Profiles in Social Work

Episode 12 – Jennifer Gibbins-Muir

Intro - Hi, I'm Charmaine Williams, Associate Professor and Associate Dean, Academic, for the University of Toronto, Factor-Inwentash Faculty of Social Work. Welcome to Profiles in Social Work. This podcast series is produced by our Faculty and Alumni Association. In 2014 the Factor-Inwentash Faculty of Social Work is celebrating 100 years of contributing to Social Work Practice and Education. You can find out more about us by visiting us online at www.socialwork.utoronto.ca We're glad you could join us today. The series Profiles in Social Work highlights how social workers are making a positive difference in our communities by presenting stories of how social work graduates are using their degrees. We hope you will enjoy this series. Especially if you are thinking about a career in social work or interested in hearing about what social workers do.

Profile – Jennifer Gibbins-Muir

My name is Jennifer Gibbins-Muir and I graduated from the Factor-Inwentash Faculty of Social Work in 2001.

From a very young age I very much wanted to hear people's stories and try to offer support to people who were going through very difficult times in their life so very early on I remember getting involved as a student in a mentorship programs and different peer groups and then just slowly over time through volunteering I just really felt that I had this connection with people. So when I was in my undergrad program I did a lot of work in the corrections system and met a social worker who was providing support services to inmates and that really opened the door to a world that I didn't even know existed in social work. I soon learned that there was much more to social work than just child welfare. I decided to apply to social work and that lead me to U of T and that's essentially how I got involved.

Coming from an undergraduate experience in a small town I think I was struck by this huge city, just the diversity of the city and being part of the University of Toronto, that was very appealing to me. I was also really looking at getting the most out of my practicum and I felt very strongly that being in Toronto and the wealth of practicum options was just far superior than some of the smaller graduate programs in social work.

Definitely there were a few classes, but the bulk of my clinical skills was learned and obtained through really great practicum experiences and field instructors. There were a few professors in the program that I really connected with as well and it was through their instruction and watching them do social work that stands out.

I was very fortunate. I have been at the same setting since I graduated and I work in a very large hospital in the mental health program. I do a combination of inpatient work and outpatient psychotherapy and I work with adults who are living with severe persistent recurrent mental health issues. Some of the work is more about resource counseling, building of supports, but the bulk of the work I do is with families and individuals providing psychotherapy caregiver support, looking at interpersonal relationships with family members and that is the bulk of what I do.

I do run a variety of groups as well for the inpatients, more like skills building groups as well as some recreation based, relaxation and stress management and just trying to introduce a notion of finding meaning and having a spiritual connection as part of the recovery process.

I work with adults, men and women ages eighteen all the way up to sixty-five who come through our emergency department. They may be homeless; they may be very, very successful people, so people from all walks of life; Every cultural background, every socioeconomic region. They come from our emergency department into our inpatient program and they may be suffering with a range of mental health difficulties; suicidality to self-harming behavior, depression, all the way up to bi-polar disorder or schizophrenia. So there's a huge range of mental health conditions that present themselves and many times we get some familiar faces and that just really speaks to the recurrent nature of the illness and just how difficult it is often for people to cope with mental health issues.

I think in the last several years there has been this push to reduce lengths of stay in the hospital and really pump up resources in the community, in part because it's cost efficient, it's more cost effective. But also to try to normalize mental health and not present it in such a way as to scare people and send a message that people with psychiatric histories have to be locked up. That's kind of the history of why things lead to more community based mental health support. That being said there's a huge lack of services particularly for people who have the more serious mental health conditions like schizophrenia or bipolar disorder or concurrent mental health and addictions problems. Really the goal of an inpatient setting is for patients to come into hospital and really try to provide them an environment that will stabilize the symptoms and often times doing

that in a kind of a contained inpatient setting is more helpful than out in the community setting. You can treat symptoms much more aggressively, so much faster in the hospital than in a community setting when perhaps they may just see a doctor or social worker once every several weeks. And also, just having access to an interdisciplinary team, so not just seeing a psychiatrist or family doctor once every several weeks but having access to social work services or an occupational therapist, pharmacist, spiritual care advisor, that holistic approach to treatment is often missing in the community. I think again, there's a shift to that more holistic approach. Still there's a ways to go. There are certainly benefits to hospital based treatment.

When I work with patients in the program, so as inpatients, I would follow them from the point of entrance, so I try to start engaging with them from day one or two. My goal is just to be present and to offer support while they're, you know, adjusting to being in hospital. They may have a range of emotions, they may be angry that they're there against their will, cause that often happens, trying to validate that and just try to make it as easy as possible. And then as the symptoms stabilize, as patients are improving in their recovery, I can try to sort out "what are their needs?" "what do their support systems consist of?" "Are they interested in enhancing their support networks?" "do they need housing?" "Do they need money?" "Do they need the very basics?" It's not uncommon for patients to come to us with literally nothing. No shoes, no money, no identification. Sometimes I feel like a detective or a PI trying to track down family or try to figure out "Who is this John Doe?" he may or may not give us his real name so often it takes time to sort that all out. There are times as patients improve that there may be a role for psycho-education trying to increase the awareness of what it is they are going through and try to normalize that whole experience. They could be grieving living with a label of some kind of mental illness and what does that represent to them, "what does that mean to them?" "How do they see their future?" It may look very, very bleak and offering support through that. If there is family or friends involved, providing them with knowledge about the illness symptoms or where to go for help "what are red flags that things may not be going well?" Developing a safety plan. "Who do they call at two in the morning if the client is psychotic?" By week three or four if the patient is still in hospital, there's a very clear plan for them when they leave so families know what to look for in terms of symptoms, a patient knows where they're going to be going when they leave, they have access to follow-up, they have a place to go if they want it. We really try to follow the client or the patients lead and that often can be very difficult. It is not uncommon for patients to decline all of our efforts to provide help. It's not uncommon for patients to leave without a home, or without money, without clothing. A lot of the time providing psychotherapy, hardcore psychotherapy, really getting into issues isn't

conducive for inpatients for a variety of reasons. They may be too ill, they may not be interested, they may already have a therapist. So the bulk of the psychotherapy happens with outpatients. I have some patients I follow once they're discharged they'll come to see me every week for a variety of reasons related to family stress or they may be struggling with something from their childhood or adolescence they could be trying to work out a variety of issues and just need some help and support while they go through that process. And for some clients just having that connection to the hospital could be quite supportive knowing that when they leave there is continuity of care. That they can come back and touch base with the mental health professional.

The rewards far exceed the challenges. It's difficult work and that's when the support of your colleagues and other supports that I build up in my personal life is so important, because you want to protect from burnout. But the rewards: when you watch a patient slowly invite you in, when they are willing to tell you their story. It's just, it's difficult to describe but it just makes all of the stress, the frustration, worthwhile, because you see this person beyond the symptoms, behind the label and they, for the most part, are very receptive to people wanting to help them. I also feel very valued by my colleagues. I think I have the luxury in mental health of feeling like what I contribute is very valued and very respected by not only clients but by the psychiatrists and the nurses and everybody else on my team. That's very rewarding; And having the flexibility to really define role on the ward. When I started there were no groups. I asked for the opportunity to provide psychotherapy ongoing because I saw a gap, not knowing if the plans that we made together, whether they actually happened or if they got lost in this system that is, in mental health, you know sitting on waiting lists for months and months and not knowing if they're connected to supports when they leave. So seeing that gap and being given permission to provide ongoing support to patients has been hugely beneficial for me but also for the program.

The field of social work is so vast and the opportunities are so rich. You can work in a hospital, you can work in private practice, you can work in forensics, you can work in child welfare. There's just so many opportunities that if you don't take the time to learn about it you'd never know. You can literally work on the streets. For people who are considering a career in social work you have so many opportunities, particularly being at U of T, there's just so many experiences at your fingertips that you probably have no idea are there waiting for you. Certainly take the time, ask the questions. Make sure you get what you really want out of your time at U of T in the program. Self-directed learning.

Being a social worker to me means I can really feel like I'm wearing many different hats and juggling many different priorities at the same time. Really knowing that I have the privilege, the real privilege of working with people who may not have ever accepted help before or wanted it, and just feeling very privileged to have that opportunity to connect with people that may not have ever been given support before.

Outro - This is Charmaine Williams from the University of Toronto Factor-Inwentash Faculty of Social Work. Thank you for listening to our podcast. In 2014 our school is celebrating 100 years of social work research, teaching and community service. For more information about the faculty and our programs we invite you to visit our website at www.socialwork.utoronto.ca