to trauma and psychiatric illness” (as cited in Devaney, Taylor, & Vincent, 2015, p.76). These findings emphasize the importance of adopting a trauma-informed care approach within our health care system as it is essential in reducing the risk of traumatization or re-traumatization of women.

My learning objectives for my practicum were focused on getting a better understanding of how our current health care system can become more trauma-informed by participating in the following activities:

1. Review and critically analyze Saskatchewan Health Authority policy relating to patient engagement and health equity.
2. Explore and apply leading practices in promoting and supporting ally-ship, reconciliation, decolonization and trauma-informed principles in health care settings.
3. Enable personal reflection and professional growth.
4. Incorporate a literature review, theory, policy and practice implications, and practicum experiences into a final report.
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In order to complete my learning objectives, I participated in a variety of activities throughout my practicum. To get a better understanding of how or if our health care system was taking a trauma-informed care approach, I accompanied my practicum supervisor to meetings with professionals and students from a variation of practices. Most of these meetings entailed discussing how our health care system, and other organizations, could be more trauma-informed through educational sessions. My practicum supervisor and I met with emergency department nurses, and law and social work students from Community Legal Assistance Services for Saskatoon Inner City Inc. (CLASSIC). I was also given the opportunity to present to an undergraduate social work class to discuss my experiences with working with women who use substances while pregnant, while also reflecting on my findings in the literature. I also met with my practicum supervisor at least two to three times a week to debrief and try to better understand how current health care system could become more trauma-informed for women who use substances while pregnant. To further my knowledge in this area, I did an extensive literature review on substance use and pregnancy.

The literature review entailed looking at the current laws and policies in place regarding substance use and pregnancy, trying to better understand how different forms of violence effects this population of women, if any organizations in Canada were utilizing harm reduction and trauma-informed care approaches, and how cultural safety can be applied to women who use substances. After having a better idea of the literature, I came to notice there was minimal literature that directly discussed the experiences of women who use substances while pregnant when accessing health care. This furthered my interest in completing a quality improvement project.
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The goal of the quality improvement project was to bring to light some of the experiences and challenges women who use substances while pregnant have within our health care system. In order to go forward with this I had to create a consent form, interview questions, consult with community agencies, receive Research Ethics Board and Operational Approval, all of which will be discussed later in the report. I felt it was also important to better understand women’s experiences and how our health care system can improve in reducing the risk of trauma and re-traumatization, as well as gaining a better understanding on how to keep families together due to the rates of children being placed in foster care is increasing. Baxtor (2018, November 20) reported in his article that newborns apprehended at birth has increased in Saskatchewan from 103 in 2013 to 148 in 2017, and children in care has increased from 2,880 in June 2014 to 3,279 in June 2018. When comparing Saskatchewan to Canada, Saskatchewan has higher rates of children being placed in foster care with 7.64 of 1000 children going into care versus the rest of Canada that averages 1.57 of 1000 children (MacLaurin et al., 2008). These statistics, along with the stories of women who engaged in the quality improvement project are key reasons for our health care system to start to take a trauma-informed care approach.

My report will also discuss how trauma-and violence-informed care, harm reduction, and cultural safety are essential ingredients for reducing the risk of trauma or re-traumatization of women who use substances while pregnant. Ultimately, there will need to be a shift in the way our current health care system works with women who are labelled as ‘high risk’. The next section of my report will provide in-depth detail of what trauma-informed care is.

What is Trauma-Informed Care?

Over 40 years ago, feminist movements began to draw attention to domestic violence issues which sparked the creation of trauma-informed care (Wilson, Pence, & Conradi, 2013).
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Feminist movements combined with an increase in research around PTSD amongst soldiers created an increase in discussion around trauma in mental health systems (Wilson et al., 2013). By 1994 the Substance Abuse and Mental Health Administration (SAMHSA) in the United States began to explore, “…the high prevalence of physical and sexual abuse among women served by the public mental health system” (p.4). This created opportunities for trauma survivors to discuss the physical and mental impacts trauma had on their lives (Wilson et al., 2013).

American researchers Felitti et al., (1998) published the first results of the Adverse Childhood Experiences (ACEs) study. This study discovered that the more ACEs a child had the more likely they would experience mental health and/or physical health issues in adulthood (Leitch, 2017). ACEs include, but are not limited to, experiencing the divorce of parents, having a parent(s) who are struggling with mental health and/or addiction issues, and experiencing one or more types of abuse (physical, sexual, and emotional) (Leitch, 2017). This was the first study done on the collective impact that various types of traumatic or adverse experiences had on the future health of children.

Trauma-informed care is a person-centered and strength-based approach (Carello & Butler, 2015). Trauma-informed approaches:

…understand the ways in which violence, victimization, and other traumatic experiences may have impacted the lives of the individuals involved and to apply that understanding to the design of systems and provision of services so they can accommodate trauma survivors’ needs and are consonant with healing and recovery (Carello & Butler, 2015 p.264).

Training health care providers to be more mindful that individuals accessing their services may have a trauma history, ongoing trauma, or both is essential in reducing the risk of re-
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traumatization (Fallot & Harris, 2009). Fallot and Harris (2009) created five core values of trauma-informed care, which are, “safety, trustworthiness, choice, collaboration, and empowerment” (p.3). As a person-centered approach, trauma-informed care aims to provide a sense of safety, control, and choice for individuals accessing services (Carello & Butler, 2015). Safety is a key aspect as individuals often do not access services due to feeling unsafe from past trauma and/or previous poor experiences (Carello & Butler, 2015). Trustworthiness, or trust, means that health care providers are informing clients about the care they receive in a transparent way (Carello & Butler, 2015). Transparency is essential for women who use substances while pregnant as there are often fears about their unborn child being apprehended. The third value, choice, means allowing patients to be involved in decisions around their care and providing options (Carello & Butler, 2015). For women who use substances while pregnant, the feeling of having no choices or say is not uncommon. The fourth value, collaboration, means health care providers work with the patient, and sometimes their families, on creating a treatment plan that attempts to meet the patient where they are at. For example, women who use substances while pregnant often have child protection workers come to the Labour and Delivery Unit once they have delivered. Although having child protection workers meet women in the hospital is not ideal, women should have the option of where the meeting takes place and who they have present as supports. The last value, empowerment, emphasizes the patient’s strengths. For example, health care providers can work with the women and inquire what techniques and approaches have worked best to reduce substance use. Fallot and Harris’s (2009) five core values are complemented by the Substance Abuse and Mental Health Services Administration (SAMHSA) “The four R’s” of trauma-informed care: realization, recognize, respond, and resist
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re-traumatization. These are essential components that health care providers will need to incorporate into their daily practice in order to take a trauma-informed care approach.

The first ‘R’, realization, asks health care providers and systems to understand that trauma can be caused by single or multiple events (SAMHSA, 2014). Realization also means that trauma does not only affect people individually, but can also impact whole families (e.g., families who are physically violent towards one another), communities (e.g., high suicide rates in northern communities), and is ingrained in systems (e.g., child welfare) (SAMHSA, 2014). The second ‘R’ focuses on recognizing the signs of trauma, such as the acute signs of trauma response and broader mental health and chronic health concerns that can occur because of trauma (SAMHSA, 2014). The third ‘R’, respond, suggests that whole organizations and systems become orientated to what trauma-informed care entails (SAMHSA, 2014). This also means that organizations and systems review policy and procedures to ensure that they reflect trauma-informed values, and be changed if they do not (SAMHSA, 2014). Lastly, resisting re-traumatization means staff trained in trauma-informed care will be able to recognize policies, procedures, and behaviours that pose a risk to re-traumatizing clients and their coworkers (SAMHSA, 2014). The utilization of the four ‘R’s’ is critical when working with women who use substances while pregnant as it aims to reduce the risk of women experiencing trauma or being re-traumatized when accessing care. Trauma-informed care is unique because the approach does not only entail acknowledging that individuals accessing care may have a trauma history, but also acknowledges that health care providers may have trauma histories of their own. This approach also acknowledges that individuals providing care are at high risk of experiencing vicarious trauma.
Understanding Vicarious Trauma

Vicarious, or secondary trauma, is the, “…occurrence of trauma symptoms in clinicians due to the constant exposure to the experiences and the stories of their client” (Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014, p.113). Health care providers are at greatest risk of experiencing vicarious trauma if they are continually hearing trauma stories from clients, have a personal or family history of trauma, or have unhealthy boundaries with clients (Deyoung & Deyoung, 2015). Some signs of vicarious trauma are hypervigilance, minimizing, guilt, chronic exhaustion, feeling hopeless, and increased negative thinking (Lipsky & Burk, 2009). Trauma-informed systems must also acknowledge that staff may have their own trauma histories, and are at risk for, or may be experiencing the effects of, vicarious trauma. Trauma-informed organizations must also, “place a high regard on staff health and wellness and in helping staff develop the same self-soothing, self-regulation, self-compassion, and self-care skills as is being offered the people to whom they are providing services.” (Lipsky & Burk, 2009, p.125). For health care providers, one aspect of this could be becoming attuned to what Bolton et al., (2013) discussed in their trauma-informed toolkit as the ABC’s of addressing trauma exposure: awareness, balance, and connection. This approach requires health care providers to be aware of their own needs and limits when it comes to their ability to manage their emotions, maintain a healthy balance between work and personal life, and their ability to reach out to their co-workers and managers to debrief. The increase in staff wellness can prevent traumatization and re-traumatization of their clients and themselves (Bolton et al., 2013). Being trauma-informed also means becoming mindful of how language can contribute to traumatization of individuals accessing health care services.
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The Term ‘High Risk’ and Societal Views

Throughout my practicum and this report, I made a conscious choice around the language I used when discussing women who use substances while pregnant. The reason for this is due to the fact that the language we use can reinforce stigma, cause trauma, and re-traumatize individuals (British Columbia Provincial Mental Health and Substance Use Planning Council, 2013). The primary focus of my project was on prenatal and childbirth service experiences of women living with HIV and/or who had used illicit drugs while pregnant, I will first discuss the notion of ‘risk’, particularly in the context of ‘high risk pregnancy’.

In practice, the term ‘high risk pregnancy’ was used as criteria for accessing services. For example, in my role as a case manager, a woman’s pregnancy must be identified as ‘high risk’ in order to access case management support. However, in the health care system, the term ‘high risk’ can mean a few things. ‘High risk’ can be defined as, “…likely to result in failure, harm, or injury: having a lot of risk” (Merriam-Webster Dictionary, 2019). In the context of my former role as a case manager, using the term ‘high risk’ can unconsciously and consciously create assumptions about this population of women and reinforce negative stereotypes that already exist. Some language I have heard health care providers use to describe this population of women is that they will be “inadequate parents” and are “uncaring” because they continue to use substances. Women who are labelled as ‘high risk’ will have birth alerts placed on their charts. Birth alerts inform health care providers that child welfare services should be contacted once the woman has delivered her baby. The language used, and visible labels being placed on women’s charts, create the risk for a woman to be judged negatively prior to health care providers meeting her. These pre-judgments of women before they even meet the hospital care providers can negatively influence the way care providers treat women while on their units.
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It was found in a study done by Anita (2012) that nurses expressed feeling resentment towards women who used substances when having to care for their babies who were experiencing neonatal absence syndrome (NAS) after birth. Another study done by Fraser, Barnes, Biggs, and Kain (2007) interviewed nurses about their experiences working on the neonatal unit. In their study, nurses openly admitted that women who had babies with NAS were often judged negatively. One nurse stated, “…we talk about judgement, and yeah, we do (judge them). “We don’t mean to, but you just do, and the parents think, ‘well the baby’s gone to the nursery and it’s started on medication, and I’m gonna be worried that I never get this baby back’…” (Fraser et al., 2007, p.1368).

Fears of being judged, feeling unsafe, and fears of having their child(ren) apprehended are some of the primary reasons discussed in the literature as to why women do not access prenatal care earlier in their pregnancy, or at all (Brittain et al., 2017; Bucharski, Brockman, & Lambert, 1999; Carter, 2002; Macrory & Boyd, 2007; Milligan et al., 2002; Ann Van Herk, Smith, & Andrew, 2011). The label of ‘high risk’ also contributes to an unequal power dynamic between the woman accessing services and health care providers. Further imbalance of power between providers and people accessing service can create the perception that women who use substances are not equal and are negatively viewed as the ‘other’.

The concept of ‘othering’ has evolved over centuries of dominant cultures reinforcing their own cultural beliefs on individuals who they feel are primitive and of less value than them (Bernasconi, 2012). It is a way to, “…group individuals according to identifiable features such as skin color, size, gender, length of hair, choice of clothing and so on, [which] usually means that they do not conform to some norm that we have established for ourselves” (Bernasconi, 2012, p.152). Women with ‘high risk’ pregnancies are often viewed as not conforming to the norms
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that Western culture has used to define what a ‘good’ mother is (Ann Van Herk et al., 2011). Othering often occurs not because of character flaws, but rather because people become fearful or anxious about things they do not understand (Bernasconi, 2012). In order to manage these anxieties, the dominant society pressures or tries to assimilate the ‘other’ to fit the dominant cultures familiar model of being (Bernasconi, 2012). As it stands today, women who have ‘high risk’ pregnancies are essentially forced to attend addictions treatment, are shamed for using substances, and are threatened with the apprehension of their child(ren) by health care providers and child welfare workers. This often results in women feeling like inadequate mothers and being uncomfortable accessing health care services. These approaches can presumably be linked to health care professionals’ fears and anxieties of the unknown. An example of this is the exact effects substance use will have on an unborn child. I believe there are also anxieties around the social conditions experienced by women who use substances, due to the lack of education in our health care system on how to respectfully, compassionately, and safely work with women who have ‘high risk’ pregnancies. Given these negative connotations of the term ‘high risk’, I asked participants in my quality improvement project to suggest an alternate term(s) to describe themselves and their pregnancies.

When exploring an alternate term(s) to replace ‘high risk’ it was suggested by my practicum supervisor that I ask the women from my quality improvement project what they felt would be a better term to use. Three out of the four women interviewed agreed that the term had a negative connotation attached to it; however, none had any suggestions on what the term ‘high risk’ should be changed to. One mother, Diane, discussed how the term ‘high risk’ is negative but might be needed. She stated:
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…there’s no way to sugar coat it, you know, it’s better that people have a clear understanding of the situation and parameters rather than make it sort of diplomacy correct or whatever and then there be that openness for misinterpretation for the situation or the individual’s needs.

To try and reduce some of the negative connotation, I will be referring to women who are labelled as ‘high risk’ as women who use substances while pregnant. Before getting further into the report I would like to acknowledge my social location.

**Social Location and Women Who Use Substances When Pregnant**

Social location plays a significant role in how a person views and reacts to other individuals and events in the world. My social location first started to evolve when I was born in Saskatoon, Saskatchewan. My mother came from an English farming family, whereas my father grew up in a Polish and Ukrainian home in Saskatoon. My mother’s parents were happily married, substance use or mental health was not an issue, and neither was there any physical or emotional violence. On the other hand, my father’s upbringing entailed having a father who had a substance use issue and was often physically abusive. My parents divorced when I was three. My father’s presence was quite inconsistent throughout my earlier years, which I eventually found out was due to a combination of him struggling with bipolar disorder, a substance use disorder and being incarcerated. When speaking to my father before his death from cancer in 2015, he noted that alcohol helped him manage his symptoms and cope with things that happened during his childhood. Having a parent struggle with mental health and addiction issues has given me insight into how mental health and addition issues are not a character flaw, but often a means to cope, or a reaction to, something negative that has occurred in someone’s life.
How would I describe my social location today? I am an educated, middle-class, heterosexual woman, with no physical disabilities. I am not a mother, nor have I ever experienced pregnancy. My experiences as a child and my social location are important to acknowledge as it has influenced my perceptions and the approaches I use when I worked with women who use substances while pregnant and throughout my practicum.

I have often wondered if I had been a mother myself, if my approaches in my daily practice would have been different when working with women who used substances while pregnant. Given my personal experiences with having a parent struggle with mental health and addiction issues, and furthered education in this area, I do not believe my approaches would necessarily change. Not being a parent, or having any significant emotional connection to a child, has allowed me to emotionally disconnect more easily and focus more on the mothers needs during their pregnancy. If I ever become a mother, I would have to be mindful about comparing my parenting styles to those of the women I worked with. I’d have to ask myself, “Do I associate certain behaviors with ‘good’ and ‘bad’ parenting? Am I unconsciously or consciously pushing my views of parenting on the women I work with?” I would also have to be mindful that not all children will have the same experiences with their mother that I did with my father, and that an individual’s social location can play a role how they perceive the world.

Although I have never been a mother, and have no way of directly relating to the perspectives of women who use substances while pregnant, I do have a perspective of what it’s like to be a child whose parent struggled with substance use, which affected some of their parenting rights.

When I was seven years old, I recall spending time with my father in a supervised visiting suite after he was released from the federal penitentiary. During our visits, a social worker would sit outside the door and document everything my father and I did. When it was
time to leave, I recall my father becoming tearful and often giving me a long hug. The heartbreak I witnessed in my father’s eyes was often confusing to me as a child. I often thought to myself, ‘Did I do something wrong?’, ‘Why is he sad?’, ‘Do I get to come back and see him again?’ I view this experience with my father as a strength because it often makes me reflect on how a child may feel having to visit their parent in a visiting suite. More specifically, I’ve become an advocate for women to have consistent visits with their child(ren). I’ve also found I am more cautious about suggesting a child be placed in care because the decision not only affects the parent, but it also has lasting effects on the child. Although there are some strengths to this perspective there are also drawbacks.

One challenge to having this perspective is that I sometimes found myself becoming upset with clients for not attending visits with their children, yet when they missed their doctors appointments I did not have similar feelings. When it came to missing appointments with their children, the rational thought that social factors affected their ability to make the visit was not enough to overshadow the emotions that I felt. I found that I would have some of the same feelings as I did as a child when my father would not show up to a visit, which affected my empathy around the client’s reason for not attending the visit. Throughout my practicum, I tried to be mindful of how my social location would guide my interactions with health care providers, members of the community, and women who participated in my quality improvement project.

**What my Practicum Entailed**

**Trauma-Informed Care Training for Emergency Department Nurses**

For my practicum, I wanted to better understand how and where our current health system was implementing trauma-informed approaches, especially for women who were using substances when pregnant. I accompanied my practicum supervisor to six trauma-informed care
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training sessions for nurses who worked in one of our city’s Emergency Departments. Two of these sessions I was able to co-facilitate. At first, I was relieved to see a place that some of my previous clients had often labelled as traumatizing, scary, and judgmental taking steps to become more mindful of how trauma can affect people’s lives and how to reduce re-traumatization. Over the course of six sessions, there was an average of two to four nurses in each one which led me to conclude it would take significant amount of time to train all the nurses, and the rest of the Emergency Department staff. This realization left me feeling slightly hopeless that large system changes could come from these training sessions. I soon found out that the training sessions were not implemented because staff wanted to further their knowledge on trauma-informed care, but rather a reaction to an incident that occurred between a patient and a group of health care providers in the Emergency Department. This was concerning, because trauma-informed care education is not to be used as means of punishment, but as stated before, an organizational approach that entails the training of all staff to improve services for their clients and coworkers (Raja, Hasnain, Hoersch, Gove-Yin, & Rajagopalan, 2015). Throughout the six sessions there were two common themes that arose amongst nursing staff.

The first theme was that nursing staff appreciated the information shared throughout the sessions, yet there was a common response of, “This is great and all but it’s hard to try and implement another thing when we are so busy and aren’t supported.” When reviewing the literature, it is not uncommon for nurses to feel unsupported, resulting in a direct correlation between staff workloads and capacity to provide compassionate and patient-centered care (Macphee, Dahinten, & Havaei, 2017; Myny et al., 2011; Pearson et al., 2006). The lack of support perceived by nursing staff is concerning as trauma-informed care is not just focused on clients or patients, but also emphasizes the importance of the health and wellbeing of the
professionals who work in the organization (SAMHSA, 2014). Acknowledging the reality and impact of vicarious trauma and the organization’s responsibility to prevent, validate, and respond to trauma, is highlighted within trauma-informed care literature (British Columbia Provincial Mental Health and Substance Use Planning Council, 2013; Fallot & Harris, 2009; Isobel, 2015; SAMHSA, 2014). Throughout the six sessions, nurses discussed that they are often providing care to people who have experienced a variety of physical traumas, but also may be experiencing psychological trauma; however, they are mainly only equipped to treat the physical issues of patients.

The second theme was the labelling of potentially harmful actions of health care providers, not just nurses, as “misunderstandings”. More specifically, there have been complaints put forth by patients, family members, and other non-health care providers, who have been victims or have witnessed actions of health care providers that they felt were harmful or made individuals feel unsafe. This ultimately resulted in some health care providers being required to attend trauma-informed care training sessions.

The idea that potentially traumatic situations occurring in the Emergency Department, and other hospital settings, that are being dismissed as a “misunderstanding” is a concern as it absolves the health care provider of responsibility for their actions. Health care providers and patients will often have different views of what is appropriate care, yet I believe there is a difference between a genuine misunderstanding in communication and an individual feeling unsafe when accessing services. This is where trauma-informed care approaches within our hospital settings, and especially maternal care units, can play a crucial role in reducing feelings of unsafety amongst patients. Another part of my practicum where the impact of trauma on individuals and communities was explored was with students from CLASSIC.
Meetings with CLASSIC

Part of my practicum entailed meeting with CLASSIC, which is a legal clinic that is run by law students who offer legal advice and advocacy. CLASSIC also accepts undergraduate social work practicum students each semester. The social work students collaborate with the law students on addressing social issues clients may have, such as information on housing and income assistance. Since CLASSIC often serves some of our city’s most vulnerable populations, the agency has made it a priority to provide students and staff with education on non-legal challenges their clients may encounter. This includes, but is not limited to, how broader social context (including trauma) may impact peoples’ ability to access services.

The students at CLASSIC were educated on what trauma is and were provided with suggestions on how to take a trauma-informed and anti-oppressive approach in their daily work. For example, some of the clients CLASSIC serves are homeless and/or using substances, which can make attending scheduled appointments difficult. It was also discussed how to be mindful of some of the barriers clients may have, and that some of their clients may have previous negative experiences with the justice system. Our second meeting with CLASSIC was closer to the end of the term and entailed discussing issues or concerns the students had with clients over the term. There was also a brief discussion around vicarious trauma.

For the second meeting with CLASSIC, my practicum supervisor and I listened while students shared stories of their more challenging or complex experiences working with clients. We provided debriefing, feedback, and suggestions on how to approach these types of situations. Several students shared experiences where a client would become upset with them without provocation, not show up for appointments, and avoid going into court rooms. This resulted in a discussion of how court rooms can often be traumatizing for clients, especially if they have had
child welfare involvement or have been arrested before. The students also discussed having conflicting feelings about what it meant to work in the best interest of the client. One student discussed not being able to emotionally disconnect from some of her clients. This made me reflect further on Jenkins (2013) article, which discussed how lawyers are expected to keep their emotions separate from their cases and how, like health care providers, they are at risk for experiencing vicarious trauma.

Jenkins (2013) discussed how lawyers are at risk for experiencing vicarious trauma yet are expected to keep their emotions separate from their cases. The law students discussed how it was sometimes difficult to not become emotionally involved with or feel sorry for their clients. The expectation placed on lawyers to have no emotional connection with their clients is unrealistic and unfair. Having a lack of emotion or empathy towards clients in fear may compromise the case could put the client at risk. For example, if a woman is charging her partner or ex-partner with domestic violence and discusses the details of the incident(s) to her lawyer, the lawyer’s response to this event is important as the woman is at risk for feeling disregarded or dehumanized. Conveying a lack of emotion and empathy when a client tells their story can have a negative impact on the client who is often sharing vulnerable information. The lawyer’s response to the details of the story can also have a negative impact on clients themselves as one of the most harmful things for someone with a traumatic experience is to disregard their trauma story (Fallot & Harris, 2009). This made me reflect more on how current laws may increase the risk to be traumatized or re-traumatized for a woman who uses substance. Lawyers, regardless if they agree, are expected to uphold the law and can contribute to the traumatizing or re-traumatizing effects of laws or policies implemented.
Harmful policies aimed at women who use substances.

When reviewing the literature, the law around women who use substances while pregnant varies from country to country. In Russia and Ukraine, the state has the legal right to apprehend children from women who are diagnosed with a substance use issue, while also denying them access to safe housing and other benefits (Pinkham & Malinowska-Sempruch, 2007). Countries within in Eastern-Europe and Central Asia have created laws where individuals are denied free antiretroviral medications (treatment for HIV) and safe housing for using substances (Pinkham Malinowska-Sempruch, 2007). In the United States, women continue to be arrested immediately after giving birth and charged with trying to harm their unborn baby (Pinkham & Malinowska-Sempruch, 2007). There are also eighteen states within the United States that view pregnancy and substance use as a form of child abuse, such as in 2014 when Tennessee criminalized substance use during pregnancy (Greaves & Poole, 2004).

When looking at Canada’s policies surrounding substance use and pregnancy, child welfare services often use the mother’s substance use as a primary reason to apprehend a baby at birth or shortly after (Greaves et al., 2002; Pinkham & Malinowska-Sempruch, 2007; Tait, 2000). In our country, there has been some debate if women who use substances should be charged with harming their unborn child and mandated to attend treatment. In the 1997 case of a Winnipeg woman, the court tried to mandate her to attend treatment while also charging her with harming her unborn child (Greaves & Poole, 2004). In this case, the court concluded that the unborn child was not considered a child yet, therefore it had no rights and that the mother could not be charged (Greaves & Poole, 2004). Although this specific case demonstrated that women could not be charged for substance use during pregnancy, policies within the child welfare system continue to directly and indirectly reinforce the perspective that women who use
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substances while pregnant are harming their children. For example, Greaves and Poole (2004) discussed how the Risk Assessment Model for Child Protection in British Columbia uses language that suggests women who use substances while pregnant may negatively impact the safety and well-being of their children, such as their increased chances to be unable to maintain employment or being at risk for dangerous driving. For lawyers working within a system that is filled with interpreting and enforcing such laws and policies, it’s hard to imagine that working in the best interest of this population of women is truly feasible. Such laws and policies contribute to one of the many reasons why women do not access health care earlier in their pregnancy or at all (El-Bassel, Terlikbaeva, & Pinkham, 2010; Pinkham & Malinowska-Sempruch 2007).

Presentation for Undergraduate Social Work

My interest in trauma-informed care and the approaches used with women who use substances while pregnant led to an opportunity to present to a University of Regina undergraduate social work class about pregnancy and substance use. Being able to discuss my work experiences and knowledge in this area was a little surreal as it didn’t feel like long ago that I was completing my Bachelor of Social Work degree. When it comes to undergraduate education in this area, I believe the profession of social work could do a better job in educating undergraduate students on the signs, symptoms, and approaches for trauma. When I was completing my undergraduate degree, trauma-informed care was not an approach that was talked about, nor was there many opportunities to take classes focusing on trauma, mental health, or addiction issues. I would argue that a class on trauma, mental health and addiction issues should be part of the Bachelor of Social Work class requirements, as all three of these issues are relevant in all areas of social work practice. Mental health, addiction, and trauma - and the intersections between these experiences - can affect individuals who access a variety of systems and services
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that employ social workers, such as the justice, child welfare, health, education, and social service systems. Within the health system, trauma does not only affect individuals who are struggling with substance use and mental health issues but can affect people accessing any service or program. This can include, but is not limited to, individuals who are receiving treatment for disease, injury, illness, or navigating life transitions such as, pregnancy, parenting, aging, and end of life care. I think it would be beneficial for the profession of social work to strongly consider educating undergraduate students on trauma-informed care as it requires individuals to acknowledge that anyone accessing their services may have experienced, or be experiencing, some form of trauma.

Quality Improvement Project

For my practicum, I decided to develop and implement a quality improvement project on the experiences of women who have ‘high risk’ pregnancies in accessing prenatal and childbirth related services in Saskatoon. To be eligible to participate in this project women had to be:

- Age 18 or older.
- Pregnant or had given birth in the last 18 months.
- HIV positive, using substances, or both during pregnancy.

I decided to do this project for three reasons. The first reason is that the literature on women who use substances while pregnant primarily centres on the characteristics of women who do not access prenatal care, nurse’s experiences when working with this population of women, program evaluations, or approaches used with women who use substances, but does not specifically discuss the experiences of women who use substances from their point of view. The second reason was when I worked with women who used substances while pregnant, I often noticed a lack of basic education and understanding of trauma, substance use, and mental health as
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demonstrated through health care providers’ words and actions when providing services to this population of women. For example, one of my clients who used crystal meth and alcohol was asked repeatedly if she wanted to go on methadone, yet she was not using opiates. Another example is I would often be told by health care providers that clients would not be able to keep their babies, solely due to their substance use. One of the issues with this is they did not have in-depth information about any of the women, their social context, or support networks, nor the power to make those decisions regarding child welfare issues. These preconceived notions about what it means to be a “good” parent, and who has the right to parent, arguably influence health care provider’s interactions with this population of women. Lastly, in order to create appropriate and trauma-informed resources for women who use substances while pregnant, it is essential to get the perspective of women who are accessing the services. If this is not done, this allows structural violence, which will be discussed later, to continue within society and our health care system.

For my project, I created a project description, interview questions (see Appendix 1), and consent form (see Appendix 2). I met with two community agencies, Healthy Mother Healthy Baby and KidsFirst, and sought their guidance and feedback around the project and interview questions. These agencies were approached due to the population of women they work with. Healthy Mother Healthy Baby works with women who are currently pregnant and are needing extra support in the community to have their basic needs met. KidsFirst works with mothers who have children up to the age of two years old. Both agencies do in-home visits, provide education around maternal, child, and family health and development, and try to assist women in addressing barriers that prevent their basic needs from being met. I also worked with both agencies during my role as a HIV case manager and noticed that program staff often took a
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person-centred and compassionate approach with the women they worked with. Following these meetings, I met with a manager of the Labor and Delivery unit in Saskatoon who expressed support for the project and suggested the development of a product which could be used for educational purposes for health care providers within Maternal Services.

Once Healthy Mother Healthy Baby, KidsFirst, and Maternal Services were on board I completed my Research Ethics Board (REB) application. My practicum supervisor and I anticipated that the REB application would receive an exemption due to it being a quality improvement project versus a research project; however, this was not the case. The REB application ended up being subjected to a full review, which took six weeks to be approved (see Appendix 3). Once the project received ethics approval, I sought Operational Approval from the Saskatchewan Health Authority before starting my interviews (see Appendix 4). My goal was to interview five women; however, due to the lengthy process of the REB application and Operational Approval I was only able to interview four women.

The four women shared both negative and positive experiences they had with accessing prenatal and childbirth related services. From the interviews four themes arose: education on methadone, fear of apprehension and judgement, feelings of defeat and loss of hope, and missed opportunities. I will also discuss the positive experiences the women had and their suggestions for future resources. To maintain confidentiality the names of the mothers have been changed.

Interview Themes

Education on Methadone

Two out of the four women were receiving opioid substitution therapy (methadone) at some point during at least one of their pregnancies. Substitution therapy using methadone or suboxone is often used as a harm reduction approach to help an individual manage their use of
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opiates. In Diane’s and Cynthia’s experiences, health care providers expressed negative views related to being on methadone during their pregnancies. Diane reported that she went on methadone after she was prescribed opiates for a back injury. She noticed a difference in the way the nursing staff treated her during her first pregnancy when she was on methadone versus her second pregnancy when she was not. Diane discussed how she was too scared to tell medical staff she was on methadone due to fears of being judged. She discussed how nursing staff refused to give her the methadone right away when she asked therefore resulting in her experiencing withdrawal symptoms. She stated that, “There was this presumption that I was an incapable mother you know, completely ignoring the fact that there was withdrawal symptoms that were essentially caused by nursing staff because they refused to bring me my methadone on time”. She shared how staff, “…made no attempt on their part to understand why I had been using pain killers and why I had been on methadone. It was just assumed that I was a junkie and treated as such.”

Cynthia had a similar experience as Diane with her most recent pregnancy where health care staff assumed she was using drugs; however, her methadone dose was too high thus causing side effects. She stated, “They assumed that I was using drugs and they got social services involved…so [my baby] almost got apprehended from me because of that and it wasn’t it. It was my medication was too high my methadone…” The negative assumptions around methadone should be addressed as it influences health care provider’s interactions with women who are being treated using substitution therapy. As stated before, treatment using methadone (and other forms of substitution therapy, such as suboxone) is a harm reduction approach with goals to help individuals stop or reduce harms of opiate use. Health care provider’s negative biases and behaviours towards women who use substitution therapy during pregnancy can be understood
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through the previously discussed literature on nurses who work in neonatal units (Fraser et al., 2007). Health care providers should be provided with accurate and current information on substitution therapy, as lack of education in this area poses risks for women and their child(ren). Some of these risks are: experiencing distressing withdrawal symptoms, the potential to have their child(ren) apprehended and being uncomfortable with discussing their needs with health care providers due to fear of judgement.

**Fears of Child Apprehension andJudgement**

Three out of the four mothers discussed how their fears of having child welfare involvement, and being judged by health care providers, made them uncomfortable when discussing needs with prenatal and childbirth health care providers. All four participants had previous child welfare involvement with their older children, which instilled an underlying fear with their most recent pregnancies.

Diane discussed how she assumed her baby would be apprehended at birth due to her previous child welfare involvement. She stated that, “…in the past because of that element the sort of accepted practice was to automatically apprehend a new baby and then make sure the mom has gone through the appropriate channels…” Cynthia mentioned she felt like she was being judged when she needed to go out for a smoke and requested staff watch her baby. She mentioned how her discomfort made her avoid speaking with nursing staff about her needs. Cynthia further discussed how she struggled in the hospital because she was experiencing post-partum depression and nursing staff refused to watch her baby. Cynthia stated:

…I wanted to just go out for a smoke and have a little time for myself to catch myself because the nurses didn’t watch her or stuff like that. That’s what they said too, “she always asks the nurses to watch [baby]” … ’cause I needed time sometimes cause I was just
exhausted. I was going through post-partum depression at the time cause I was off my medication and stuff like that.

The judgement placed on Cynthia for her wanting to have hospital staff watch her baby had the potential to influence the way her child welfare worker perceived her parenting capacity, especially if the nursing staff was reporting that she was doing a poor job of watching her baby.

Mary also discussed feeling judged by health care providers while in hospital when she delivered her baby in Winnipeg. She mentioned that, “…a lot of women … are scared to reach out for help after they have baby.” Being afraid to access health care and other resources in fear of their child(ren) being apprehended, and their capacity as parents being negatively judged, aligns with what was previously discussed in the literature. To reduce women’s fears of negative judgments by health care providers, Cynthia discussed how she felt it would be better if the health care providers discussed with her why child welfare was involved. When she was asked how her experience could have been improved, she stated, “… [it would be better if] ... I was able to take my baby home and that they talked to me about…what’s going on.” When it comes to trauma-informed care, communication and transparency are key to making individuals feel safe when accessing services. People accessing services also have the right to collaborate with health care providers on their care and decisions that are being made. Along with feeling fear and judgement, three out of the four women experienced feeling defeat and having a loss of hope.

**Feeling Defeated and Loss of Hope: Why Try?**

Sally expressed how she was told at the beginning of her pregnancy that her baby was going to be apprehended at birth, which reduced her willingness to access services regarding her substance use. She stated, “…I didn’t really want to be at detox because I knew I was told by social services back home that [baby] was being apprehended right from the start” and if she
knew this wasn’t the case she, “probably wouldn’t have been using [her] whole pregnancy.” She also stated, “Why get clean…everyone was forcing me up here.”

Cynthia also discussed feeling defeated when health care staff failed to discuss with her why child welfare was involved, and stated, “…I just thought, ‘Why did they have to do that? Why couldn’t they just talk to me or something about it instead of assuming I’m using drugs?’” Cynthia also mentioned how she, “…actually had a home set up for [baby]”, which she felt was adequate enough for her to take baby home, but the lack of communication made her feel confused and defeated.

Diane discussed how she felt hopeless when trying to navigate services and shared some of her frustrations when trying to access supports. When her first child was apprehended, she stated she, “…fell from grace, terminal velocity, and there was nothing there to catch me and I had nowhere to go…I was too old for like EGADZ programs… I couldn’t access certain housing things…” Diane also discussed how lots of expectations are placed on mothers to try and navigate and connect with services and barriers to doing so such as, having access to a phone or a computer are often not acknowledged by services providers or systems. She stated she would contact multiple offices and services providers, “…would just say ‘no there’s nothing we can do to help you, no there is nothing we can do to help you, no there’s nothing’ and there’s only so far, so much you can have that door slammed in your face before you… just give up…” To become more trauma-informed our health care system, both in the community and hospital-based services, will need to become more mindful of the barriers women encounter that make it difficult to meet the expectations that are placed upon them. Such barriers and assumptions made about women with ‘high risk’ pregnancies often result in missed opportunities.
Missed Opportunities

Sally discussed her frustrations with having to be placed on a waiting list for Wakamow, a detox Centre in Moose Jaw; however, Wakamow staff failed to inform her that women over 20 weeks pregnant are not eligible for their services. This delayed the process of her getting into a detox centre as she had to call a different centre located in Saskatoon where she was placed on another waiting list. She also discussed that if she would have known she had a chance of keeping her baby and the different processes of getting into a detox, she probably would have stopped using drugs earlier in her pregnancy.

Another missed opportunity was identified by Diane when she spoke about the failure of nursing staff to understand why she was on methadone. If nursing staff took the time to better understand why Diane was on methadone it could have reduced the negative judgements and assumptions she experienced. Increased knowledge and understanding might have also allowed for an appropriate plan to be put in place where Diane did not have to be approached by child welfare services when leaving the hospital. Diane stated that, “… I ended up having the Ministry [of Social Services], stop me from leaving the hospital with my [baby]… on the day that we were discharged because they wanted to talk to me.” Having this happen can be traumatizing and can affirm the woman’s fears of having her child(ren) apprehended and contribute to these ongoing fears in the future.

Cynthia spoke of a missed opportunity with her first baby. Cynthia mentioned how she was not informed by any health care providers, or child welfare services, of addiction treatment centres that were able to accommodate both her and her baby. She stated, “…it would have made it easier for me but I ended up still using. I was an addict for six years, but when I found out about my [HIV] diagnosis, my status, I just quit drugs right then cause I knew if I continued to
lead the lifestyle I wouldn’t have made it too far.” Cynthia ended up being diagnosed with HIV after continued substance use. It’s hard not to wonder if she was connected to the appropriate treatment services during her first pregnancy, if it would have impacted her choices around substance use – and prevented a HIV diagnosis. Although there were missed opportunities, all the participants discussed positive experiences and resources that were helpful during their prenatal and postnatal periods.

**Positive Experiences with Prenatal and Childbirth Related Services**

All four of the women discussed how having compassionate and person-centered services put in place improved their prenatal-and childbirth-related experiences for their most recent pregnancies compared to previous pregnancies.

Two out of the four women accessed Sanctum, a harm-reduction based residential program for women who are pregnant and using substances or women who have given birth and are continuing to use substances or are in recovery. Both women who accessed Sanctum found the programs offered were helpful and improved their experiences. Sally stated, “They send us to Pathways (a program that runs twice a week and discusses topics around recovery, healthy relationships, and parenting skills) once in a while through the MACSI (Metis Addiction Council of Saskatchewan) Centre. [They provide] a little bit of everything, but one good thing about Sanctum is they have childcare…” Similar to Sally, Cynthia expressed how Sanctum was very accessible and helped her learn more about parenting.

All four women discussed how being connected with the KidsFirst program has been helpful, and both Mary and Diane discussed how being connected to 601 Outreach (a community based organization in Saskatoon that provides some of the following: safe consumption supplies, education on HIV, a drop-in centre with lunch, housing support, groups, and access to a phone
and computers) was also helpful. Regarding her labour and delivery team, Diane noted that her birthing experience was better this time around as he felt she had confidence in her medical team. Sally had discussed how her experience with doctors in her hometown as well as in the hospital were positive. Cynthia noted that her family physician this time around opened the door to multiple services for her, “she got me on methadone, she got me on medication, she got me to treatment, she introduced me to an addiction worker, she took me to treatment…I got clean and since then I’ve been clean.” Diane also mentioned how with her most recent pregnancy, her anesthesiologist took the time to discuss her previous experience with getting an epidural that did not go well and worked with her to make her most recent experience more positive. She also discussed how the nursing staff seemed to be more mindful the second time around that she may have a trauma history. Diane stated, “The hospital staff had been put on notice that the potential father was dangerous and stuff like that. So they were really…kind of respectful of the fact of that I may have trauma.” Diane’s positive experiences are examples of taking a trauma-informed care approach; however, it is unclear if health care providers knew they were doing this at the time. Lastly, Mary mentioned how having all the services she needed at her clinic was beneficial because she did not have to worry about transportation. Sally also identified how it was helpful having health care providers come to Sanctum because she also encountered barriers to transportation.

**Gaps in Services**

The women who were interviewed identified a range of improvements around needed resources and supports. Sally discussed how she hopes there will be more services for pregnant women offered in smaller centres in terms of detox and addiction services, due to most services being based in Regina and Saskatoon. She suggested that if child welfare is going to be involved,
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that they discuss a case plan earlier in pregnancy versus telling a woman that her only choice is to have her baby apprehended. Similarly, Diane discussed her experiences with the Prenatal Pilot Project, which is a project through the Ministry of Social Services where child welfare workers become involved in case planning with women once they are 30 weeks pregnant. She stated, “it’s a pretty big thing because it gives you the opportunity to defend yourself before the crap hits the fan and you’re on the other side of the Section 9, which is not a good side to be on.” Diane also expressed a desire for information on where to access services around mental health, and for women who are pregnant and using substances as women don’t always have access to computers. Mary discussed wanting more services for women once they have given birth and referred to a program she attended in Winnipeg. She stated, “…it’s something like Pathways and I took it in Winnipeg for mothers of substance abuse, yea, and that really helped.” Mary also hoped there would be more services offered for women who are experiencing post-partum depression. Similar to Mary, Cynthia also hoped there would be more open dialogue about post-partum depression. Cynthia also identified having access to more information about treatment centres for women and children and having health care providers and child welfare workers get to know the women they are working with better. She stated, “…Family support services [would be helpful]. Help getting around to know the women more and stuff like that.”

Approaches That Informed the Analysis of Practicum Experiences and Activities

Trauma-and Violence-Informed Care

Trauma-and violence-informed care is an extension of trauma-informed care. Trauma-and violence-informed care acknowledges that women who have substance use issues or are pregnant and using substances are at an increased risk for abuse and violence (El-Bassel et al., 2010; Hien et al., 2010). In spite of this, society continues to negatively stigmatize women who
use substances while pregnant (Fraser et al., 2007; Macrory & Boyd, 2007). Keeping Fallot and Harris’s (2009) core values of trauma-informed care and SAMHSA “Four R’s” in mind, I would argue that when using a trauma-informed care approach health care providers must also be mindful of the violence women who use substances encounter (EQUIP Health Care, 2019).

A trauma-and violence-informed care approach broadens a trauma-informed care approach to acknowledge that women who use substances are more likely to experience interpersonal and structural violence and, “…expands this concept to account for intersections effects of systemic and interpersonal violence” (EQUIP Health Care, 2019, p.1). Winter and Leighton, (2001) stated that:

Structural violence directly illustrates a power system wherein social structures or institutions cause harm to people in a way that results in maldevelopment or deprivation. Because it is a product of human decisions and not natural occurrences, and because it is correctable and preventable through human agency, there is increasing advocacy that we call it violence (as cited in Lee, 2016, p.110).

Structural violence is often perpetuated by professionals upholding policies and procedures that were created by people with power which ignore or fail to understand the unique needs of individuals who have little to no power in the eyes of society (Lee, 2016). When individuals with power create and maintain policy and procedures that do not acknowledge the needs of individuals who use substances, especially women, it reinforces a dominant view of this population which then can translate into discrimination and racism in health care settings (Wathen, 2018). This structural discrimination and racism within our health care system contributes to environments that increases an individual’s likelihood of experiencing trauma or being re-traumatized. An example of this is the reports of tubal ligations (where a woman’s
fallopian tubes are clamped or severed) of Indigenous women after they gave birth in Saskatoon hospitals. Such procedures are one act of structural violence and, “were justified as an effort to help Indigenous women manage the size of their families.” (Kurkup, 2017, p.1). The health care providers who participated in the procedures, as well as the nursing staff and social workers who suggested the women have this procedure done, were enforcing their own beliefs on what is an appropriate and manageable family size. More specifically, by not having the procedure done the Indigenous women were viewed as failing to meet the dominant cultures ideals of parenting.

Structural violence also creates and reinforces negative stereotypes, which consciously and unconsciously influences health care provider’s approaches when working with stigmatized and oppressed populations (Lee, 2016). Gilligan (1999) discussed how structural violence is a contributing factor to health inequities, as it leads to “increased rates of disabilities and deaths among the people who occupy the bottom class” (as cited in Lee 2016, p.111). What is concerning about this is the deaths that occur are more often amongst people living below or close to the poverty line, and can be preventable, such as with HIV (Lee, 2016). Structural violence is a contributor to inadequate access to, and experiences of, care as people are often too afraid to seek help in fear of having another poor experience or being judged. This is evident throughout the literature for women who use substances while pregnant. It was discussed in several articles that women often do not access prenatal care due to fear of judgment, apprehension of their child, and services not meeting their unique needs (Corse & Smith, 1998; Friedman, Heneghan, & Rosenthal, 2009; Grella, 1997; Hankin, McCaul, & Heussner, 2000; Heaman et al., 2014; Macry & Boyd, 2007; Nelson-Zlupko, Kauffman, & Dore 1995; Tait 2000; Wright & Walker, 2007) A specific example of structural violence that was found in the literature is the lack of women centered treatment centres.
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**Lack of women centered treatment centres.**

Just over 50 years ago, substance use issues were treated the same as having a severe mental illness, resulting in individuals with substance use issues being placed in psychiatric hospitals (Tait, 2000). The rise in cocaine use in the 1980’s sparked research around the effects of substances on an unborn child, which created a push to develop women centred treatment options (Tait, 2000). During this period, most treatment centres took a medical, disease, or male-based approach, which disregards the unique needs of women who use substances (Tait, 2000). To a large extent this practice continues today. This continued lack of responsive, appropriate, safe and accessible substance use treatment is a form of structural violence as women are expected to follow treatment programs that ascribe to one of the three stated models. Women who use substances often need support around a broader range of psychosocial issues such as, intimate partner violence, and are more likely to have sexual and physical abuse histories (Ashley, Marsden, & Brady, 2003; Covington, 2008) that are not addressed in many mainstream treatment centers. Women also face barriers accessing treatment due to the increased likelihood that they will be the primary care giver for their child(ren) (Nelson-Zlupko et al., 1995). Women who use substances often do not stay in treatment centres as, “…[their] responsibility for children, lack of access to childcare services, society’s punitive attitude towards substance abuse by women as child bearers are barriers…” (Ashley et al., 2003, p.21). Similarly, the lack of access to child care and transportation often play a significant role in women being able to attend community-based treatment options, such as workshops (Ashley et al., 2003; Dakof et al., 2003; Haller, Miles, & Dawson, 2003; Milligan et, al., 2002; Teagle & Brindis, 1998). Another issue is that many programs do not provide integrated services alongside substance use treatment, such as programming around violence, trauma, and prenatal care.
Interpersonal violence amongst women who use substances.

Unfortunately, women who use substances while pregnant do not only encounter structural violence, but they are also more likely to encounter interpersonal violence (IPV) than women who do not. In Canada, a study on intimate partner violence found that women represented 80% of IPV (Sinha, 2011). When reviewing the literature on women who use substances, a study by Brittian et al., (2017) and Martin, English, Kathryn Anderson, Cilenti, and Kupper (1996) found that women who were using substances prior to pregnancy were more likely to continue using substances while pregnant if they were experiencing IPV. Women who used substances with their partners were also more likely to report ongoing IPV (El-Bassel et al., 2010; Torchalla, Linden, Strehlau, Neilson, & Kraus, 2014). Women are also sometimes forced to work on the streets, which increases their chances of contracting HIV and become victims of different forms of violence (El-Bassel et al., 2010; Hien et al., 2010). Martin et al. (1996) did a review of studies on prenatal women and pregnancy and found that, “4% to 26% of prenatal patients were violence victims before their current pregnancy and that 1% to 17% experience violence during pregnancy” (p.991). Martin et al. (1996) demonstrated that women are still being abused before and during pregnancy.

Effects of intergenerational violence.

When working with women who are pregnant and using substances, health care providers should also be mindful of how women and their families can be affected by intergenerational violence and trauma. Intergenerational violence can occur when patterns of violence are passed down from one generation to the next (Black, Sussman, & Unger, 2010). Environments where violence is present can cause individuals to have insecure attachment styles, which has been linked to the increased risk of individuals becoming perpetrators of violence, or repeat victims of
violence (Siegel, 2013). An example of intergenerational violence is the impact of colonization, such as residential schools, on Indigenous families and communities. Due to the ongoing violence of colonial policies and discrimination that generations of children experienced in residential schools and through other forms of colonization, there is a notably higher amount of violence within Indigenous communities versus non-Indigenous communities (e.g., higher incarceration rates) (Scrim, 2017). Colonization introduced patriarchy to Indigenous communities, which in combination with residential schools, has created a shift in the role of women in many Indigenous communities (Ann Van Herk et al., 2011). When working with women who use substances, a trauma-and violence-informed approach would require health care providers to acknowledge that intergenerational violence and trauma does exist. Health care providers need to adapt their practice to reflect an understanding of how intergenerational violence and trauma may be affecting a woman’s ability to manage stress and trauma symptoms.

When working with women who use substances while pregnant, it is also important to look at how toxic stress is playing a role in their lives. Toxic stress, “disrupts the architecture of the developing brain and can result in permanent changes. These changes have long-term consequences on future education, vocational abilities, and health outcomes.” (Rushton & Kraft, p.44, 2013). Toxic stress occurs when an individual encounters an event, or multiple events, that is perceived as stressful (Devaney et al., 2015). This results in the brain adapting to stress as if its life threatening and alters the individual’s flight, fight, and freeze response (Devaney et al., 2015). Experiencing toxic stress can become problematic when a woman becomes a parent, as her ability to cope with the stress of parenting and respond to her baby’s cries may be more challenging than for a woman who is not dealing with toxic stress (Devaney et al., 2015). Toxic stress plays a large role in an individual’s approach to coping with stress and can result in the use
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of substances as a coping strategy. Emotional dysregulation can also result from toxic stress, which then can affect a mother’s ability to bond with her baby (Rushton & Kraft, 2013). Consequently, a woman may be at risk for being labelled as a “bad mother”, as she may be perceived as not adequately bonding with her newborn baby and responding to its needs (Rushton & Kraft, 2013). A trauma-and violence-informed care lens would allow health care providers to make more appropriate referrals for women who are experiencing toxic stress. Referrals to help cope with this level of stress could include supports around emotional regulation and positive parenting techniques, which would occur in a hospital or community setting (Rushton & Kraft, 2013).

Harm Reduction

Harm reduction approaches were first adopted in Europe and Australia as a response to the AIDS crisis (Rosenbaum & Irwin, 2000), and were introduced in Canada in the 1990s (British Columbia Centre of Excellence for Women’s Health, 2015). The AIDS Network (2014) defines harm reduction as a, “…public health approach that aims to reduce drug-related harm experienced by individuals and communities, without necessarily reducing the consumption of drugs.” For women who use substances while pregnant, the British Columbia Centre of Excellence for Women’s Health (2010) report Mothering and Substance Use: Approaches to Prevention, Harm Reduction ad Treatment defined harm reduction as:

…attending to [the woman’s] basic needs such nutrition and housing. Harm reduction approaches take a pragmatic and compassionate approach to care. Service providers are willing to discuss goals other than complete abstinence from all substances (in spite of the known risks) and consider all aspects of harm. In this approach, there is recognition of the interconnectedness of many areas of women’s lives, such as trauma, mental illness,
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health, and substance use. Accordingly, engagement in treatment begins with what is most important and possible for the woman (p.3).

In addition to reducing the potential harms of substance use, harm reduction also addresses biopsychosocial factors that impact women who use substances and tries to manage stressors that may influence substance use. As harm reduction approaches have become more widespread, a variety of programs for women who use substances while pregnant have developed in communities across Canada.

Arguably there continues to be a lack of services, due in part to the negative stigma attached to women who use substances while pregnant. A study done by Rosenbaum and Irwin (2000), aimed to better understand what women who used substances while pregnant thought harm reduction was. What they found was women often engaged in behaviours they thought would reduce harm to their baby, such as using marijuana versus crystal meth, and trying to find a safer place to live in (Rosenbaum & Irwin, 2000). Women admitted that due to negative stigma, they relied on the internet for information to educate themselves on the effects of substances on their baby (Rosenbaum & Irwin, 2000). There were a range of techniques which women used that they believed to be harm reduction approaches, such as drinking pickle juice or vinegar to cleanse all the substances from their body (Rosenbaum & Irwin, 2000). The results of this study clearly affirmed that women do not want to harm their babies; however, not seeking the guidance of health care professionals on harm reduction strategies and tools, prenatal health, and how to safely reduce or stop substance use can cause complications. When it comes to looking at community and hospital settings there were some community agencies in cities across Canada that openly take a harm reduction approach, but only one in a hospital setting.
Harm reduction organizations in Canada: A literature review

When reviewing the literature on Canadian organizations that take a harm reduction approach with women who use substances while pregnant nine community programs across Canada were found:

- Sheway, a drop-in center located in Vancouver, British Columbia that offers sexual health and addictions counselling, food and nutrition support, and methadone maintenance (Torchalla et al., 2014) opened in 1993 (Poole, 2000). An evaluation of the program’s effectiveness stated that there were issues with measuring decreases in substance use amongst women who accessed services. A key success identified in the report was that however, 58% of children born to a mother in the program were not apprehended at any time (Poole, 2000).

- Crabtree Corner Housing, located in Vancouver, British Columbia, which provides housing for women who are pregnant or already a parent and using substances (Torchalla et al., 2014). Crabtree Corner Housing offers parenting classes, meal programs, and information around family and child development (Torchalla et al., 2014).

- Maxxine Wright Place, in Surrey, British Columbia, supports women who have been impacted by violence, abuse, substance use, or all the above (British Columbia Centre of Excellence for Women’s Health, 2015). This organization provides programs, such as addictions counselling, housing, outreach workers, hot meals, and a dental hygienist (British Columbia Centre of Excellence for Women’s Health, 2015).

- HerWay Home located in Victoria, British Columbia, provides outreach services for women who have been affected by substance abuse, trauma, or poverty (British Columbia’s Centre of Excellence for Women’s Health, 2015).
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- H.E.R (Healthy, Empowered and Resilient) pregnancy program, based in the inner city of Edmonton, Alberta (British Columbia Centre of Excellence for Women’s Health, 2015). The program began in 2007 after Streetworks needle exchange noticed many women who worked on the streets becoming pregnant and needing extra support (British Columbia Centre of Excellence for Women’s Health, 2015). H.E.R. works with women who have little to no prenatal care and are street involved (British Columbia Centre of Excellence for Women’s Health, 2015). An evaluative study was conducted over an 18-month period which reported that 26% of women accessing H.E.R. reduced their substance use, 27% engaged in safer use, and 40% quit using substances, all indicators that the services provided were helpful (British Columbia Centre of Excellence for Women’s Health, 2015).

- Sanctum 1.5, in Saskatoon, Saskatchewan opened in October 2018 and provides a shelter for women who are pregnant and using substances, while also allowing the women to stay there up to three months after their baby is born.

- Manito Ikew Kagiikwe (The Mothering Project) located in Winnipeg, Manitoba works with vulnerable women in a variety of ways that ranges from housing, consulting with a midwife, food preparation, information on child development, and methadone treatment (British Columbia Centre of Excellence for Women’s Health, 2015). In 2015, Manito Ikew Kagiikwe had 49 women engaged in their program. Of the 49 women, 36% abstained from substances, 47% reduced substance use, 53% of women brought their babies home with them from hospital, and 63% of the families connected to the program were housed (O’Brien, 2015).
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- The New Choices program located in Hamilton, Ontario, offers women who use substances during pregnancy or who have children in their care the ability to access nutritional, addiction and individual counselling, and provides parenting and child development programs (Sword, Niccols, & Fan, 2004). New Choices philosophy is based around a person-centered approach and helps connect women to prenatal supports (Sword et al., 2004). A study was done on New Choices effectiveness, and it was found that women who access the program had decreased or stopped substance use, had improved physical and mental health, and reported improved relationships with their children (Sword et al., 2004).

- The Breaking the Cycle Outreach Pregnancy Program in Toronto, Ontario, works with mothers and their infants up to age six (Racine, Motz, Leslie, & Pepler, 2009). The program provides FASD screening, parenting programs, childcare, addictions counselling, and outreach workers who do home visits (Racine et al., 2009). Women who were engaged in this program saw an increase in maternal health, reduced substance use, and about 50% of the referrals to external supports such as, addiction treatment, counselling and health care providers, followed through with appointments and maintained engagement (Racine et al., 2009).

These community programs have demonstrated the importance of having integrated programs as well as the effectiveness of harm reduction approaches. When reviewing the literature there was only one place in Canada, known as Fir Square, that openly takes a harm reduction approach with women in a hospital setting.

Fir Square opened in 2013 in Vancouver, British Columbia. Fir Square staff works with women who use substances by providing care to them and their newborns in a single unit
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(Torchalla et al., 2014). The 11-bed unit consists of both an antepartum and post-partum unit (Greaves & Poole, 2004). The goal of Fir square is to keep mother and baby together versus having baby go into care (Kraus, 2010). Arrangements have been made between Fir Square and child welfare services to create, “…an ‘apprehension free’ zone, preventing child apprehension by child welfare authorities in the period immediately following birth, while attachment and health stabilization achieved and mothers’ desires and needs can be assessed.” (Greaves & Poole, 2004, p.91). Fir Square provides, “…parenting classes, addiction and trauma counselling, and detoxification and stabilization programs” (Kraus 2010, p.7), while also working with the mother to set supports up for her and her baby in the community (Kraus, 2010).

When using harm reduction approaches with women who use substances while pregnant, it means taking a person-centered approach and meeting the woman where she is at, while also providing education and support in different areas. This includes, but its not limited to, education on STI testing, access to safe consumption supplies, providing transportation and child care, creating integrated programs, providing low barrier services (e.g little-to-no wait times to see a doctor, streamlined intake processes, simplified program eligibility criteria), access to addictions and individual counselling, and access to food vouchers (British Columbia Centre of Excellence for Women’s Health, 2015). It should be noted that some women may struggle with a harm reduction approach, meaning that health care providers must collaborate with the women to see which approach works best for them. More specially, during my quality improvement project a woman who accessed Sanctum 1.5 found it hard to be in a harm reduction home and maintain sobriety. Sally stated, “Ah it was alright, it was hard because I’ve been sober since I’ve been there and being a harm reduction house with everybody else using quite a bit was quite difficult.” Although she found being surrounded by individuals who were continuing to use substances
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challenging, she still found the program to be beneficial. Taking a harm reduction and trauma- and violence-informed approach are essential ingredients in creating culturally safe systems.

Cultural Safety

The theoretical perspective of cultural safety originated in New Zealand in 1992 when it became evident that the Treaty of Waitangi was not being upheld, due to a noticeable increase in negative health outcomes and suicides for Maori people when compared to non-Maori people (Papps & Ramsden, 1996). Wood and Schwass (1993) defined cultural safety as a theoretical perspective that:

…aims to counter tendencies in health care that create cultural risk (or unsafety) – those situations that arise when people from one ethnocultural group believe they are demeaned, diminished, or disempowered by the actions and delivery of systems of people from another culture (as cited in Browne et al., 2009, p.169).

The term cultural safety is often applied to the treatment of Indigenous People within health care settings (McCall & Pauly, 2019); however, it can also be used to when discussing the care that individuals who use illicit substances receive. McCall and Pauly (2019) did a qualitative study on cultural safety in healthcare for people who use illicit substances where they interviewed 19 nurses and 15 patients. The interviews with nurses concluded that there continues to be misconceptions about addiction and pain control, and some nursing staff expressed feeling uncomfortable working with individuals with substance use issues (McCall & Pauly, 2019). There findings also demonstrated that individuals who use illicit substances continue to feel they are being labelled as ‘junkies’ or ‘addicts’, which reduces their willingness to access health care (McCall & Pauly, 2019). Cultural safety is not about protecting someone’s culture but rather
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aims to reduce, “health care practices that cause patients to feel unsafe and powerless.” (McCall & Pauly, 2019, p.3)

For women who use substances while pregnant, cultural safety is a key factor that influences willingness to access services. As was stated before, one of the reasons women do not access care earlier on in their pregnancy is due to the treatment they have received by health care professionals either when they weren’t pregnant or with a previous pregnancy(ies). Pauly et al. (2013) discuss how nursing staff in hospital settings can make acute care more culturally safe for individuals who use illicit substances which entails five principles that should be followed.

**Principles of cultural safety.**

The first principle of cultural safety is acknowledging that discrimination and stereotypes do in fact exist in health care and influence how health care professionals interact with individuals who use substances (Pauly et al., 2013). Applying this principle to women who use substances when pregnant, would require health care providers to acknowledge that judgment does occur from health care providers and ideas of what constitutes “good” and “bad” parenting imposed upon women who use substances.

The second principle requires health systems to explore how hospital polices can negatively impact the accessibility of care, care experiences, and outcomes for people who use substances (Pauly et al., 2013). In the context of women who use substances while pregnant, a birth alert is often placed on women’s chart, which allows for negative judgement to be placed on the women before health care professionals even meet her.

The third principle means understanding that there are social inequities that affect people’s ability to access health care (Pauly et al., 2013). An example of this would be being mindful of which social determinants of heath may be underlying the health and social statues,
behaviours, decisions, and experiences of a woman who uses substances while pregnant. It also means understanding how these factors can affect a woman’s ability to attend appointments, reduce substance use, and be trusting of health care providers.

The fourth principle asks health care providers to, “…convey unconditional acceptance of patience regardless of their decisions or circumstances…” (Pauly et al., 2013, p.2). This means understanding that there are different world views on parenting and that there is no one way to be classified as a ‘good parent’. Even if a woman uses substances while pregnant, it does not automatically mean she will be a poor mother. Health care providers should explore the woman’s strengths and utilize these strengths throughout her care.

The final principle is to, “…treat patients with dignity and respect at all times “(Pauly et al., 2013, p.2). This is similar, if not identical to value one in the Canadian Association of Social Workers, *Code of Ethics* (2005), “respect for inherent dignity and worth for all persons” (p.4). This principle implores health care providers to respect women who use substances at all times during their hospital stay, and clearly positions shaming or making women feel bad for their substance use as inappropriate and unacceptable. Rather, health care providers should be looking at whether their current policies and procedures use a harm reduction approach (Pauly et al., 2013). If there are no such policies in place then policies should be revised appropriately (Pauly et al., 2013).

**Implications for Social Work**

Social workers work with women who use substances in a variety of settings. When working with women who use substances while pregnant, it will be important to understand which biopsychosocial factors have influenced and continue to influence substance use. I have found that within social work, the well-being of a child is always considered, but little
consideration is given to the mother’s needs as well. Arguably within social work, a person-centered and strengths-based approach should be taken with women who use substances. As stated, earlier women who use substances often avoid accessing services due to fears of child apprehension, negative judgment, and poor previous past experiences. Support and health care services often do not address the unique needs of women, let alone those who use substances while pregnant. The Canadian Association of Social Workers (CASW) (2005a) value two of the Code of Ethics clearly states that:

…Social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand choice for all persons, with special regard for those who are marginalized, disadvantaged, vulnerable, and/or have exceptional needs. Social workers oppose prejudice and discrimination against any person or group of persons, on any grounds, and specifically challenge views and actions that stereotype particular persons or groups (p.9).

Value two clearly highlights that social workers must promote equitable distribution of resources and reduces barriers to such resources. It also highlights that social workers must challenge views that stereotype groups of people. Women who use substances arguably encounter multiple negative stereotypes, such as they are inadequate parents, careless, and irresponsible. For services to be improved, and barriers to be reduced, the profession of social work especially within child welfare, community clinics and hospital settings will need to re-evaluate the way women who use substances are perceived and treated. When reflecting back on the interviews of the women from the quality improvement project, one woman mentioned how she was told at the beginning of the pregnancy by a child protection worker that she would have no chance of keeping her baby. The approach taken by the child protection worker was far from trauma-
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informed and essentially unethical. This approach taken by the child protection worker could ultimately be contributing to the increasing rates of children coming into care. It is recommended that not only social workers take a more trauma-informed care approach, but also take a step back and try to understand how the current system they work in, as well as their own personal beliefs, can be harmful and pose a risk of traumatizing or re-traumatizing the individuals they work with.

Another implication is that further education is needed within health care and child welfare systems on how women who use substances experience structural violence within the systems social workers are employed. Bachelor of Social Work courses should also make it a requirement for social work students to learn more about trauma, mental health, and addiction issues. As value one states, “Social workers uphold the right of every person to be free from violence and threat of violence” (CASW, 2005a, p.9). By not addressing the personal, intergenerational, and structural violence women who use substances while pregnant encounter, social workers are aiding in the trauma our systems create versus improving women’s experiences. More specifically, 4.1.4 of the Guidelines for Ethical Practice states that:

Social workers appropriately challenge and work to improve policies, procedures, practices and services that are not in the best interest of the clients, are inequitable, are in any way oppressive, disempowering or culturally inappropriate, and demonstrate discrimination (CASW, 2005b, p.40).

Social workers should consider reviewing their place of employment’s policies, procedures and practices and advocate to change those that are not trauma-informed. As uncovered by the quality improvement project, women are missing out on opportunities to improve their quality of life. Instead of reducing the risk that a mother and baby may have, social workers and
organizations are aiding in greater risk to occur for women due to the lack of harm reduction and trauma-informed care approaches. As a profession, there needs to be more accountability for the actions of social workers in all systems, especially those in child welfare and health care settings.

Currently, social workers in the Saskatchewan Health Authority are mandated to be a registered with the Saskatchewan Association of Social Workers (SASW); however, those working in child welfare are not. Having social workers registered with SASW is one mean to try and keep social workers accountable for engaging in ethical and non-harmful practice. If unethical practice occurs, it is the role of SASW to hold the social worker accountable, along with the organization that the social worker is employed. Accountability should also be upheld by supervisors and management to ensure that social workers are following policy and procedures, as well as upholding the *Code of Ethics*. One way to do this is by having reviews every six months or annually with each worker. If policies and procedures do not correlate with the *Code of Ethics*, it is the responsibility of the social worker to advocate for change around such policies and procedures. Working in health care, I know there are often issues around time constraints; however, we are creating more work for ourselves and the system by not holding one another accountable.

Arguably, social workers should take a harm reduction approach, due to its person-centered approach qualities. This entails working on goals women have created for themselves versus goals the social worker has created, which correlates with our *Code of Ethics*. As stated earlier, harm reduction recognizes that mental illness and trauma often intersect in women who use substances lives. Harm reduction also correlates with the CASW *Code of Ethics*, as social workers are supposed to aim to reduce barriers to services for vulnerable populations.
Conclusion

Overall, what I have learned from my practicum is that our health care system within Canada, and globally, tends to penalize women who use substances when pregnant, through negative assumptions, poor treatment and harmful policies. For health care to be less traumatizing or re-traumatizing for women who use substances while pregnant, a critical shift to a trauma-informed approach will need to occur. Such a shift entails health care providers being mindful of the multiple ways women who use substances experience violence. More specifically, part of trauma-informed care means taking a universal precautions approach, which means, “…operating as if every [woman] who comes into our care has experienced a traumatic event.” (Marcellus 2014, p.310). When it comes to prenatal and childbirth related services, there is some positive work that is being done; however, women continue to have poor experiences that reinforce fears, or create new ones, for future births. The quality improvement project revealed that further education is needed amongst health care professionals around the use of methadone, and why women continue to use substances while pregnant. It also revealed that there needs to be a shift to trauma-informed approaches, and that current policies and procedures within our health care system need to be challenged. Given the current evidence that harm reduction programs in Canada are effective, community and inpatient settings should strongly consider re-evaluating policies, procedures, and practices that are not trauma-informed as women continue to hide pregnancies, feel ashamed, and are traumatized or re-traumatized due to the care they received. Trauma-informed care would also benefit the staff of such organizations as it acknowledges that people working within systems may have their own trauma story, which then influences their interactions with clients and patients. For any change to occur within our
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systems, health care providers will need to take a critical shift to a trauma-informed care lens in order to provide the quality of care women who use substances deserve.
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APPENDIX 1: Interview Guide

Interview Guide

To keep the information shared in the interview as confidential as possible, I would encourage you to try and not use or state your name at anytime or state any identifying factors throughout the interview. This insure that’s the information gathered throughout the interview can not be linked back to you unless you chose it to be. If at any time you are uncomfortable with a question, we can skip over it and return to it later if you chose. You do not have to answer all the questions. As stated in the consent form, you are also able to stop the interview at any time. If you have any questions or concerns during or after the interview, feel free to let me know and we can address them.

Questions

What was your experience with accessing prenatal care?

How, if anything, could have your experience been improved?

How has your experience been accessing childbirth related services?

How, if anything, could have your experience been improved?

When you hear the term ‘high risk’ pregnancy how does that make you feel?  
- Is there another word you would use?

What do you hope to see offered in the future for women and their children?
APPENDIX 2: Consent Form for Quality Improvement Project

**Project Title:** HIGH-RISK WOMEN’S EXPERIENCES OF PRENATAL AND CHILDBIRTH RELATED SERVICES IN THE SASKATCHEWAN HEALTH AUTHORITY

**Project Team:**
- Shannon Hurley, Graduate Student
  Public Health Observatory, Population & Public Health Services
  Faculty of Social Work, University of Regina
  hurley2s@uregina.ca | 306-291-0144
- Erin Beckwell, Practicum Supervisor
  Public Health Observatory, Population & Public Health Services
  erin.beckwell@saskatchewanhealthauthority.ca | 306-655-3448
- Bonnie Jeffery, Academic Supervisor
  Faculty of Social Work, University of Regina
  bonnie.jeffery@uregina.ca | 306-953-5311

**What is this project about?**

As a graduate student with the Public Health Observatory, Population and Public Health Services with the Saskatchewan Health Authority, this project aims to better understand the approaches taken within prenatal and childbirth related services when working with women who are considered to have high-risk pregnancies (HTV positive, using substances, or both), and how services can become more trauma-informed.

By sharing your story, we hope to highlight current issues and recommend changes that can be made throughout the Saskatchewan Health Authority to have women who are considered ‘high-risk’ more comfortable accessing prenatal and childbirth related services.

Quotes or statements may be pulled from the audio recordings and used for staff education, or to recommend policy, programs, or procedures changes within prenatal and childbirth related services.

**How do I share my story?**

You will meet with Shannon (graduate student) for one to two hours at a place of your choice were confidentiality can be maintained. In order to insure your story is shared accurately, it will be audio recorded. There will be a semi-structured interview guide, and you will be asked to share part of your story about accessing prenatal and childbirth related services. How much you share is up to you, and you may stop at any time. You are welcome to have a support person with you during the interview.
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Are there risks involved?

Sharing your experiences with accessing prenatal and childbirth related services may be upsetting at times. You may skip questions and stop the interview at any time.

How will sharing my story benefit me?

You will not receive a direct benefit by participating but may find it rewarding in terms of contributing to future policy changes and improving prenatal and childbirth related services for women who are considered to have ‘high-risk’ pregnancies.

Will I be paid for my time?

Yes, you will receive a honorarium of $20.00.

How will you make sure my identity is protected?

The audio recording of your interview will be kept in a secured place, locked office, or on a computer device with a password, to which we (myself and my supervisor) have access. You can create another name for yourself which we will use when sharing your story, or if you want, we can do this for you. This will help us share direct quotes from your story. Any specific identifying part of your story, such as your health information or location, will be removed or changed.

What if I want to end my relationship with this project?

Participation is voluntary, so if at any time you wish to not to have your story used you may withdraw from the project. We will begin compiling stories at the end of March 2019. It is possible that after this time that some of your story will have been written up and/or presented.

Where do I go if I have questions about the project?

To obtain copies of the written or audio materials collected during your interview, please contact Erin Beckwell at the telephone number or email address listed on page 1. If you have questions about the project, please contact the Shannon Hurley (researcher) or Erin Beckwell. This project has been approved on ethical grounds by the University of Regina Research Ethics on April 9th, 2019. Any questions regarding your right as a participant may be addressed to the committee at (306)-585-4775 or research.ethics@uregina.ca. Out of town participants may call collect.
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SIGNED CONSENT (completed by participant)

Your signature below indicates that you have read and understand the information provided. I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the project. A copy of this Consent Form has been given to me for my records.

________________________________________  _________________________________  ____________
Name of Participant                      Signature                                    Date

________________________________________
Researcher’s Signature                  Date

ORAL CONSENT (completed by researcher)

I have read and explained this Consent Form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it.

________________________________________  _________________________________  ____________
Name of Participant                      Researcher’s Signature              Date

A copy of this form will be left with you, and a copy will be taken by the researcher.
APPENDIX 3: Research Ethics Board Certificate of Approval

The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, or related documents.

Any significant changes to your proposed method, procedures or related documents should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for the renewal and closure forms:
https://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/ethicsforms.html

Chris Street PhD
REB Chair
University of Regina
APPENDIX 4: Operational Approval from the Saskatchewan Health Authority

April 24, 2019

Shannon Hurley
Faculty of Social work, University of Regina

Study Title: High-Risk Women's Experiences of Prenatal and Childbirth Related Services in the Saskatchewan Health Authority
File Number: OA-UofR-2019-043

Authorization Granted By:

- Jacki Veregin, Manager Healthy Mother Healthy Baby Saskatoon
- Terry Ann Keenan, Manager, KidsFirst Saskatoon

RE: LETTER OF AUTHORIZATION TO CONDUCT RESEARCH

Dear Ms. Hurley,

This letter is to notify you that the above-listed research study has been reviewed and meets all criteria for Operational Approval within the Saskatchewan Health Authority (SHA).

Please note that Operational Approval is conditional upon continued review and approval by the Research Ethics Board (SHA, U of R or U of S). Should Research Ethics approval lapse or be revoked, Operational Approval will also be suspended. In addition, Operational Approval is issued based upon the details provided in the Operational Approval to Conduct Research Application Form. Should the resource utilization deviate from what was requested in the initial application, Operational Approval may be revoked and an amendment must be submitted for review. Any publications or presentations that result from this research should include a statement acknowledging the assistance of the Saskatchewan Health Authority.

This letter serves as your official authorization to conduct research; study activities may now commence.

If you have any questions, please contact the Research Approval Coordinator, Jenny Wang, at 306-766-0893 or ResearchApproval@rrqhealth.ca

Sincerely,

[Signature]

Elan Paluck, BSP, MSc, PhD
Director of Research
Saskatchewan Health Authority | 306-766-5209 | Cell: 306-539-4620