

Trauma-Informed Practice Guide

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The Trauma-Informed Practice (TIP) Guide and TIP Organizational Checklist are intended to support the translation of trauma-informed principles into practice. Included are concrete strategies to guide the professional work of practitioners assisting clients with mental health and substance use (MHSU) concerns in British Columbia.

The TIP Guide is based on: findings from current literature; lessons learned from implementation in other jurisdictions; and, ideas offered by practitioners who participated in focus groups and interviews in 2011 in each of the BC Health Regions. In these 2011 consultations, practitioners described the work they were already doing to address the needs of clients with trauma concerns and provided insights on what else might be useful at practice and system levels.

In 2012, the BC TIP Project Team again gathered feedback from practitioners and leaders in Health Regions in BC on this TIP Guide and the TIP Organizational Checklist.

An important goal of the TIP Guide and Checklist is to build on what is already working for individuals, practitioners and programs. It is not about replacing existing good practices; rather, it is about refining existing practices and informing mental health treatment professionals about trauma-informed approaches.

The project has the full endorsement of the Provincial Mental Health and Substance Use Planning Council and leadership at all levels of the BC MHSU system of care.

The TIP Guide is built on the important distinction between *trauma-informed* and *trauma-specific* services.

Trauma-informed services	Trauma-specific services
Work at the client, staff, agency, and system levels from the core principles of: trauma awareness; safety; trustworthiness, choice and collaboration; and building of strengths and skills.	Are offered in a trauma-informed environment and are focused on treating trauma through therapeutic interventions involving practitioners with specialist skills.
Discuss the connections between trauma, mental health, and substance use in the course of work with all clients; identify trauma symptoms or adaptations; and, offer supports and strategies that increase safety and support connection to services.	Offer services that are based on detailed assessment to clients with trauma, mental health, and substance use concerns that seek and consent to integrated treatment.

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TRAUMA-INFORMED PRACTICE IN THREE SETTINGS

To bring trauma-informed practice to life, we begin with three service examples illustrating different aspects of implementing trauma-informed practice in Canada [7].

SETTING: Women’s Residential Substance Use Treatment Program

In the early 1990s, the Jean Tweed Centre in Toronto began to incorporate a trauma-informed approach after clinical reviews confirmed that more than 80% of their clients had experienced abuse. The Centre began by providing training on trauma and its connection to substance use problems. The Centre continues to maintain ongoing agency-wide training, for clinical and non-clinical staff, as all staff members contribute to an overall atmosphere of safety. Four key principles shape the trauma-informed work at the Centre: avoiding re-traumatization, empowering women, working collaboratively with flexibility, and recognizing trauma symptoms as adaptations. The Centre’s trauma-informed work is based on the understanding that symptoms related to trauma are coping strategies developed to manage traumatic experiences. For example, prior to adopting a trauma-informed approach, aggressive or hostile client responses might have been perceived in a negative way; the women exhibiting these responses were seen as “difficult clients.” By viewing these behaviours through a trauma-informed lens, the Centre’s staff members see these types of responses as coping strategies and support clients in a non-judgmental way that avoids shaming. Today, all services at the Centre (inpatient, outpatient, and outreach) are informed by the perspective that substance use and trauma are connected; therefore, all interactions are guided by a welcoming, non-judgmental approach.

SETTING: Community Based Services – Linking Training and Cross Referrals

The Victoria Women’s Sexual Assault Centre (VWSAC) in Victoria, BC has a mandate of healing, education, and prevention of sexualized violence and has provided intervention and prevention services since 1982. They have undertaken community liaison through educational initiatives with partner organizations that provide community services such as housing, youth-oriented health services and reproductive health services. In 2008, VWSAC created the Trauma-Informed Practice and Support training (TIPS) in an effort to increase the community’s capacity to effectively respond to survivors of sexualized violence and trauma. Community support workers often interact with clients who disclose histories of trauma but who are not interested in, or ready for trauma counselling, as well as clients with substance use or mental health issues that seem to have roots in traumatic experiences.

The goal of providing training to community partners was to ensure that clients would receive trauma-informed care in as many places as possible, with support that consistently integrated an understanding of trauma into every interaction. Since implementing TIPS, over 250 service providers have participated in training provided by community organizations including the Victoria Immigrant and Refugee Centre Society, Boys and Girls Club, Child and Family Counselling Association, Victoria Native Friendship Centre, Threshold Housing Society and the YWCA.

SETTING: Inpatient Psychiatric Hospital Unit

In 2008, the Centre for Addiction and Mental Health (CAMH) in Toronto shifted its focus from restraint reduction to restraint prevention. To undertake this shift, they employed a trauma-informed approach. Many clients who enter inpatient psychiatry units have been abused or have experienced other forms of trauma. For decades, restraints have been used for safety purposes, yet the use of restraints can be unsafe, harmful, and traumatizing, especially for clients with histories of trauma. CAMH's trauma-informed approach to restraint prevention is an upstream approach, where the root causes of aggression are addressed before situations become critical. Many specific prevention initiatives have been implemented:

- Implementing new staff development programs that focus on crisis intervention and emphasize prevention and trauma-informed care through core clinical competencies and inter-professional collaboration
- Creating welcoming and open environments where staff members routinely check in with clients about their comfort

- Developing safety plans for all clients to identify triggers, emotions, and coping strategies to prevent and manage crises
- Allowing for greater flexibility and client input when establishing norms and rules; providing alternative ways to promote a sense of calm and safety such as art, deep breathing activities, or aromatherapy; and
- Debriefing clients after an incident of seclusion or restraint to promote healing, recovery, and learning, as well as re-establish the therapeutic relationship.

Because of these initiatives, the use of mechanical restraint decreased from 4.2% (2008-2009) to 2.2% (2010-2011); the use of seclusion decreased from 5.3% (2008-2009) to 3.4% (2010-2011); and the use of chemical restraint decreased from 4.8% (2008-2009) to 3.0% (2010-2011). Trauma-informed care influenced CAMH in providing the best care in a dynamic healthcare environment.

1. OVERVIEW

1.1 Project Objectives

This TIP Guide and Organizational Checklist are part of a trauma-informed practice project with the following objectives:

- To enhance awareness among practitioners and organizations who deliver mental health and substance use (MHSU) services in BC for clients with histories of violence and trauma.
- To identify current efforts by MHSU services in BC to provide trauma-informed and trauma-specific interventions and to increase awareness of evidence-based practices being employed in other jurisdictions.
- To increase capacity amongst MHSU practitioners and organizations to better serve people impacted by violence and trauma and thereby improve outcomes for clients of MHSU services in BC.

1.2 The Foundations of the TIP Guide

The TIP Guide is the result of collaboration and consultation between the BC Ministry of Health, the BC Centre of Excellence for Women's Health, the BC Ministry of Children and Family Development, BC Health Authorities, representatives from anti-violence organizations and MHSU service providers across the province.

The TIP Guide incorporates both academic and practice-based knowledge. The academic literature provides a view of the growing body of evidence on the nature and impact of trauma, yet there are limited studies related to the implementation of trauma-informed practice. On the other hand, a significant number of reports and manuals are available where practitioners from housing, child services, and related services have described their work implementing trauma-informed practice (See *Appendix 7*). MHSU practitioners in British Columbia provided rich contextualized views into their work to enact trauma-informed practice. In focus groups and interviews, BC practitioners, researchers, and system planners were particularly attentive to the diverse experiences of trauma affecting Aboriginal people, men and boys, girls and women, gay, lesbian, bisexual and transgendered people, veterans, refugees, and people with injuries and disabilities. As a result, the TIP Guide is grounded in evidence from research, policy, and clinical practice, with the goal of advancing the integration of trauma-informed practice at all levels: in individual practice, in organizations, and across systems.

1.3 Intended Audience

The TIP Guide is designed to inform the work of health system planners and practitioners working with adults and youth with substance use and mental health concerns. The TIP Guide may also be useful to other professionals such as primary healthcare providers, hospital emergency departments, first responders and those working with families in the child welfare system.

1.4 The Benefit of this TIP Guide

Practitioners have identified the importance of recognizing the impact of trauma on people accessing MHSU services, and of responding effectively and compassionately at the practitioner level, organizational level, and through wider collaboration across systems and sectors. The literature underscores the continuing urgent need for services to address the impact of violence and trauma in an individual's life.

While there is keen interest in and commitment to providing trauma-informed practice, strategies for implementing trauma-informed practice are not well articulated. The TIP Guide provides feasible strategies for practitioners and system planners for applying what we know about trauma-informed practice. It is intended to support engagement with principles and practices of trauma-informed practice that can be reinforced and explored further in training initiatives.

2. UNDERSTANDING TRAUMA

2.2 Definitions

The TIP Guide defines trauma as experiences that overwhelm an individual's capacity to cope. Trauma early in life, including child abuse, neglect, witnessing violence and disrupted attachment, as well as later traumatic experiences such as violence, accidents, natural disaster, war, sudden unexpected loss and other life events that are out of one's control, can be devastating.

There are a number of dimensions of trauma, including magnitude, complexity, frequency, duration, and whether it occurs from an interpersonal or external source. These dimensions can be seen in the descriptions of the following five types of trauma:

Single incident trauma is related to an unexpected and overwhelming event such as an accident, natural disaster, a single episode of abuse or assault, sudden loss, or witnessing violence.

Complex or repetitive trauma is related to ongoing abuse, domestic violence, war, ongoing betrayal, often involving being trapped emotionally and/or physically.

Developmental trauma results from exposure to early ongoing or repetitive trauma (as infants, children and youth) involving neglect, abandonment, physical abuse or assault, sexual abuse or assault, emotional abuse, witnessing violence or death, and/or coercion or betrayal. This often occurs within the child's care giving system and interferes with healthy attachment and development.

Intergenerational trauma describes the psychological or emotional effects that can be experienced by people who live with trauma survivors. Coping and adaptation patterns developed in response to trauma can be passed from one generation to the next [11].

Historical trauma is a cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma. These collective traumas are inflicted by a subjugating, dominant population. Examples of historical trauma include genocide, colonialism (for example, Indian hospitals and residential schools), slavery and war [12, 13]. Intergenerational trauma is an aspect of historical trauma.

2.3 Effects of Trauma

Reactions to trauma vary from person to person, from minor disruptions in an individual's life, to debilitating responses. Across the continuum, people may experience anxiety, terror, shock, shame, emotional numbness, disconnection, intrusive thoughts, helplessness and powerlessness. An important variable is the age at which the trauma occurs. For children, early trauma can have especially negative consequences, impacting the development of the brain and normal developmental progression. Memory is often affected—people may not remember parts of what happened, but at the same time may be overwhelmed by sporadic memories that return in flashbacks. Nightmares, depression, irritability, and jumpiness are common. All of these responses can interfere with an individual's sense of safety, self, and self-efficacy, as well as the ability to regulate emotions and navigate relationships.

The physiological adaptations that some people develop in response to trauma and to perceived ongoing threats produce a underlying state of “dysregulation”—difficulty controlling or regulating emotional reactions or behaviours, and/or an imbalance in the body, which often results in hyperarousal and hypervigilance (in which an individual seems to overreact to every situation) or listlessness and dissociation (in which an individual seems numb and disconnected in stressful or dangerous situations). This dysregulation of the brain and body systems perpetuates mental, emotional, and physical distress.

Physical health also is affected: trauma survivors may experience chronic pain, gynaecological difficulties, gastrointestinal problems, asthma, heart palpitations, headaches and musculoskeletal difficulties. Chronic danger and anticipation of violence stresses the immune system and can lead to an increased susceptibility to autoimmune disorders such as chronic fatigue and other illnesses.

Post-Traumatic Stress Disorder (PTSD) is one type of mental health disorder that can result from trauma [14]. Experiencing symptoms from three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms are central to the current diagnostic criteria for PTSD.

The Centre for Addiction and Mental Health have published definitions and descriptions of responses to trauma that support awareness among clients of substance use services [15] and for service providers [16, 17]. *See following table for a brief summary of these.*

Common Questions About Trauma

This pamphlet explains trauma and its effects in plain language and can be a useful resource to share with clients.

www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/commonquestionsabouttrauma.html

Bridging Responses: A Front-Line Worker's Guide to Supporting Women Who Have Post-Traumatic Stress

This guide to providing trauma-informed services was written for front-line workers who work with women in a variety of settings. It provides information about the responses women can have to trauma and how to recognize these responses. Additionally, it includes practical information on trauma-informed interventions and referrals.

www.camh.net/publications/camh_publications/bridging_responses.html

First Stage Trauma Treatment: A Guide for Mental Health Professionals Working With Women

This book gives therapists key information and strategies to help women clients develop fundamental skills to manage the responses to complex post-traumatic stress, such as depression, chronic anxiety, substance use problems, self-harming behaviour, suicidal thoughts and feelings of self-hate and emptiness. With this foundation, women can move to other stages of treatment that involve exploring the traumatic events in more depth and working on other issues in their lives.

http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/first_stage_trauma/Pages/default.aspx

2.4 Connections to Substance Use and Mental Health Concerns

Trauma can be life changing, especially for those who have faced multiple traumatic events, repeated experiences of abuse, or prolonged exposure to abuse. The experience of even one traumatic event can have devastating consequences for the individual involved.

Trauma is common

Among all Canadians:

- 76% of Canadian adults report some form of trauma exposure in their lifetime, 9.2% meet the criteria for PTSD [1]
- An estimated 50% of all Canadian women and 33% of Canadian men have survived at least one incidence of sexual or physical violence [2]

Among people in BC seeking/needing help with substance use and mental health concerns:

- 63% of women entering treatment for substance use problems at the Aurora Centre indicated that they had experienced physical violence, and 41% had experienced sexual violence [3]
- 44.6% of participants in the North American Opiate Medication Initiative (NAOMI) in Vancouver reported a history of physical or sexual abuse, and 62.5% reported emotional abuse [4]
- Very high rates of trauma and PTSD have been found in people with serious mental illnesses [5]. 58% of women at Riverview Psychiatric Hospital had been sexually abused as children [6]

Among BC youth with substance use and related risks:

- As many as 25% of youth engaging in addictions services reported a history of trauma, according to VIHA data

Among people experiencing homelessness in BC:

- 51% of homeless people from three BC communities interviewed reported childhood sexual abuse, 55% reported physical abuse, 60% reported neglect, 58% reported emotional abuse; and 57% met the criteria for current PTSD [8]

Among Canadians with mental health and substance use concerns beyond BC:

- 90% of women in treatment for alcohol problems at 5 Canadian treatment centres indicated abuse-related trauma as a child or adult; 60% indicated other forms of trauma [9]
- 90% of females and 62% of males youths in co-occurring disorders treatment at CAMH endorsed concerns with traumatic distress [10]

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The American ACE study looked at the life histories of over 17,000 people to determine the connections between adverse childhood experiences and health in adulthood [18]. They looked at eight categories relating to abuse and to growing up in dysfunctional households (including witnessing violence against their mother). The study found that adverse childhood experiences were vastly more common than recognized, often coexisting and directly linked to later life substance use and mental health problems, as well as a range of chronic diseases such as diabetes [19, 20].

Clinicians working with trauma survivors have also identified that these clients tend to experience significantly more co-occurring mental health difficulties, such as depression, sexual dysfunction, dissociation, anger, suicidality, self-harm, as well as substance use problems and addictions, than people experiencing mental health problems without trauma histories [21].

To meaningfully facilitate change and healing, it is important for MHSU service providers to help people make the connections between their experience of trauma and their problematic MHSU concerns [22]. System planners and service providers can make a significant positive difference in client engagement, retention, and outcomes by making MHSU services emotionally and physically safe. It is also important to create opportunities for learning, build coping skills, and provide clients with the experience of choice and control.

A multi-site study at nine women's treatment locations, funded by the Substance Abuse Mental Health Services Administration (SAMHSA) in the US, found that integrated, trauma-informed models of substance use and mental health treatment for women were more effective than treatment that was not trauma-informed, and did not result in increased service costs [23]. This study tested specific models of integrated approaches (such as Seeking Safety [24]), generated principles for trauma-informed practice [25], effectively included consumer voice [26], and identified approaches to "relational systems change" [27].

2.5 Trauma and Potential for Misdiagnosis

It is very common for people accessing MHSU services to report prior experiences of trauma and violence. Often people who have experienced trauma see their use of substances as beneficial, as helping them “to cope” with trauma-related stress. Unfortunately, this seemingly adaptive coping mechanism can make people more vulnerable to substance use problems.

When service providers do not bring an understanding of trauma and how certain symptoms demonstrate an attempt to cope with trauma, misdiagnosis and inadequate treatment can result. For example, without applying a trauma lens, coping mechanisms may be given diagnoses such as bipolar disorder, and treated primarily with anti-depressant medications [28]. In other cases, borderline personality disorder can be inaccurately diagnosed, especially among women who have experienced trauma [29]. Behaviour problems in children and youth, which may have developed as a way to cope with past trauma, may be diagnosed as attention deficit hyperactivity, oppositional defiant, and conduct disorders.

It can be helpful for service providers to understand that people with complex PTSD do not have symptoms that comprise multiple diagnoses, but represent the complex physical, emotional, cognitive, interpersonal, spiritual, and behavioral effects of trauma [30, 31]. The lens of complex trauma can provide a conceptually coherent view of symptoms as a basis for compassionate treatment planning [29].

3. TRAUMA-INFORMED APPROACHES

The MHSU sector is increasingly aware of the need for a continuum of services that includes both specialized and non-specialized MHSU services *and* involves multidisciplinary and multisectoral approaches, to better respond to the acuity and chronicity of these types of problems [32]. Trauma-informed practice builds on this by recognizing the need to respond to an individual's intersecting experiences of trauma, mental health, and substance use concerns. A trauma-informed approach acknowledges that this is achieved not only in specialized services that specifically treat trauma but also in practical, attuned ways at all levels of support and care, across all settings. For children, developmentally appropriate options need to be considered in collaboration with their families/caregivers. Definitions of trauma-informed and trauma-specific services are provided below.

3.1 Trauma-Informed Services

Trauma-informed services take into account an understanding of trauma in all aspects of service delivery and place priority on the individual's safety, choice, and control [33]. Such services create a treatment culture of nonviolence, learning, and collaboration [34].

Utilizing a trauma-informed approach does not necessarily require disclosure of trauma. Rather, services are provided in ways that recognize the need for physical and emotional safety, as well as choice and control in decisions affecting one's treatment. Trauma-informed practice is more about the overall essence of the approach, or way of being in the relationship, than a specific treatment strategy or method.

At the same time, determining if trauma has occurred is important when working with children who are developmentally vulnerable and have a right to protection from harm under the law. If a service professional suspects that the child may have experienced abuse that has not been reported to authorities, they are required to report to Child Welfare and/or police.

In trauma-informed services, safety and empowerment for the service user are central, and are embedded in policies, practices, and staff relational approaches. Service providers cultivate safety in every interaction and avoid confrontational approaches.

Trauma-informed approaches are similar to harm-reduction-oriented approaches, in that they both focus on safety and engagement. A key aspect of trauma-informed services is to create an environment where service users do not experience further traumatization or re-traumatization (events that reflect earlier experiences of powerlessness and loss of control) and where they can make decisions about their treatment needs at a pace that feels safe to them.

3.2 Trauma-Specific Services

Trauma-specific services more directly address the need for healing from traumatic life experiences and facilitate trauma recovery through specialized counselling and other clinical interventions. They include specific therapies such as trauma-focused cognitive behavioral therapy and other approaches such as stress inoculation, exposure, skills development, sensorimotor psychotherapy, eye movement desensitization and reprocessing, and healing and empowerment [35]. Some trauma related approaches have both trauma-informed and trauma-specific aspects such as the Seeking Safety model, a present-focused model, developed by Lisa Najavits, for addressing substance use concerns and trauma or PTSD [24].

The focus of the TIP Guide is on trauma-informed approaches within service systems. Service providers working in a trauma-informed systems need to be aware of trauma-specific services available to clients wishing to pursue treatment.

3.3 Principles and Practices of Trauma-Informed Approaches

Researchers and clinicians have identified principles of trauma-informed practice. For the purpose of the TIP Guide, the following four principles have been distilled from the literature and clinician input. The four principles provide a framework within which a trauma-informed approach may be incorporated:

1. **TRAUMA AWARENESS**—A trauma-informed approach begins with building awareness among staff and clients of the commonness of trauma experiences; how the impact of trauma can be central to one’s development; the wide range of adaptations people make to cope and survive after trauma; and the relationship of trauma with substance use, physical health, and mental health concerns. This knowledge is the foundation of an organizational culture of trauma-informed care [36].
2. **EMPHASIS ON SAFETY AND TRUSTWORTHINESS**—Physical, emotional, and cultural safety for clients is key to trauma-informed practice because trauma survivors often feel unsafe, are likely to have experienced abuse of power in important relationships, and may currently be in unsafe relationships or living situations. Safety and trustworthiness are established through such practices as welcoming intake procedures; adapting the physical space to be less threatening; providing clear information about the programming; ensuring informed consent; creating crisis plans; demonstrating predictable expectations; and scheduling appointments consistently [37].

The safety and needs of practitioners must also be considered within a trauma-informed service approach. Safety measures and changes in treatment culture are key aspects of implementation of a trauma-informed approach. Trauma-informed services demonstrate awareness of vicarious trauma and staff burnout. Whether or not providers have experienced trauma themselves, they may be triggered by client responses and behaviours. Key elements of trauma-informed services include staff education, clinical supervision, and policies and activities that support staff self-care.

- 3. OPPORTUNITY FOR CHOICE, COLLABORATION, AND CONNECTION**—Trauma-informed services create safe environments that foster a sense of efficacy, self-determination, dignity, and personal control for those receiving care. Practitioners try to communicate openly, equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices as to treatment preferences, and work collaboratively with clients. In addition, having the opportunity to establish safe connections—with treatment providers, families, peers, and the wider community—is reparative for those with early/ongoing experiences of trauma. This experience of choice, collaboration, and connection is often extended to inviting individual involvement in evaluating the treatment services, and forming service user advisory councils that provide advice on service design as well as service users' rights and grievances.
- 4. STRENGTHS BASED AND SKILL BUILDING**—Clients in trauma-informed services are assisted to identify their strengths and to (further) develop resiliency and coping skills. Practitioners emphasize teaching and modeling skills for recognizing triggers, calming, centering, and staying present. Sandra Bloom, in her Sanctuary Model of trauma-informed organizational change [38], described this as having an organizational culture characterized by 'emotional intelligence' and 'social learning'. Again, a parallel attention must be paid to practitioner competencies and learning these skills and values.

Trauma-informed services involve service users, practitioners, managers, and all other personnel working in ways that demonstrate an understanding of the needs of people who have experienced trauma. Together with individual interactions, service practices, and policies, they create a non-hierarchical and supportive organizational culture.

MHSU providers can operationalize the principles of trauma-informed service by integrating practices such as universal screening/identification of the effects of trauma, strengths-based assessment, and education about trauma. The principles and practices are underpinned by provision of training and clinical supervision, development of service partnerships, meaningful involvement and inclusion of people accessing services, as well as culturally competent practice. The TIP Guide grounds practice by introducing key concepts, examples, and resources to support trauma-informed practice.

3.4 Trauma-Informed Approaches with Different Populations

A key aspect of trauma-informed practice is understanding how trauma can be experienced differently by immigrants and refugees, people with developmental disabilities, women, men, children and youth, Aboriginal peoples, and other populations [39-42]. Service providers must tailor their MHSU approaches and take the differing experiences of various populations into account [43, 44].

Of particular note is our increasing understanding of the impact of historical and intergenerational trauma for Aboriginal peoples in Canada and the implications for trauma-informed services for Aboriginal peoples as part of a broad approach to policy, treatment and community supports. When First Nations, Inuit and Métis children were taken from their families and forced to attend residential schools between the 1860's and 1990's, a process of intergenerational trauma was sparked. In residential schools, Aboriginal children were subjected to loss of family, language, and culture as well as extreme forms of degradation and often ritualized abuse [45] including, neglect, physical, and sexual abuse by some residential school staff. Parents and other community members also experienced trauma as they dealt with the incredible loss of their children and their identities as parents, grandparents, siblings, aunts and uncles. Residential schools were supported by aggressive assimilation policies that aimed to destroy the values and cultures of Aboriginal people. The harms that these policies have had on Aboriginal people are devastating and continue to affect the health and well-being of many individuals and communities today. This is consistent with the definition of historical trauma provided by Maria Yellow Horse Brave Heart, who has developed historical trauma and unresolved grief theory and interventions among American Indians. She defines historical trauma as “the cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma” [13].

In a recent study, Aboriginal women participating in treatment at National Native Alcohol and Drug Abuse Program (NNADAP) treatment centres identified the RECLAIM principles as important for treatment providers to understand and apply when supporting Aboriginal women's healing from illicit drug abuse [46]. The “R” of RECLAIM stands for recognition of “the impact of trauma in women's healing (ranging from the intergenerational effects of colonialism through to the disproportionate rates of inter-personal violence faced by Aboriginal women)”.

The Provincial Health Services Authority has developed an on-line *Indigenous Cultural Competency Training Program* for people working with the health authorities in British Columbia. Participants have an opportunity to strengthen their understanding about aspects of colonial history and contexts for social disparities and inequities. The training promotes a culturally competent view of historical trauma that can assist service providers in building self-awareness and skills in this area. This type of cultural competence is essential to trauma-informed practice with Aboriginal people.

Trauma-informed practice has also been implemented for young men and women. At the Centre for Addiction and Mental Health in Ontario, in the Youth Addiction and Concurrent Disorders Service, trauma-informed approaches in the assessment and treatment planning processes have been used to enhance motivation to stay in treatment. Empowerment in treatment planning, choice about family involvement, choice in treatment options, risk reduction strategies, and comprehensive strategies

for creating safety are all aspects of this trauma-informed approach within a treatment setting [47].

3.5 Trauma-Informed Approaches in Different Settings

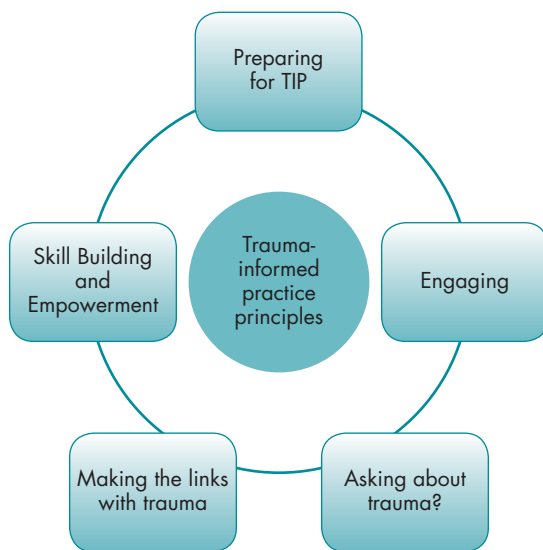
Trauma-informed practice can be implemented at multiple levels. Some examples:

- In Kamloops, BC, substance use, mental health, and primary care service providers have worked collaboratively to build increased awareness about trauma-informed practice and integrate it into service delivery. This initiative has led to a local and regional community of practice, several shared training opportunities on various aspects of trauma-informed practice, regular cross-sectoral dialogue, and a working group that designed a curriculum to be offered on a regular basis. This initiative was later extended to include the acute and tertiary services within the area and a strategic plan for enhancing trauma-informed practice within these areas is now in development.
- The Heartwood Centre for Women in Vancouver has integrated both trauma-informed and trauma-specific practice into an inpatient substance use treatment setting. Trauma-informed principles have shaped the development of the program's holistic approach to offering coordinated substance use, mental health, and primary health services within the context of one program. The principles are considered in all interactions with women who participate in the program.
- The Atira Women's Resource Society in Vancouver offers 17 supportive housing programs, serving women with a range of needs, including women who are homeless, who are pregnant or new mothers, who struggle with mental health and/or substance use and who have experienced violence and abuse. Atira has been working with a trauma-informed approach for many years, recognizing that the effects of trauma and violence are closely linked to MHSU and working in collaborative ways with women to build trust and create safe environments. Over time, Atira has continued to deepen their trauma-informed practice by using the Organizational Checklist (see *Appendix 2*) to support shifts at the organizational level.
- The Centre for Addiction and Mental Health in Toronto, Canada's largest mental health and addiction teaching hospital (see www.camh.net) has undertaken organization-wide change processes to minimize the use of restraints in their services and to involve service users in consultation on services (including implementing a client bill of rights) [48].
- Many shelters serving homeless people with MHSU concerns have successfully applied trauma-informed practice [36].
- For all MHSU counsellors in all community and institutional settings, evidence-based practices such as Motivational Interviewing are consistent with trauma-informed practice, in their valuing of collaborative, empowering stances [49].

4. IMPLEMENTING TRAUMA-INFORMED APPROACHES

It is necessary to integrate trauma-informed practice at every level of service delivery. The TIP Guide recognizes the interconnectedness of decision making, policy, and practice, and offers tailored components for both system planners and practitioners. Readers are encouraged to use the resource as it makes the most sense to them. There are two key components to this TIP Guide:

- An Organizational Checklist is included in *Appendix 2* to support discussion and action on implementation of trauma-informed practice at the program/agency/organization level;
- Key practice approaches are offered, which draw upon skills and strategies described in the available literature. The practice level approaches are organized as described and illustrated in the diagram below:



1. **Preparing for trauma-informed practice**— Foundational topics are addressed which will assist in the preparation for implementing trauma-informed care. These topics include, self-awareness; vicarious trauma; trauma awareness; and the power of language. Such preparation is a continuous process, foundational to all interactions and conversations with clients.
2. **Engagement**—Although engagement is an ongoing process in providing care, it warrants focused attention for its crucial role in trauma-informed practice in MHSU services. This section translates trauma-informed principles into skills and strategies to specifically support engagement, which can be used throughout all interactions.
3. **Asking about trauma?**—It is important to remember that it is not necessary for someone to disclose trauma in order to receive trauma-informed care. There are varying perspectives on how to discuss trauma, and how much information should be gathered about trauma histories. Depending on the service and population served, the approach may be more formal or informal. This section provides some guidelines, skills, and strategies to support the conversation as it relates to current functioning. It also offers ideas for responding to disclosure and making referrals in a trauma-informed way.
4. **Making the links with trauma**—Trauma-informed practice may also involve helping people make the link between their past experiences and present health and to reframe their responses as attempts to cope with what they have been through. Although not everyone involved in trauma-informed practice will provide trauma-specific information, all information can be provided in

a trauma-informed way. This section outlines guidelines for sharing information, key messages related to trauma, and additional skills and strategies for information exchange.

5. ***Skill building and empowerment***—At any point in the conversation, a trauma response may be triggered. In that moment, it is essential to provide safety through grounding and containment skills. This section offers a stepped approach to assist individuals in managing an in-the-moment trauma response through a range of grounding and self-care skills and practices that aim to proactively preserve safety and strengthen resiliency.

Resources—Trauma-informed treatment related resources and additional web resources are included to support additional learning.

Continuum of Trauma-Informed Practice

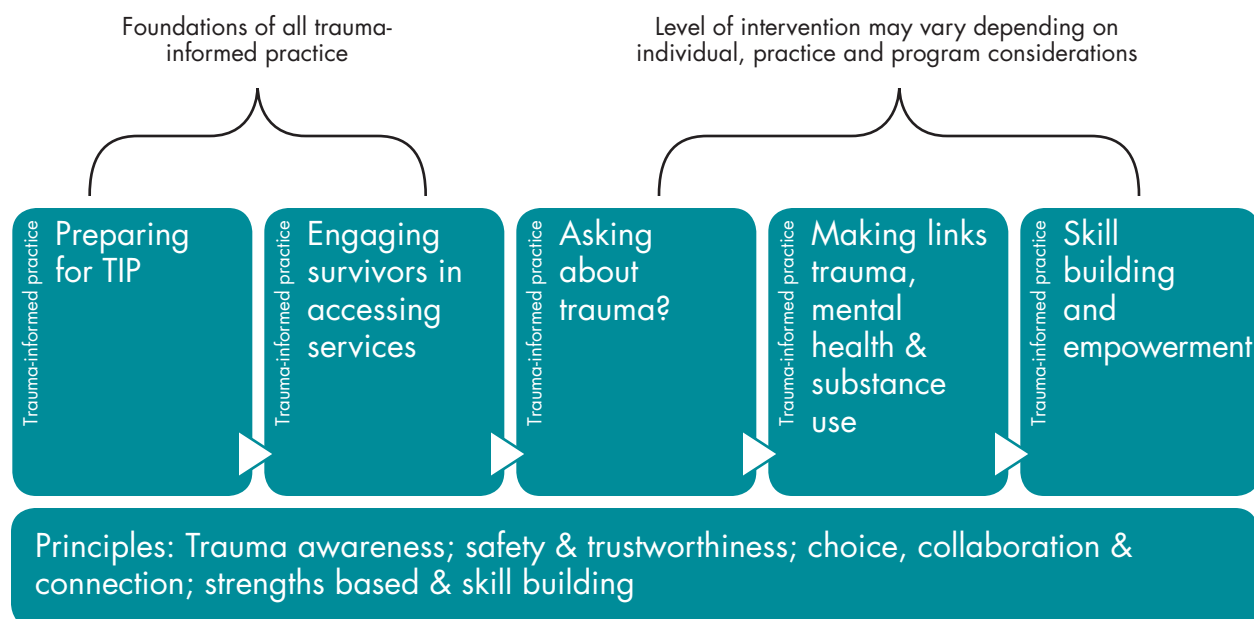
Some trauma-informed components, such as preparing for practice and engagement, are consistent across contexts and roles and are ongoing processes in all interactions.

Other components, like asking about trauma, making links with trauma, and skill building, will vary depending on individual needs and resources, scope of role and service, purpose and goal of intervention, program policies, etc.

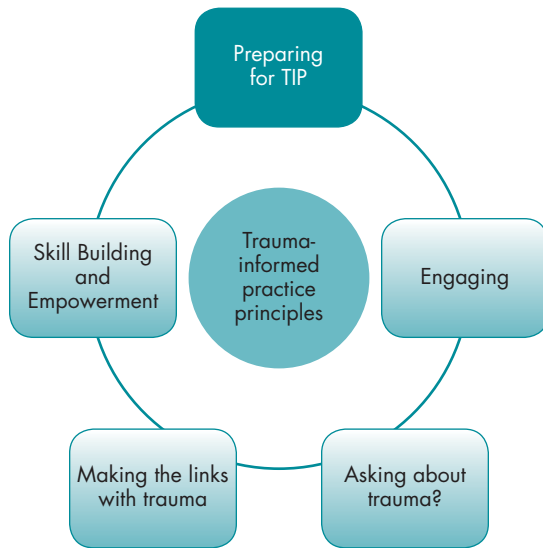
For some practitioners and programs, it may be enough to increase awareness and purposefulness of trauma-informed practice in terms of self-reflection and overall engagement processes.

Others may be required to screen for experiences of trauma, in formal or informal ways, and may be able to offer additional support, such as a psycho-education or skill building groups.

The goal is to build on what is already working for individuals, practitioners, and programs. It is not about replacing existing good practices; rather, it is about refining and being knowledgeable about trauma-informed approaches.



4.1 Preparing for Trauma-Informed Practice



Trauma-informed practice means integrating an understanding of trauma into all levels of care and avoiding re-traumatization or minimizing the individual’s experiences of trauma. As practitioners, there is a heightened awareness and deliberation to the work: questions are asked on a need-to-know basis in the best interest of the individual being supported; attention is paid to the individual’s spoken and unspoken responses; and approaches are adapted to respond to the individual’s needs. Trauma-informed practice is an overall way of working, rather than a specific set of techniques or strategies. There is no formula. Providing trauma-informed care means recognizing that some people will need more support and different types of support than others (for example, the driver of a vehicle who injures a

pedestrian; a family who has fled war in their home country; a young mother who has experienced numerous forms of interpersonal violence throughout her life; a child or youth who has experienced abuse or witnessed domestic violence). It is also important to remember that human beings are resilient and resourceful, and the majority of healing happens outside of formal treatment services.

To help prepare for trauma-informed practice, there are a number of considerations at different levels:

1. The personal level (self-awareness and self-compassion on the part of practitioners)
2. The practice level (in our interactions with clients)
3. The organizational level (see the *Organizational Checklist* section, Overall Program Mandate)

Personal Level

When it comes to experiences of trauma, the distinction between practitioner (or anyone providing some level of support or service) and those accessing care can become blurred. Many practitioners have experienced and/or witnessed varying degrees of trauma themselves, and many more have been exposed to repeated stories of trauma and abuse. With this in mind, self-awareness and understanding vicarious trauma are critical components of this work.

Self-Awareness

A strong therapeutic relationship is important in facilitating healing for many people. Therefore it is essential that practitioners know themselves well and recognize what they bring to the interaction—their own story, diversity, culture, beliefs about recovery, triggers, and vulnerabilities. Trauma-informed clinical

supervision can provide ongoing support to practitioners as they build self-awareness in these areas. A central belief of trauma-informed practice is that people can recover, and the approach is grounded in hope and the honouring of each individual’s resiliency. Some questions a practitioner may want to ask or reflect on in collaboration with a clinical supervisor might include:

1. What are my underlying assumptions about the experience of those with trauma and how people recover? How might this belief influence my work with others?
2. What particular responses or behaviours of those I am assisting might trigger me? How do I know when this is happening? How will I respond?
3. How do my cultural background and personal experiences of diversity influence my interactions with others? What am I bringing to the relationship?
4. There may be some experiences in my life that could influence my ability to provide trauma-informed care. How am I managing? What am I noticing in my body? Are there areas in my life that I need to pay more attention to? Who can I turn to for support?

Vicarious Trauma, Compassion Fatigue and Burnout

Working in the areas of MHSU services is both rewarding and challenging. Vicarious traumatization refers to “the cumulative transformative effect on the helper working with the survivors of traumatic life events” [50]. The impact of vicarious trauma occurs on a continuum and is influenced by a number of factors such as role and how much traumatic information a practitioner is exposed to, the degree of support in the workplace, personal life support, and personal experiences of trauma.

The influence of vicarious trauma can be seen and felt on both personal and professional levels, and in some instances, the community level.

Examples of the impact of vicarious trauma at the professional level might include (and are not limited to):

Professional Impacts			
Job performance	Morale	Behavioural	Interpersonal
Obsession about detail Decreased productivity Avoidance of certain tasks Low motivation	Loss of interest Apathy Dissatisfaction Decreased confidence	Frequent job changes Overwork Tardiness Exhaustion	Poor communication Staff conflicts Withdrawal from others Impatience

[51]

A study by UBC researchers on preventing vicarious trauma [52] found protective factors such as: developing mindful self awareness, active optimism, countering isolation and holistic self-care as important. They also found empathetic engagement with clients to be sustaining, not a contributor to vicarious trauma. The empathetic engagement they found nourishing to service providers was characterised by heartfelt concern and clarity about interpersonal boundaries.

Example:

*“As a social work student doing my practicum placement on a general psychiatry inpatient unit, I saw firsthand the delicate balance of providing care and needing care, and the impact of systemic re-traumatization. A gentleman had been admitted that morning and was pacing the halls and becoming more agitated by the minute. Attempts by staff to de-escalate the situation were unsuccessful and a code white (violent patient) was called. The situation went from bad to worse as he was cornered by numerous personnel. The gentleman was a social worker with a history of trauma.”
(Social Worker)*

To address vicarious trauma, it is suggested to pay attention to three key areas, known as the ABC’s:

- Awareness of our needs, emotions, and limits
- Balance between our work, leisure time, and rest
- Connection to ourselves, to others, and to something greater (e.g., spirituality) [51]

»»» See *INFO SHEET ON SELF-CARE FOR PRACTITIONERS (APPENDIX 1)*

Practice Level

Service and support begin at the first point of contact. Although specific roles and responsibilities may vary, overall interactions are respectful, supportive, collaborative, hopeful, and strengths-focused. Two key areas of practitioner influence in trauma-informed practice are:

- Increasing trauma awareness
- Use of language to de-stigmatize and normalize an individual’s responses and reframe from a strength-based perspective

Trauma Awareness

Trauma awareness, for both the practitioner and clients, is one of the key principles of trauma-informed care. Being trauma-aware does not mean the practitioner has to be a trauma expert. However, the practitioner does need to know enough to be able to recognize possible trauma responses and, if appropriate, explain to clients what trauma is, and its effects. This will inform practice on many levels, helping practitioners and clients make the links between current adaptations and past experiences.

Trauma can impact every aspect of an individual’s life and may show up in different ways. Although trauma responses are unique to each individual, with some reporting few problems and others reporting many, the following table includes some of the difficulties that are often reported by people who have experienced trauma. An individual may not report, or may not experience, these difficulties, but this does not necessarily indicate that the individual has not been exposed to trauma, nor that they do not need support.

Physical	Emotional or Cognitive	Spiritual	Interpersonal	Behavioural
Unexplained chronic pain or numbness Stress-related conditions (e.g., chronic fatigue) Headaches Sleep problems Breathing problems Digestive problems	Depression Anxiety Anger management Compulsive and obsessive behaviours Dissociation Being overwhelmed with memories of the trauma Difficulty concentrating, feeling distracted Fearfulness Emotionally numb/flat Loss of time and memory problems Suicidal thoughts	Loss of meaning, or faith Loss of connection to: self, family, culture, community, nature, a higher power Feelings of shame, guilt Self-blame Self-hate Feel completely different from others No sense of connection Feeling like a ‘bad’ person	Frequent conflict in relationships Lack of trust Difficulty establishing and maintaining close relationships Experiences of revictimization Difficulty setting boundaries	Substance use Difficulty enjoying time with family/friends Avoiding specific places, people, situations (e.g., driving, public places) Shoplifting Disordered eating Self-harm High-risk sexual behaviours Suicidal impulses Gambling Isolation Justice system involvement

[16, 17, 53]

For children, additional responses to consider include fear of separation from parents and regressive behaviors such as thumb sucking, bedwetting, fear of darkness and nightmares.

Example:

“As the first point of contact and the one who keeps everything running, the receptionist in our program struggles with a few people who chronically miss appointments and don’t follow-up. With a greater understanding of the many barriers some people face, she now works with these individuals to help figure out what is getting in the way of making appointments and how to make it easier/reduce barriers.”

Because trauma may have different meanings in different cultures and responses to trauma may also be expressed differently, cultural competence is an important component of trauma-informed care [36]. Further, diversity has many forms, for example: women, men, children, youth, Aboriginal Peoples, veterans, lesbian, gay, bisexual, two-spirit, transgender, and questioning (LGB2STQ), immigrants, etc. Practitioners need to know as much as possible about the individual they are supporting. To help learn about different populations, consider:

- Connecting with the community you are supporting
- Remaining curious and respectfully asking appropriate questions to help you understand
- Seeking out practitioners who do similar work
- Accessing resources for self-study

Example:

“Two of the biggest things that I had to do in frontline practice were to really learn about the people that I was working with because we didn’t necessarily share a culture or a socio-historical background. So a lot of what I was seeing happening, particularly with the highly vulnerable people was foreign to me, and I didn’t know how to respond to it. And in a lot of cases by happenstance a lot of what they were struggling with was a response to a system that hadn’t been caring, had even further traumatized, and I happened to be part of that system, so I was a recipient of a lot of anger. So the thing that I had to learn was understanding, understanding where they were coming from, and trying to put myself into that place, of going to where they are, I had to understand that it’s not about me.”
(Outreach Nurse)

The Power of Language

Working in a trauma-informed way requires a shift in thinking and language. Unfortunately, the behaviours and responses of those with trauma experiences are often misunderstood and labelled in stigmatizing and deficit-based ways (e.g., something is missing or wrong with the individual). Practitioners play a very important role in offering another way of understanding trauma responses—as attempts to cope and adapt to the overwhelming impact of trauma; normal responses to an abnormal event. This reframing serves to empower individuals and de-stigmatize their experience. Practitioners also make the shift in their practice from “what is wrong with this person?” to “what has happened to this person?” This can be particularly helpful when the practitioner feels stuck and struggles to understand. The practitioner may not know the whole story; however, working in this way helps you uncover many layers and complexities and may require adaptation of the approach accordingly.

The following table includes examples of deficit-based phrases and language, commonly associated with working with individuals with trauma experiences, and offers suggestions of how to reframe from a trauma-informed and strengths-based perspective.

FROM (Deficit Perspective)	TO (Trauma-Informed & Strengths-Based)
What is wrong?	What has happened?
Symptoms	Adaptations
Disorder	Response
Attention seeking	The individual is trying to connect in the best way they know how
Borderline	The individual is doing the best they can given their early experiences
Controlling	The individual seems to be trying to assert their power
Manipulative	The individual has difficulty asking directly for what they want
Malingering	Seeking help in a way that feels safer

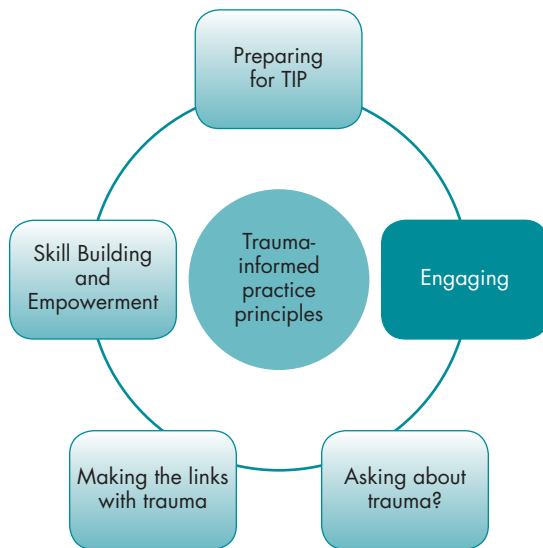
(Adapted from Royal College of Nursing, 2008, pg. 18 [54])

Organizational Level

Trauma informed practice is possible within trauma-informed organizations and systems. Dr. Sandra Bloom and colleagues have documented how organizations are vulnerable to the impact of trauma and chronic stress, and how important it is for whole organizational cultures to shift, towards democratic, non-violent (safe), emotionally intelligent ways of working in order for trauma-informed practice to thrive [38]. As such, key to preparing for trauma-informed practice is engaging all staff in discussion and action on becoming trauma informed. *Appendix 2* provides a checklist to kickstart organizational level discussions and action toward becoming trauma-informed.

A list of tips for Recovery-Oriented, Trauma Informed Agencies [55] can be found at <http://www.homelesshub.ca/library/10-Tips-for-Recovery-Oriented-Trauma-Informed-Agencies-33505.aspx>

4.2 Engaging



In order for service systems to provide trauma-informed care and truly reach those that need support, service user engagement and retention are critical. This is visibly apparent with more marginalized and traumatized populations who struggle to make an initial connection and subsequently may not return or follow-up. Often these individuals and families are members of communities who have faced systemic forms of discrimination, and/or are living in a social context that has been shaped by historical inequities [56]. Trauma-informed services aim to increase access, engagement, and the benefits received from MHSU programs for those individuals impacted by violence and trauma [56]. Although engagement is an ongoing process, woven throughout all interactions, it is foundational and merits distinction as an essential component of trauma-informed practice.

People come to MHSU services through a variety of pathways and experiences. How they get there, whether they came of their own volition, the breadth and extent of their previous contact with the system, how they expect to be treated (supported, shamed, questioned, “fixed”, labelled, etc.), must all be taken into account. In order to effectively engage individuals impacted by violence and trauma in MHSU services, practitioners are guided by the principles of safety and trustworthiness, and collaboration and choice [57]. These principles are relevant whether someone is voluntarily seeking support or has been mandated or compelled by an external source. It is also important to consider age, developmental, and cultural factors as part of effective and respectful engagement.

Principles in Practice

Safety & Trustworthiness

Depending on the type of trauma experienced, individuals may feel unsafe in new environments and have difficulty trusting others and their intentions. People come to services with a whole host of life experiences that shape how they feel, what they think, and how they respond to interacting with practitioners and services. Recognizing this is powerful, both for the practitioner and for the individual accessing services. The practitioner recognizes that an individual’s reactions are not necessarily personal or about the practitioner’s skills. Instead they may be influenced by what has come before, or perhaps expectations of what is to come. For the individual accessing services, it gives permission to have reactions without feeling like they are disrespecting a system or an individual practitioner.

For those who have experienced interpersonal trauma or other forms of oppression and violence, boundary violations and abuses of power may have been present in past interactions. Some of the individuals accessing services may even be currently living in unsafe circumstances such as violent relationships [58]. At the same time, this should not be assumed—many who have experienced trauma have supportive families and social networks, and may not even identify with the language of ‘trauma’. Harris [59] notes that, “trust and safety, rather than being assumed from the beginning, must be earned and demonstrated over time” (p. 20). There are a number of ways practitioners make physical and emotional safety and trustworthiness explicit:

1. Consider all barriers (visible/invisible, concrete/perceived) to engagement:
 - Using a social-determinants-of-health lens can help practitioners broaden their understanding of the realities of many individual’s lives and the numerous influences that impact an individual or family’s ability to access services (poverty, homelessness, gender, etc.).
 - There may be barriers that result from current policies and rules, such as immigration law (no health coverage for someone who does not have legal status), or fear of losing children, housing or employment if MHSU concerns or trauma is disclosed.
 - There may also be very real invisible barriers that are directly or indirectly related to prior experiences with institutions and authority. For example, individuals from cultures that have experienced intergenerational oppression or refugees distrusting of governmental organizations.
2. Attend to immediate needs:
 - Food, clothing, medical concerns, immediate safety, housing, transportation, and child care must all be addressed. If the mandate of the practitioner’s organization does not include addressing immediate needs, provide a referral to organizations that can help. Wherever possible, support the individual to make contact by phone, online, or in person.
 - Address signs of intoxication. It is neither safe nor possible for either party to have a helpful conversation if the individual is intoxicated. The practitioner’s only agenda is then to plan how to support safety and to convey willingness to talk when the individual is no longer impaired [24].
 - Similarly, if someone is acutely psychotic or suicidal, the necessary steps to ensure safety should be taken, including accessing emergency services and carrying out crisis intervention measures.

3. Be as transparent, consistent and predictable as possible:
 - Offer translation services, or allow an interpreter to be present if required or possible.
 - Allow a support person to be present if the individual thinks that would be helpful.
 - Explain why before doing something.
 - If a promise is made (to make a referral, make a follow-up phone call), follow-through in a timely manner.
 - Acknowledge and take responsibility for miscommunication.
 - Ensure that self-disclosure is used only in the best interest of the individual [17].

4. Respect healthy boundaries and expectations by clarifying the practitioner's role:
 - Outline the parameters of what can and cannot be done.
 - Maintain focus on client information that is relevant to the type of work agreed to. Ask for trauma details only when it is necessary for trauma-specific interventions.
 - Use a professional tone that also conveys genuine care and concern [53].
 - Start and finish appointments on time; discuss back-up plans when the practitioner will be away (both planned and unplanned).
 - Explain how and when to contact the practitioner.
 - Be aware of dual roles. For example, offer support to parents, keeping in mind legal responsibility to report child welfare concerns and make referrals as needed.

5. Clearly outline program/treatment expectations:
 - The rights of those accessing services.
 - Content and format of treatment.
 - Attendance and participation.
 - The guidelines around substance use and/or other medications.
 - Specific rules of program—be clear and consistent in explanation and enforcement.

6. Obtain informed consent; explain how information will be shared and the limits to confidentiality:
 - Respond to verbal and non-verbal communication.
 - Use plain language without jargon. Offer a print copy of the consent form.
 - Ask for the individual's understanding; work to mitigate any concerns the individual may have about the limits to confidentiality.
 - When working with children and youth, outline what will and will not be shared with parents and in what circumstances (discussing with both parents and youth as appropriate).
7. Collaboratively develop some grounding strategies:
 - Ask what physical and emotional safety means to the individual.
 - Use open questions to develop a plan together. *'What have you found helpful to calm down and get focused when you're feeling anxious? What makes it worse? What is helpful from my side to offer you the best support when you are upset?'*

Example:

"As a physician, what I have noticed in my practice is that some Aboriginal clients may feel disconnected from systems and personnel, not believing that they are meant to be helpful. This may stem from traumatic experiences in the past. Often, Aboriginal clients will not interact well with health systems, procedures or personnel, fearful that their traumatic experiences of neglect, disrespect and racism will re-occur. Reassurance and discussion around trust (e.g., trust-building)—and acknowledgement that occurrences in the past may be contributing to the current situation—can go a long way therapeutically. Acknowledging that what has happened to bring us to this moment—in contrast to reinforcing a perspective that focuses on individual failures or inadequacies—may open the individual to therapeutic intervention. In summary, this gives the practitioner the actions: to reassure, to build trust, to acknowledge past trauma, to not blame the person, and be prepared to hear and to help them when the opportunity occurs." (Physician)

"In our women's day treatment program, we discussed how everyone has a legal responsibility to call child welfare with concerns about harm to children. As professionals, we explained that if we needed to make the call, we would invite them to be in the room with us, to be able to hear our end of the conversation, if they wanted." (Program Manager)

Practice Example:

The Centre for Addiction and Mental Health (CAMH) Client Bill of Rights outlines 10 rights:

1. Right to be Treated with Respect
2. Right to Freedom from Harm
3. Right to Dignity and Independence
4. Right to Quality Services that Comply with Standards
5. Right to Effective Communication
6. Right to be Fully Informed
7. Right to Make an Informed Choice, and Give Informed Consent to Treatment
8. The Right to Support
9. Rights in Respect of Research or Teaching
10. Right to Complain

For more information go to: http://www.camh.ca/en/hospital/visiting_camh/rights_and_policies/Documents/billofclientrights.pdf

Collaboration & Choice

Experiences of trauma often leave individuals feeling powerless, with little choice or control over what has happened to them (interpersonal violence, natural disaster, etc.), and possibly, what they have done (war, political violence, motor vehicle accident, etc.). It is imperative in trauma-informed practice that every effort is made to empower individuals (when working with children and youth, strategies for empowerment should be consistent with developmental stage). Collaboration involves sharing expertise and power. Individuals actively participate and chart their own course of action, guided by the practitioner’s knowledge, experience, and access to resources. The relationship and engagement build as the practitioner elicits the individual’s ideas, resources, beliefs, and strengths. By engaging with the individual as an active participant in their own treatment (along with the child/youth’s family/caretakers where needed), the practitioner can tailor assistance specific to unique needs. Offering choice, whenever possible, gives control and responsibility back to individuals. Choice can relate to all aspects of service, for example: how they will be contacted; who will be involved in their care; and what the priorities and goals of treatment will be [57]. Having a sense of personal control in interactions with practitioners who have more power is crucial to engagement and establishing and maintaining safety [53].

Some strategies practitioners can use to support collaboration and choice include:

1. Working through the details together:
 - How the individual is contacted—by phone, in person, at home or office
 - Time of day of appointments or meetings
 - The preferred gender of the practitioner the individual would like to work with
 - How and whether messages can be left
2. Exploring and problem solving barriers to participation and attendance (child care, transportation, non-support at home, language):
 - What, if any, obstacles do they foresee in getting to the program/service or connecting in the community/at home?
 - Brainstorm ideas together to remove or reduce barriers
3. Eliciting the individual's priorities and hopes for treatment:
 - Find out what is most pressing for them
 - What are their hopes, expectations, concerns, etc.?
 - Clarify their understanding of why they are speaking with the practitioner and how they got there (e.g., self-referred, mandated, family member request, or school-based referral)
4. Inquiring about others who may be helpful to include in some aspect of their care (a support person, another professional, etc.):
 - Clearly outline how they would like the other person involved; review confidentiality with all those involved
 - Before the meeting, speak with the individual alone to confirm their decision to include others
 - Be sure to communicate directly with the individual receiving care (including minors). This is especially important when speaking through an interpreter or with someone who has cognitive challenges [53].
5. Using statements that make collaboration and choice explicit:
 - 'I'd like to understand your perspective.'
 - 'Let's look at this together.'
 - 'Let's figure out the plan that will work best for you.'
 - 'What is most important for you that we should start with?'
 - 'It is important to have your feedback every step of the way.'
 - 'This may or may not work for you. You know yourself best.'
 - 'Please let me know at any time if you would like a break or if something feels uncomfortable for you. You can choose to pass on any question.'

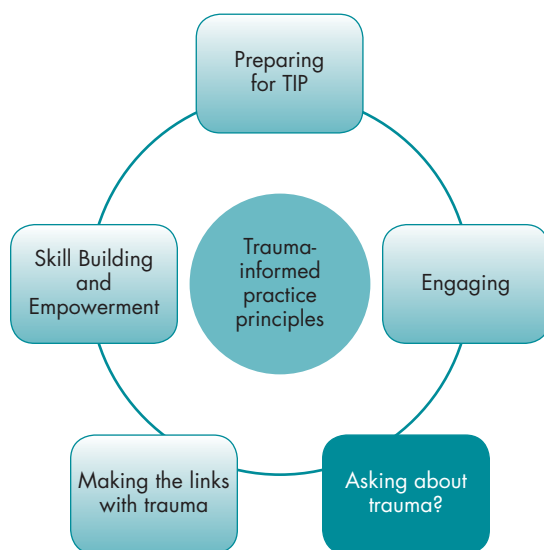
- Use appropriate metaphors: ‘You are the expert or the driver. I can offer to be your GPS or map to help guide you to available resources etc.’
6. Working in a feedback-informed way:
- Purposefully elicit from individuals and families their perspective of the overall experience (e.g., “What was it like for you to get here today?” or “How was it for you to talk about this?”)
 - Continuously check in throughout the course of your work with someone

Example:

“A 14-year-old male youth was referred to mental health services by his probation officer after being placed on probation for breaking and entering. The youth was reluctant to attend sessions, and said that his PO could make him attend but he couldn’t make him talk. The clinician pointed out that counselling was a voluntary service and it was up to him to decide if he wanted to take this opportunity to work on some of the issues that may have contributed to him being on probation and try to avoid it happening again in the future. He was informed of limits to confidentiality, including information requested by the PO, and it was left up to the youth to set the agenda and determine if this would be helpful or not. Motivational interviewing was one of the approaches taken with this youth.”

▶▶▶▶ See *INFO SHEET ON TRAUMA-INFORMED ENGAGEMENT SKILLS* (APPENDIX 3)

4.3 Asking About Trauma



Working in a trauma-informed way does not require disclosure of trauma; therefore, asking about trauma directly may or may not be a part of the conversation in the process of engagement. What is important in the process of screening and/or **engagement** is to notice signs of trauma, and to help potential treatment participants to manage these. At the same time, there is consensus in the literature around the importance of asking about histories of violence and trauma within MHSU **assessment** practices [36, 60-62].

There are varying perspectives on how much information should be gathered at intake, how information should be gathered, and when/if questions should be asked at all. On the one hand, there are concerns that if service providers ask too much, too soon, too directly, people may feel unsafe and may not engage with services. Some would even argue that past trauma should not be asked about directly at all, especially if the resources are not available to respond. On the other hand, if practitioners do not notice and discuss trauma symptoms, individuals may go untreated or not receive appropriate care. Another consideration is that, for some, violence/trauma may have become normalized and they may not identify their experiences as traumatic, and this could potentially be missed as a contributing factor to their current health.

Because there is no clear answer, practitioners and programs are encouraged to consider “Do we need to ask?” and “If yes, how might we do it in a trauma-informed way?” It is also important to distinguish between asking from a trauma-informed lens, whereby the focus is on establishing rapport, trust, and safety, versus asking from a trauma-specific lens which has a different purpose related to tailored, specific treatment. Depending on the setting (e.g., inpatient or outreach), programs will collect information in more or less structured ways. Some programs may gather such details as when the trauma occurred and how the experience is impacting current functioning [56]. Alternatively, a more informal approach may be taken in some settings, one that minimizes the amount of information gathered and recognizes the importance of establishing safety, adequate support, and coping to manage trauma disclosures [56]. Whether screening and assessment practices are formal or informal, and regardless of self-disclosure, the prevalence of trauma history for individuals accessing MHSU services justifies the use of trauma-informed approaches with all individuals.

Practitioners may be hesitant to discuss trauma, for fear of upsetting the individual they are working with and evoking a trauma response. At the same time, if trauma is not acknowledged as often connected to MHSU concerns, there is a risk of conveying a sense of discomfort with the topic, and unknowingly shutting the individual down—an experience that in and of itself can be re-traumatizing in terms of taking away the individual’s voice and perpetuating shame. It may be helpful for practitioners to know that overall, the evidence indicates that when discussion about violence and trauma is takes place in a trauma-informed way, this does not lead to traumatic stress responses [36, 63].

It is important to approach any questions about trauma from an age-developmental and culturally sensitive perspective. When working with children and youth, it is important to know if there is unreported abuse and if they are currently safe from harm. In addition to creating space for discussion of past experiences of violence/trauma, practitioners also need to be aware of the potential current safety concerns and not make assumptions that the violence is only historical (see safety planning resources in *Appendix 4: Asking about trauma and responding to disclosure*).

Guidelines

Although there will be variation in screening/assessment practices, the following guidelines assist practitioners in these important and sensitive conversations [27, 53, 58, 64]:

1. Remember that screening/assessment is also about engagement and relationship building.
2. Consider the purpose of the information collected. How will this information strengthen the individual’s engagement, care, and recovery?
3. Keep the conversation safe, contained, and connected to present functioning and health. Practitioners do not need to know the details of the trauma experience to provide trauma-informed care.
4. Offer choice and emphasize the individual’s autonomy at numerous points in the screening and assessment processes. For example, remind the client that they can choose whether or not they answer questions, when they need to take a break, etc.
5. Increase the sense of safety through attention to physical environment—ensure as much privacy as possible and have information related to trauma visible and accessible.
6. Review and clarify limits to confidentiality—explain with whom and how the information may be shared, the limits of access and confidentiality, and how records are kept.

7. Provide a rationale for asking questions about trauma and normalize the process by explaining or otherwise indicating that trauma reactions are normal, expected, and part of our survival mechanism.
8. Pay attention to signs of a trauma response (see Possible Signs of a Trauma Response table below). If a trauma response occurs, pause the conversation, help the individual to connect to the present moment, and provide supportive containment and grounding (see Section 4.5: Skill Building and Empowerment).
9. Ask about the individual's strengths, such as their interests, goals, coping skills, community connections, survival strategies, spirituality, etc.
10. Balance screening and assessment with engagement. Having familiarity and ease with the screening and assessment tools and processes helps ensure that the relationship will not be compromised.
11. Keep the conversation open. Topics can be revisited as the sense of safety is strengthened.
12. Avoid creating a power dynamic by limiting the number of questions asked in a row. Use more reflections in conversations (see OARS skills in *Appendix 3: Trauma-informed Engagement Skills*).
13. Continue to use a feedback-informed approach, e.g., "How was this conversation for you?"
14. Use clinical judgment in terms of when not to ask, for example, when someone is in crisis, when there is a high level of emotion (such as anger), when someone is in the acute stages of substance withdrawal/intoxication or psychosis, or when basic immediate needs and current safety are paramount. There may be another opportunity for a more thorough assessment at a later time.

Possible Signs of a Trauma Response

- Sweating
- Change in breathing (breathing quickly or holding breath)
- Muscle stiffness, difficulty relaxing
- Flood of strong emotions (e.g., anger, sadness, etc.)
- Rapid heart rate
- Startle response, flinching
- Shaking
- Staring into the distance
- Becoming disconnected from present conversation, losing focus
- Inability to concentrate or respond to instructions
- Inability to speak

[53]

Practice Example:

Recognizing the need for a simple yet effective way to screen for co-occurring disorders with varied populations across multiple settings, the Co-Occurring Joint Action Council (COJAC) in California developed a formal tool called the COJAC Screening Tool (CST). There are three questions for substance use, three questions for mental health issues, and three questions for trauma (see a copy of the tool in the Appendix 4a). The tool is currently undergoing a two-year validation study and is available for use. <http://www.adp.ca.gov/cojac/screening.shtml>

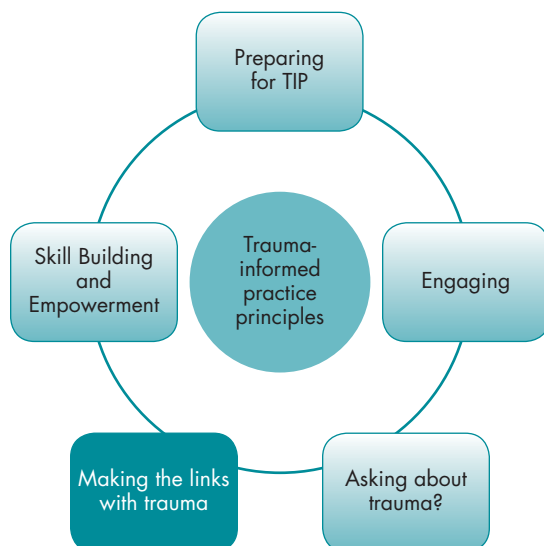
Cultural awareness is also an important consideration in the approach taken to screening and assessment. In some instances, practitioners and community members have worked together to find ways to modify standardized tools, for example, by taking more of a narrative approach and creating space for the story first and then filling in necessary information as it arises. Two other examples, shared by a counsellor using traditional approaches to enhance work with children and youth in a BC First Nations community, include building a relationship over a cup of tea, and using the symbolism of a cedar tree to guide assessment:

“We can come and have tea, and so really acknowledging that coming and having tea is a language that has a significant impact in our culture and in many cultures. And I don’t know that that’s even only in just aboriginal cultures, but in any culture that has a value for the teachings that elders and knowledge holders have to give.”

“...going back to the teaching of the cedar tree; in that tree are the roots, and the stronger those roots are, and the longer those roots are, the better that tree can stand...so really using the symbolism of the loved one standing, standing strong against whatever, comes and sticks and breaks their branches, right.”

»»» See INFO SHEET ON ASKING ABOUT TRAUMA AND RESPONDING TO DISCLOSURE (APPENDIX 4)

4.4 Making the Links with Trauma



Trauma-informed practice can help individuals recognize the connection between their past experiences and present situations, separate the past from the present, and exercise choice and control. Empowering information can provide significant relief from suffering, instill hope, create meaning, and help develop new narratives [17]. While continuing to strengthen engagement and collaboration, practitioners find opportunities to offer tailored information that will help individuals link

their current difficulties to the self-protective coping responses used to adapt to overwhelming life experiences. It is important to note that not everyone involved in trauma-informed practice will provide trauma-specific information; however, all information can be provided in a trauma-informed way.

Individuals with a history of trauma often seek help when in a state of crisis and extreme distress [17]. They may have a bewildering array of symptoms or adaptations to their traumatic experiences which affect their ability to access, engage with, and benefit from MHSU treatment [56]. For some, the distress may not be so obvious and acute. However, they, or someone close to them, may recognize that something is not quite right; perhaps in terms of chronic health problems, depression, anxiety, and/or interpersonal challenges. Their responses may become harder to manage or ignore. Children or youth may be referred for help by their family or physician due to emotional or behavioral concerns and the link to possible trauma may not be obvious to them.

As practitioners become more trauma aware themselves, they are better able to assist those accessing services make the links between what has happened to them and what is happening to them, and how this influences their responses to the world (see the Trauma Response table in Section 4.1: Preparing for Trauma-Informed Practice). It is important to note that the meaning an individual or family gives to violence and trauma may vary based on the diversity of experiences and cultural context [25]. It is not necessary to identify with the language of “trauma” in order to receive trauma-informed support and assistance with current challenges.

Examples:

“Two years ago, Karen took a leave from work following repeated abusive and bullying exchanges with her boss. She thought she would only be off for a month, but became so depressed that returning to work was not possible. During this time she also began having flashbacks of childhood violence. It wasn’t until a professional framed her work experience in the context of trauma, that it finally all made sense to her; why her childhood memories would also surface at this time; and why her experience at work was so debilitating. This understanding led her to seek mental health support.”

“12-year-old Tracey had been running away from home and engaging in high risk behaviours for the past year and her parents felt they had tried everything but nothing seemed to help her. She was hanging around with a tough older crowd and was recently picked up [by police] for vandalism at the school. Tracey agreed to see the school counsellor, but denied that there was anything wrong when asked if something had happened that could have upset her or could be contributing to how she was feeling and behaving now. Eventually Tracey disclosed that her uncle, who had sexually abused her when she was 6 years old, had moved back to town a little over a year ago. She felt unsafe when he visited their home and felt her parents wouldn’t believe or support her if she told them.”

The following provides guidelines for making links with trauma; key messages to use when sharing information; skills and strategies for having the conversation; and possible practice traps.

Guidelines

Sharing information is a critical part of any practice. Whether it is a conversation about stress responses or offering resources, information can be shared in a trauma-informed way that takes into account, age, stage of development, and culture to guide information sharing. Haskell highlights four areas [17]:

- **Pacing and timing** of when information should be offered is individualized; it may happen over several conversations. It is paramount that safety has been established and it should remain central in the conversation.
- **Readiness** of individuals to receive information about the possible connections between their current experiences and past trauma varies greatly. Some may not want or need it; others may not be ready (in terms of coping and resources) to make the links; and others may need to slowly integrate pieces over time. To avoid getting ahead of readiness, trauma-informed practitioners offer choices—whether someone even wants information, how much they want, and when.

- **Listening & normalizing** are important components of sharing information. They also help prevent the practitioner from doing all of the talking. When practitioners stay connected using reflective listening skills and regular summaries (see OARS skills in *Appendix 3: Trauma-Informed Engagement Skills*), they help individuals feel heard and understood. Pauses in the discussion reduce the risk of overwhelming the individual by providing too much information, too quickly.
- **Understanding reactions and linking responses** to trauma help the individual normalize their experience and offer a larger context to understand what is happening to them.

Key Messages when Making Links

The trauma-informed practitioner tailors the shared information to each individual and situation. It is important to consider several factors, including age and stage of development; type of trauma experienced; resources and capacity to integrate the content; and cultural influences. Some of the messages that might be conveyed are:

Trauma awareness, including definitions of abuse/neglect; biological, psychological, physiological, and social contexts of trauma; reframed interpretation of a situation (something *has happened* to them, not something *is wrong* with them). An example of trauma-informed messaging might be,

“When a child experiences abuse or neglect, they feel helpless and trapped. These overwhelming, distressful feelings can change how the brain and body work and affect memory, thinking, and relationships. Many people don’t know it is still affecting their lives so many years later.”

De-stigmatizing and normalizing responses such as flashbacks, dissociation, hyper-arousal, emotional numbing, or avoidance [17]. An example of trauma-informed messaging might be,

“This feeling of not being able to relax; this high anxiety and always being on guard; the changes in your daily patterns and avoiding certain things, these are common responses to trauma. You are not going crazy.”

Emphasizing resiliency and hope. Making the links with trauma may elicit a range of reactions, such as relief, clarity, surprise, uncertainty and, for some, even hopelessness that things will never get better. Practitioners are encouraged to highlight strengths and resiliency and offer hope when it may not feel possible [43]. An example of trauma-informed messaging might be,

“You have been managing the best you can following the accident at work, and now realize you may need some more support. Today you’ve had the courage to come to our program and speak with me. Although it may not feel like it at this moment, over time and with support, people do recover from trauma.”

What happened is not their fault. This message will depend on the type of trauma experienced. If appropriate, perhaps a genuine statement such as,

“I am so sorry this has happened to you. What has happened to you is not okay. You had no control over the situation.”

Individuals don’t need to “go it alone.” Clearly indicate how the practitioner and agency can be helpful. Without going into too much detail and getting ahead of an individual’s readiness, offer reassurance that referrals can be made (as needed and, if possible, in the community) to related trauma-informed and trauma-specific resources, as well as peer-support groups. Also, recognizing that people are not in treatment most of the time, it is important to discuss various sources of support in their own lives, what they can build on or add, who they can connect or reconnect with, and other sources of strength (see Eliciting Strengths in Section 4.3: Asking About Trauma).

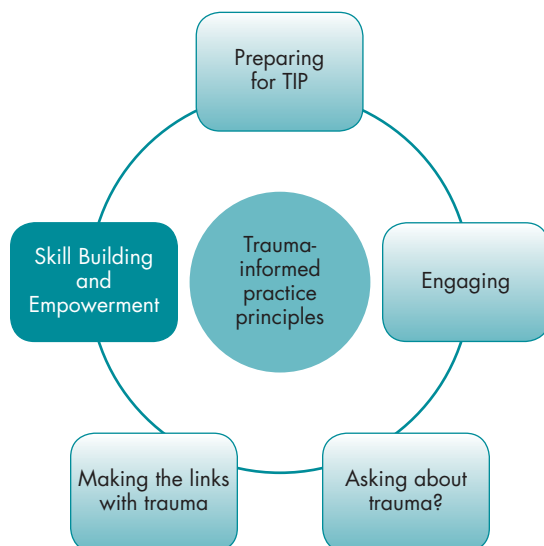
Example:

“In our parenting group we find that most parents are relieved when we share with them the link between their past trauma and being triggered by their child’s behaviour. This new understanding helps them make sense of their own reactions and look for ways to take care of themselves and their children” (Group Facilitator, CYMH).

Children and youth with a history of abuse may have experienced further trauma following the disclosure if the family and system did not support them. Acknowledging this additional trauma and understanding how difficult it may be for them to trust again, as well as being patient and supportive may help them to eventually become engaged in a helping relationship.

▄▄▄ See *INFO SHEET ON STRATEGIES FOR SHARING INFORMATION ABOUT TRAUMA (APPENDIX 5)*

4.5 Skill-Building and Empowerment



Trauma-informed practice means working from a strengths-based and empowerment approach that emphasizes establishing safety and building capacity for self-care and containment [24]. Learning to manage emotions as a component of healing is important for not only adults, but it is noted as one of the most fundamental protective factors for the healthy development of children and youth [61, 65].

Capitalizing on skills already identified in the TIP Guide, this chapter offers:

- A stepped approach to assist someone in managing an in-the-moment trauma response
- A selection of grounding and self-care skills and practices to proactively safeguard the safety and strengthen the resiliencies with clients

Individuals may appear frozen in fear, threatened, overwhelmed, angry, frustrated, anxious, depressed, or disconnected from themselves, their bodies, their families, and the world around them. Qualified practitioners can help them be curious about the links between previous trauma(s) and current thoughts/feelings/physical sensations. Practitioners can offer practical tools to help them ground and be safe, in present time and in their own bodies. As that capacity grows, they have a more realistic opportunity to successfully address the pressing issues and possible underlying trauma(s) in their lives [66]. In a parallel process, practitioners may also need to strengthen their own safety, grounding, and self-care skills as they support the empowerment of others (see Section 4.1: Preparing for Trauma-Informed Practice).

Stepped Approach

Building on previous chapters, and adapting guidelines for helping a traumatized child or adult [67], the following sequence of steps is helpful when the practitioner recognises a possible trauma response in a client. Many behaviours and strong emotional reactions have developed over time. Some are clearly linked to experiences of trauma and others are more subtle or may not be connected.

- **As the practitioner, notice internal reactions.** If there is no imminent danger, take a moment to observe one’s own bodily and emotional responses, until settled with a sense of relative calm.

- **Pay attention to the individual’s bodily responses and words.** Encourage them to keep their eyes open. Validate them by not interrupting the normal manifestations of shock and trauma (trembling, shaking, tears, numbness, etc.).
- **Offer verbal support and grounding.** While an individual is experiencing distress, encourage and support them with the warmth of undivided attention, as well as reassurance and acceptance of the body’s healing capacities. In a calm, clear, and strong voice, making sure they hear, “It’s all right to cry” (feel angry, etc.); “Just let the shaking happen; it will end on its own.” Further grounding strategies, listed below and in *Appendix 6: Teaching Grounding Skills and Self-Care*, may be helpful.
- **Remain present.** Resist the temptation to talk them out of fear, sadness, anger, embarrassment, guilt or shame to avoid one’s own uncomfortable feelings.
- **Continue to offer grounding and calming** until the individual is present, feeling safe in their own body, and connected to the practitioner and their external environment.
- **Strengthen empowerment and collaboration.** Depending on the extent of the response, invite the individual to check back in with their own body, asking “What do you need now to be safe?” “Should we continue, or is this enough for now?” Act on these suggestions; book another appointment if necessary.
- **Don’t go it alone.** If needed, ask for peer or supervisory support to help process and/or debrief the event afterwards. Identify any necessary policy and procedural concerns.

»»» See *INFO SHEET ON TEACHING GROUNDING SKILLS AND SELF-CARE STRATEGIES (APPENDIX 6)*

APPENDIX 1

Info Sheet on Self-Care for Practitioners

Just as practitioners support those they are working with to stay in the present, ground, and take care of themselves, practitioners also need to practice this approach. Many grounding strategies are helpful to stay in the present, focus, and connect to what is happening around you. These strategies could be used throughout the course of a day: when preparing to meet with someone, concluding an assessment or session, or getting ready to finish the day and shift from your professional role to your personal life. You will know what works best for you.

Some examples include:

- **Physical**—feel your feet on the floor; focus on your breath; stretch; run water over your hands
- **Mental**—scan your office and name what you see; read something out loud to yourself; imagine changing the channel in your head
- **Soothing**—imagine someone who gives you strength; put inspirational quotes up on your wall and read them as you need; develop a mantra (e.g., “No feeling is final,” “I can do anything for a day.”)

Some other ideas to help with the impact of vicarious trauma, over the longer term, at an individual level include:

- Have variety in your day and role overall—research, training, different types of conversations
- Attend continuing education
- Take scheduled breaks in the day
- Develop a personal debriefing plan, with peers or a clinical supervisor
- Set realistic goals for yourself
- Explore spiritual beliefs
- Actively use body therapies [51]

The Centre for Addiction and Mental Health in Ontario have found it beneficial to offer trauma-informed body centred interventions such as laughter yoga to staff and clients alike [68]. A number of MHSU services across Canada have offered mindfulness training to support staff health.

For some, completing a more detailed self-care checklist may be helpful to assess different areas of personal and professional life. The following are two different examples:

1. The Self-Care Checklist (page 30) from the Guidebook on Vicarious Trauma [51] can be downloaded at http://publications.gc.ca/collections/collection_2008/phac-aspc/H72-21-178-2000E.pdf
2. The Personal Assessment Wheel, developed by the Coaches Training Institute can be downloaded at <http://www.thecoaches.com/res/pdf/Personal-Assessment-Wheel.pdf>

The following *Personal Preparation Plan* can be individualized as you prepare for trauma-informed practice.

Personal Preparation Plan

In preparation for meeting with someone coming for mental health and/or substance use support, I will ground myself by...

I will remind myself that...

Steps I will take to understand cultural context and diversity...

I will know the work is starting to have a negative effect on me when...

If that starts to happen, I will ground myself by...

Someone who can offer me support

1) At work: _____

2) Outside of work: _____

Two self-care strategies that help me manage are...

Practice Traps—Preparing For Trauma-Informed Practice

Increasing service demands, competing priorities, and the desire to be helpful are just a few of the variables that may influence interactions between practitioners and those accessing MHSU services. Some of the traps that practitioners can find themselves in include:

- **Fixing** and wanting to be helpful to the point of inadvertently disempowering people and taking over.
- **Becoming the expert** and losing collaboration, which is sometimes triggered by time pressures and the perceived necessity to provide ALL of the information.
- **Feeling overwhelmed** can result from feeling pushed, both personally and professionally, and sometimes when the situation of the individual being helped is so complex that it is hard to know where to start
- **Rigidity** becomes evident when there is a belief that there is only one way for people to recover (e.g., that people have to tell their story rather than tailoring the approach to each individual).
- **Believing that information alone can cause change** refers to a sense that if people just had all of the information then they would make changes for themselves. This trap is reflected in statements like, “you would think knowing that drinking only makes it worse would make them just stop.” Such statements can show a lack of understanding and can sound critical and blaming.
- **Losing awareness of body language and facial expression** can result in expressions of excessive sympathy or shock that can have an unintended effect on the conversation.

APPENDIX 2

Trauma-Informed Practice Organizational Checklist

Acknowledgement: This checklist was developed and revised through consultation with people working in the MHSU field, throughout British Columbia, in 2012. The interest and expertise of practitioners, leaders, and others is appreciated.

The Organizational Checklist is a tool that can be utilized by mental health and addictions organizations as a guideline for the implementation of trauma-informed practice. The checklist can be completed by program administrators, program evaluators, and staff to evaluate or direct the implementation of trauma-informed principles, as well as to identify areas for improving services offered by the organization or program. The checklist addresses both service-level and administrative or system-level changes.

Implementing trauma-informed practice will require a shift in organizational culture for many organizations and programs. The culture of an organization reflects what is considered important and unimportant, how it understands the people it serves, and how it puts these understandings into daily practice (Fallot & Harris, 2009). Culture expresses the basic values of a program. The implementation of trauma-informed practice is most effective when it begins with a widespread recognition of the impact trauma has on MHSU and the importance of being trauma-informed for improving the outcomes of those accessing these services.

A Word About the “Checklist” Approach in this Context

The word “checklist” is sometimes used with reference to simple, task oriented ‘to do’ types of lists. A checklist format is used here to point to a comprehensive list of focus areas to take into consideration when undertaking system enhancements related to trauma-informed practice. The complex nature of system change is recognised, as is the variety of settings this will be used in and that one size (or list) does not fit all.

This checklist tool was developed to be used as a starting point for an ongoing process in the pursuit of excellence in trauma-informed practice. The questions were drawn from checklists developed in other jurisdictions [See for example, 37, 69] and from consultation with MHSU service providers in British Columbia. Not all organizations will have the staffing or other resources to fully meet all the criteria presented below. However, the checklist tool provides an opportunity for discussion and reflection on the ability of an organization to provide the best available trauma-informed services. The checklist is not intended to place unnecessary pressure on an organization, but rather to provide direction for services to work toward. The checklist can also be used on an ongoing basis to identify and document barriers, issues, and successes in the process of implementing trauma-informed principles across the organization.

Trauma Informed Organizational Checklist

Contents of the Checklist

The following 8 areas of organizational practice are briefly covered in this checklist

1. Overall Policy and Program Mandate
2. Leadership
3. Hiring Practices
4. Training for Staff
5. Support and Supervision of Staff
6. Screening and Assessment
7. Policies and Procedures
8. Monitoring and Evaluation

Scoring

The checklist is designed to support a process of rating the extent to which services meet the range of TIP criteria using the following scale:

1. Fully achieved
2. Partially achieved (in progress)
3. Not achieved
4. Not applicable

Use of this rating scale is designed to be complemented with a description of how the criteria are met to facilitate seeing the practices of the organization as a whole and to support further achievements.

1. OVERALL POLICY AND PROGRAM MANDATE

For most organizations, a commitment to trauma-informed practice represents a shift in culture and values. A wide spread commitment to trauma-informed practice ensures that all people who come into contact with the MHSU system in British Columbia, regardless of where they enter the system, will encounter services that are sensitive to the impact of trauma.

A clearly written policy statement or paper publicly declares a commitment to trauma-informed services and makes it clear that incorporating trauma-informed practices is a priority for the organization.

Criteria	Status	Evidence of meeting criteria
Overall philosophy		
<i>Your organization includes trauma recovery as part of its mandate.</i>		
Clearly written policy statement		
<i>Your organization has a policy or position statement that includes a commitment to trauma-informed principles and practices.</i>		
<i>The policy/position statement identifies the relationship between trauma and recovery, as well as the implications for service access and design.</i>		
<i>The policy/position statement is endorsed by leadership.</i>		
Evidence informed policies		
<i>Services are based on an optimistic, evidence-informed, trauma-informed model.</i>		

»»» See Section 3.3: *PRINCIPLES AND PRACTICES OF TRAUMA-INFORMED APPROACHES* in the Trauma-Informed Practice Guide

»»» See Section 4.2: *PREPARING FOR TRAUMA-INFORMED PRACTICE* in the Trauma-Informed Practice Guide

2. LEADERSHIP

At the administrative level, a commitment to trauma-informed practice is essential to support the cultural change of the organization. “Courageous leadership” is always the key to system change and without it, widespread change is unlikely to occur [70]. Administration provides guidance, direction, and ongoing review of the implementation of trauma-informed practice.

The size and role of the working group which will lead the integration of trauma-informed practice for the organization will depend on the size and resources of the organization. The working group should be diverse and representative of the organization. For example, it should include all levels of staff and represent the diversity of the staff and clients. The role of the working group is to represent and communicate with their constituency, as well as to become trainers and champions for implementing trauma-informed services. The working group can create goals, objectives, and action steps for implementing trauma-informed practice.

Criteria	Status	Evidence of meeting criteria
Overall Leadership Style		
<i>Program directors and clinical supervisors understand the work of direct care staff as it relates to the provision of services to people who have experienced trauma.</i>		
<i>Leadership allows staff time and other resources (e.g., space, funding) to focus on implementing trauma-informed services.</i>		
Collaboration		
<i>Collaboration and shared decision making is a key part of leadership style. Collaboration is inclusive of clients in the development of trauma-informed approaches.</i>		
<i>Clients and staff members are encouraged to provide suggestions, feedback, and ideas, and there is a structured process for this.</i>		
Point of responsibility		
<i>There is a clearly defined point of responsibility for implementing trauma-informed services. This may involve a trauma “initiative,” “committee,” or “working group” that is fully supported and endorsed by administration and includes clients.</i>		

»»» See Section 4.2: *PREPARING FOR TRAUMA-INFORMED PRACTICE* In the Trauma-Informed Practice Guide

3. HIRING PRACTICES

Incorporating trauma information into the job description and interview questions for people joining the organization will increase the likelihood that new staff will be knowledgeable about and skilled in trauma-informed practice.

Criteria	Status	Evidence of meeting criteria
Trauma in job description/ interview		
<i>Job descriptions include knowledge, skills, and abilities to work with trauma survivors.</i>		
<i>Job interviews include trauma content, including questions about knowledge and skills related to trauma-informed practice.</i>		

4. TRAINING FOR STAFF

As programs prepare to offer trauma-informed care, training is imperative. Specifically, training in the nature of trauma and its effects as well as training in cultural competence (Hopper, 2010). Questions for program planners and decision makers to consider include:

- What training has staff received on trauma and its impacts?
- What training has staff received on cultural competence?
- Are staff encouraged to seek out training opportunities and make suggestions for what is needed?
- How is the learning from training being sustained?
- What opportunities are there for peer led learning initiatives, such as *communities of practice*?

It is important for staff to receive training in relation to trauma-informed practice as is relevant for the organization. Research and clinical experience continue to provide new knowledge. Ongoing training and training opportunities ensure that staff knowledge and skills remain current and clinically relevant.

Criteria	Status	Evidence of meeting criteria
Training to promote general awareness of trauma		
<i>All staff, at all levels, receive basic foundational training, and continued training (as appropriate) that furthers their understanding of trauma.</i>		
<i>Staff members are released from their usual duties so that they may attend training.</i>		
Staff receive training on the following topics:		
<i>The links between mental health, substance use, and trauma (and co-occurring disorders).</i>		
<i>Cultural competency—including different cultural practices, beliefs, rituals; different cultural responses to trauma; and the importance of linking cultural safety and trauma-informed practice.</i>		
<i>How gender influences the types of trauma experienced, as well as individual and systemic responses to trauma.</i>		
<i>Communication and relationship skills—including non-confrontational limit setting, “people first” language (e.g., people who are experiencing homelessness), reflective listening skills, etc.</i>		
<i>Minimizing re-traumatization—including psycho-educational framing, coping mechanisms, a cultural safety lens, de-escalation strategies, grounding, and emotional modulation techniques.</i>		

Criteria	Status	Evidence of meeting criteria
<i>Vicarious trauma, how it manifests and ways of minimizing its effects—including self-care, resiliency, and personal/professional boundaries.</i>		
Staff receive training that promotes awareness of services		
<i>Awareness of trauma-specific services in the mental health system.</i>		
<i>Awareness of the range of specialized services outside of the MHSU system to support people with trauma, such as anti-violence services, services for refugees & victims of torture, veterans services, LGBT support services, Aboriginal healing services, and gender specific groups.</i>		

»»» See SECTION 2.4: CONNECTIONS TO SUBSTANCE USE AND MENTAL HEALTH in the Trauma-Informed Practice Guide

»»» See THE POWER OF LANGUAGE in SECTION 4.1: PREPARING FOR TRAUMA-INFORMED PRACTICE in the Trauma-Informed Practice Guide

»»» See SECTION 3: TRAUMA-INFORMED APPROACHES AND APPROACHES in APPENDIX 1-6 in the Trauma-Informed Practice Guide

»»» See VICARIOUS TRAUMA in Section 4.1: PREPARING FOR TRAUMA-INFORMED PRACTICE in the Trauma-Informed Practice Guide

5. SUPPORT AND SUPERVISION OF STAFF

Clinical supervision with a supervisor knowledgeable about trauma can assist staff with the potential effects of working with traumatized people. It also provides opportunities for staff to identify and work through problems encountered when implementing trauma-informed practice, as well as while working with clients. Separating administrative supervision from clinical supervision may allow staff to feel more comfortable, trusting, and willing to communicate problems. If staff resources are not available to separate administrative and clinical supervisory roles, organizations can work towards this by clearly defining the difference in the roles and responsibilities of both functions. Separate clinical and administrative meetings can also help to maintain the boundary between the two types of supervision. Additionally, training and policy can be developed to support the implementation of peer and group models of supervision.

Approaches for minimizing vicarious trauma and supporting practitioner self-care on a program-wide level are essential components of trauma-informed practice [36].

Criteria	Status	Evidence of meeting criteria
Regular supervision		
<i>All staff who work with trauma survivors have structured, strength-based supervision from someone who is trained in understanding trauma.</i>		
Staff Meetings		
<i>There are regular staff meetings that include opportunities for knowledge exchange on working with trauma.</i>		
<i>Staff are encouraged to discuss ethical issues associated with defining personal and professional boundaries.</i>		
Peer support		
<i>Opportunities for peer support and consultation are offered regularly.</i>		
<i>Practitioners have opportunities for group case consultation.</i>		

Criteria	Status	Evidence of meeting criteria
Support for staff safety		
<i>Part of regular supervision is used to help staff understand their own stress reactions.</i>		
<i>Self-care is encouraged among staff and issues related to safety/self-care addressed at staff meetings.</i>		
<i>The organization regularly seeks input from staff about their safety, and/or assesses staff safety through other mechanisms, and makes improvements wherever possible.</i>		
<i>The organization provides appropriate supports to staff who have experienced vicarious trauma.</i>		

»»» See *Section 4.1: PREPARING FOR TRAUMA-INFORMED PRACTICE* in the Trauma-Informed Practice Guide

»»» See *Appendix 1: SELF-CARE FOR PRACTITIONERS* in the Trauma-Informed Practice Guide

6. SCREENING AND ASSESSMENT

It is not necessary for someone to disclose trauma in order to receive trauma-informed care. There are varying perspectives on how to discuss trauma, and how much information should be gathered about trauma histories. Agencies providing differing tiers of care will work differently. It will be important to differentiate between screening for symptoms of trauma and asking about whether a treatment participant has a history of trauma. Prioritizing consumer safety, engagement, and retention can assist in the development of trauma-informed screening practices and establish a link between the purpose of screening and improving client outcomes.

Criteria	Status	Evidence of meeting criteria
Universal screening		
<i>There is an intake policy that clearly states the purpose of screening for history of trauma and how it will be used to inform service planning. The policy will apply to all clients, regardless of how they enter the system (i.e., which “door”).</i>		
<i>The screening and assessment process is fully discussed with clients. Client choice and control of what will be disclosed is emphasized throughout.</i>		
<i>The potential for re-traumatization during screening and assessment is formally acknowledged by the organization and policies are in place to minimize this risk (e.g., assessment is conducted by practitioners knowledgeable about how to support clients who display symptoms of trauma during assessment).</i>		
<i>The screening and assessment protocol is informed by currently available academic and practice evidence about being trauma-informed.</i>		
Location for intake assessment		
<i>Intake conducted in a private, confidential space.</i>		
<i>Appropriate interpreters are provided, as needed (e.g., not a family member or an interpreter not trained in trauma).</i>		
Follow-up		
<i>Screening is followed up (as appropriate) with opportunity for consumers to become aware of how trauma is connected to MHSU concerns, to learn coping skills, to disclose history of trauma at their pace.</i>		
<i>Supports are in place for consumers after assessment if trauma history is discussed.</i>		

»»» See Section 4.3: ASKING ABOUT TRAUMA in the Trauma-Informed Practice Guide

»»» See Appendix 4: ASKING ABOUT TRAUMA in the Trauma-Informed Practice Guide

7. POLICIES AND PROCEDURES

The policies and procedures of the organization should reflect their commitment to trauma-informed practices and be based on available evidence.

Criteria	Status	Evidence of meeting criteria
Overall		
<i>Your organization ensures that all current policies and protocols are not hurtful or harmful to the trauma survivor; they are respectful; and promote safety and flexibility.</i>		
Consumer choice		
<i>Clients are given full choice in what services they receive and are allowed to make decisions about their level of participation and the pacing of these services.</i>		
<i>Clients are encouraged to make informed choices through education and discussion of potential services available to them, as well as the benefits, limitations, and objectives of each.</i>		
Survivor involvement		
<i>Trauma survivors/former clients are involved in the creation and evaluation of policies and protocols.</i>		
<i>Clients are able to make suggestions for improvement in ways that are confidential and anonymous and/or public and recognized.</i>		
Cultural competency		
<i>All policies respect culture, gender, race, ethnicity, sexual orientation, and physical ability.</i>		
<i>Programs and program information are offered in multiple languages, whenever possible (relevant to the languages most common within the catchment area for your organization).</i>		
<i>Consumers are able to speak their first language, when possible.</i>		
Privacy and confidentiality		
<i>All staff and consumers are aware of what is involved in the informed consent process—including the extent and limits of confidentiality, what is kept in records, and where the records are kept.</i>		
<i>There are established processes that support consumer awareness and understanding of informed consent.</i>		

Criteria	Status	Evidence of meeting criteria
Safety and crisis planning		
<i>All clients have individualized safety plans that are fully integrated into the programs' activities. Safety plans should include a list of stressors, specific helpful strategies, specific non-helpful strategies, a list of people consumers feel safe around.</i>		
<i>There is service policy that informs how individual safety plans are used in a crisis and reviewed when necessary.</i>		
Avoiding re-traumatization		
<i>There are policies or procedures in place to minimize the possibility of re-traumatization.</i>		
Supportive/Emotionally safe program		
<i>Consumer rights are posted in visible places.</i>		
<i>The program avoids involuntary or potentially coercive aspects of treatment (e.g., involuntary medication, seclusion, restraints).</i>		
Physical Environment		
<i>The space around the program building is safe (e.g., parking lot and sidewalks well lit, directions to the program are clear).</i>		
<i>The physical environment is attuned to safety (e.g., it calming and is it comfortable).</i>		
<i>The first contacts with consumers are welcoming, respectful and engaging.</i>		
Referrals		
<i>Based on intake assessments, consumers are referred to accessible, affordable trauma-specific services as necessary.</i>		
<i>Clients are engaged in the decisions about referral(s) to external programs, if any, and are informed about what to expect of the referral agency.</i>		
<i>Consumers are supported through the transition to external services.</i>		

»»» See Section 4.2: ENGAGING in the Trauma-Informed Practice Guide

8. MONITORING AND EVALUATION

Ongoing monitoring and evaluation is important to ensure that services remain relevant to consumers and that policy and procedures are implemented consistently across the organization. An organization must decide on what indicators they wish to use to evaluate the program.

Criteria	Status	Evidence of meeting criteria
Monitoring		
<i>Information on client experiences of trauma is gathered and used to inform service planning.</i>		
Evaluation		
<i>Evaluations of trauma-informed policies and practices are conducted as part of the regular review and planning process, and this information is used to inform and adjust practice.</i>		

More information on trauma informed organizational assessment is available from

- *Developing Trauma-Informed Organizations: A Tool Kit*
Institute for Health and Recovery
www.healthrecovery.org
- *Trauma-Informed Organizational Toolkit*
Center for Mental Health Services, SAMHSA
http://66.104.246.25/ucla/Trauma_Informed_Organizational_Toolkit.pdf

APPENDIX 3

Info Sheet on Trauma-Informed Engagement Skills

Skills & Strategies for Engagement—Linking Motivational Interviewing and Trauma-Informed Practice

Motivational Interviewing (MI) [71] is an evidence-based communication style shown to improve engagement, retention, and treatment outcomes across numerous health areas including MHSU [72, 73]. The efficacy of the approach is also noted for working with youth [74, 75] and ethnic minority groups [72]. There are many parallels between the principles of MI and trauma-informed practice, including emphasis on collaboration, and respect for autonomy and empowerment. The value of integrating the approaches is gaining attention [76-78].

There are a number of skills and strategies that can be drawn from MI to build and maintain engagement and can be used throughout interactions with individuals and families: open-ended questions, affirmations, reflective listening and summaries (also known by the acronym OARS); opening statements; and, agenda setting.

1. OARS

Open-Ended Questions

Open-ended questions cannot be answered with a yes or no, or simple one word answers. They create the space for people to tell their story in their own words, thereby influencing the direction of the conversation and supporting engagement.

Practice Examples:

“What are you already doing to take care of yourself?”

“What concerns you most about your health, if anything?”

“What have you noticed helps you when you are really stressed?”

“What do you need to get out of this group to make it worth your time?”

“You’ve mentioned other similar programs you’ve attended in the past. What needs to be different this time to make it worth your while?”

“How can we support you to feel safe in this program?”

“How have you managed to get through other difficult times in your life?”

There may be situations when open-questions feel too broad or overwhelming for some (e.g., when working with youth, individuals with cognitive challenges, language barriers). One variation is to offer multiple choice answers so that the individual still has options, and the response is contained [74].

Note: Closed-ended questions that are answered with yes/no (“Do you have children?”) or one word (“How many children do you have?”) are sometimes necessary. Generally speaking, the practitioner uses more open-ended questions to engage the individual in the conversation and avoids asking too many questions in a row, rendering the individual passive in the interaction.

Affirmations

Genuine, specific, and relevant affirmations build self-efficacy and offer a compassionate mirror for self-reflection. Affirmations acknowledge effort and strength; offer appreciation and understanding; and recognize success—all important components of trauma-informed practice. Keep in mind, this may be a very different experience for individuals with a history of trauma. It may take some time for them to trust that your responses are genuine. It is important to share affirmations in a tone that conveys empathy and support.

Practice Examples:

“No matter what, you don’t give up.”

“Your children are your first priority.”

“You have been through so much in your life and are doing everything you can to make sure that things are different for the next generation.”

“You made it here today, in spite of all the chaos at home this morning.”

“I can see you practicing your grounding skills, even as we are talking.”

“You are doing really well at school even though there is a lot you are dealing with right now.”

Reflective Listening

Reflective listening is an essential skill for engaging and maintaining connection. Reflections help individuals to feel heard and valued. For many, this may be a new experience. Practitioners listen for the meaning and essence of what they believe they have heard the individual say and offer back a statement of understanding [79]. There is no wrong answer, and you have immediate feedback in terms of what the individual says next and whether the conversation keeps going. Ultimately, you want the individual to keep talking.

Reflective listening can also be quite helpful with someone who is non-verbal. Perhaps they don’t want to be there or they are not sure what is expected of them, what to say, or what is safe to say. Responding with a reflective statement is less likely to draw out resistance [71]. A question requires a response and asking too many questions can create a power-dynamic whereby the practitioner asks the questions and the individual seeking treatment feels they have to respond.

Practice Examples:

Youth: You're the third person I've had to talk to since I got here...I am so sick of answering everyone's questions.

Practitioner: It is really frustrating to have to keep retelling your story. You're wondering if I can be helpful, or if I will just pass you on to the next person.

Woman: I don't want to feel this way, but I just have no idea how to make the pain stop.

Practitioner: Nothing you have tried has worked so far...and at the same time you know somehow that things can be different.

Man: I know I need to go back to work, but every time I think about getting in the car and driving, I get knots in my stomach.

Practitioner: You are wondering how you are going to do it.

Summaries

In trauma-informed practice, summaries are a helpful way to link ideas, reflect mixed feelings about change, clarify understanding, focus and contain the conversation, and facilitate transition to next steps.

Practice Example:

"Let me make sure I understand what you have told me so far...it was a big step for you to come in and speak with someone today. You have been struggling for a while and, for the most part, have managed to take care of things on your own, go to work, manage the household... and then this big change happened when you lost your job. That's thrown you back into old familiar patterns...you're noticing that you feel on edge all the time; quick to anger; and there are days when you can't get out of bed. You're starting to isolate yourself again. It's like the ways you knew how to stop your mind from racing are gone and things are spinning out of control. This is the first time you've started to talk about all of this out loud. You've reached a point where you realize that you can't do this on your own and need some support and you're just not sure what type of support you need... What did I miss, if anything?"

2. OPENING STATEMENT

The opening statement sets the tone for the conversation. The purpose of the opening statement is to begin with role definitions and to state how this interaction may be different from other conversations they have had, including with other practitioners. The key is to convey that you will support the individual in the changes they would like to make, not to tell them what they should do [74]. Despite the best intentions of practitioners, individuals may expect to be lectured and shamed about their perceived inadequacies, substance use, mental health concerns, etc. They may walk in the door, having already rehearsed what to say in response to expected questions, and are ready to tell you all the reasons why the program or service will not work for them. Explicitly letting the individual know that you are there to support them and figure out together the most helpful way forward conveys collaboration and safety, and honours autonomy.

Practice Example:

“Thank you for taking the time to speak with me. I appreciate it’s not easy coming to a new program and speaking with someone you don’t know [introduce self & role, review confidentiality, how much time you have etc.]...Our conversation may be different than those you have had with other people you have spoken with. Rather than telling you what to change and how to fix it, I’d like to find out how I can be helpful and support you in the decisions you choose.”

3. AGENDA SETTING

Agenda setting can be done in different ways, depending on how much time you have, your role, and context. Ultimately, the goal is to collaboratively find the focus of the conversation and get a sense of what is most important to the individual at this time [80]. It is a strategy that can be returned to throughout your work together, to start the conversation, find focus, or develop a plan. It can also be adapted for a group context.

One way to begin is by using a bubble sheet or agenda setting sheet (see pg. 49 for a blank copy of the Agenda Setting Worksheet), listing some of the areas that you have conversations about with all individuals who come to your service. By limiting the conversation to 5-7 topics, you minimize the risk of overwhelming the individual. Indicating the key areas also conveys the topics you know something about, establishes the parameters of your role, normalizes the types of conversations you have, and opens up the agenda to include a variety of areas related to MHSU. Keep in mind, it is important to focus on areas that individuals can control [76] and pay attention to the language used. Leave some circles blank for other topics the individual may want to add.

Practice Example:

“Let’s take a look at this sheet together. These are some topics that other people have wanted to talk about and some of the areas where our program can offer support. For example, housing, mental health, employment, relationships, parenting support, as well as substance use...and there may be something else that is more important to you right now that you would like to add... [individual responds]...So, looking at these topics, which would be the most helpful to start with today?”

Adaptations

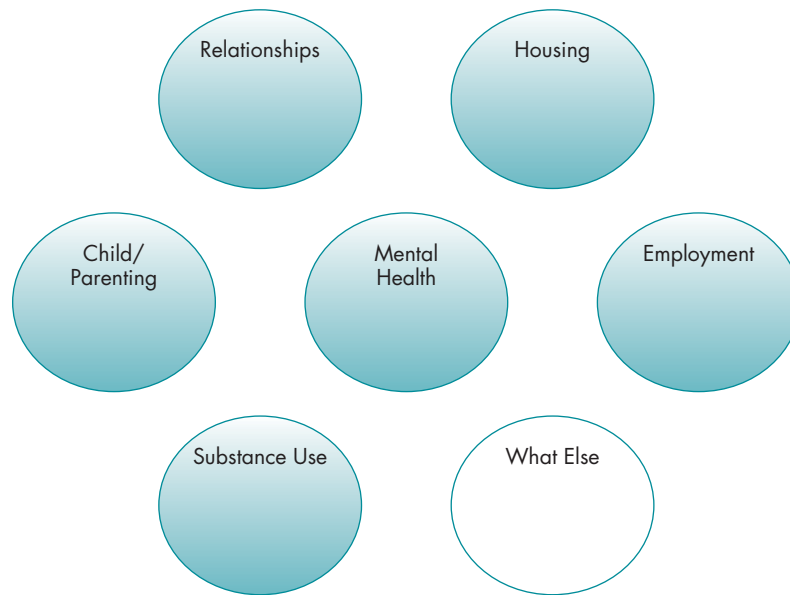
As with any strategy, you want to adapt the approach depending on who you are working with by considering diversity, age, developmental stage, and cognitive abilities [74, 81, 82]. For example, using images that are age or culturally appropriate (instead of words) and reducing the number of topics and/or using visual aids when working with someone with cognitive challenges.

Agenda Setting When Time is Limited

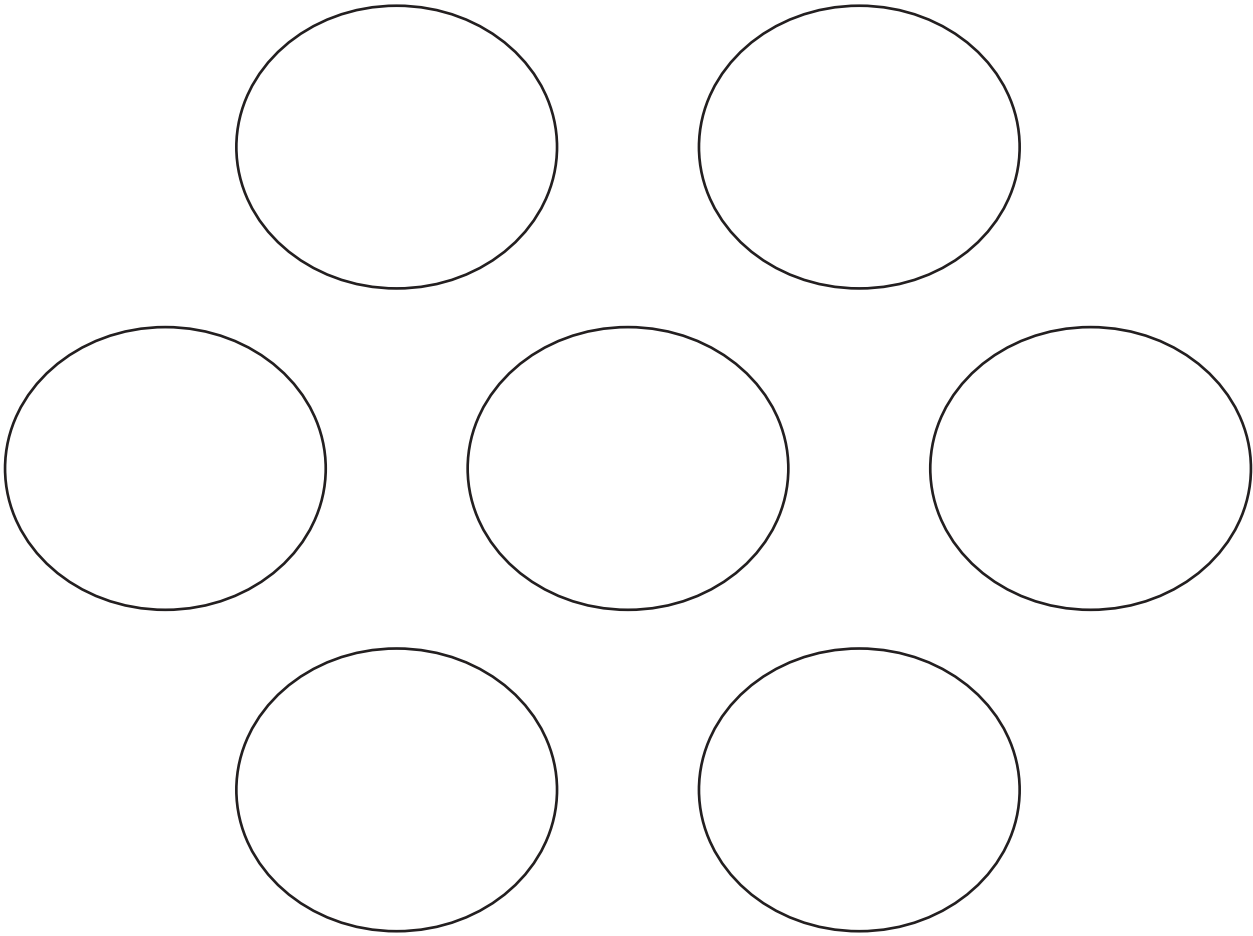
If your time is limited and you do not have the opportunity to do more comprehensive agenda setting, consider asking permission before moving too quickly into information. You can also use an open-ended question to draw out the individual’s perspective about how things are going for them.

Practice Example:

“We only have a few minutes today, and I wanted to follow-up on the conversation we started last time about your troubles sleeping and the nightmares you have been having, wondering where that conversation may have left you. Would that be okay?... [individual responds]... What have you noticed since the last time we spoke?”



Appendix 3a – Agenda Setting



APPENDIX 4

Info Sheet on Asking About Trauma and Responding to Disclosure

Skills & Strategies for Asking About Trauma

A number of skills and strategies can be used to support practitioners in asking questions about experiences of trauma, while building and maintaining safety and engagement. Depending on the practice setting and population served, practitioners will need to tailor the approach accordingly.

Providing a Rationale and Normalizing Questions

When introducing questions about past experiences of trauma, it is important that practitioners normalize the process and provide a rationale by linking past experiences to current functioning and health. The setup will vary depending on the type of program and services offered.

Practice Examples:

“Because the things we have experienced in our lives can often impact our health—even if they happened a long time ago—we ask the following questions of all people that come to our program.”

“Some women (or men) want to talk with their practitioners about very personal or difficult topics. If you do, I am open to listening. I don’t need to know all of the details, only what you think would be helpful.”

“These things can be hard to talk about. At the same time, it is important to ask because we are learning more and more about how traumatic experiences can affect a person’s health and how they manage in life. You don’t have to discuss this with me if you don’t want to. If you do, we can work together to ensure you feel safe in our program and to get whatever support or assistance you need.”

Making Choice Explicit

It is critical that individuals accessing MHSU services understand that they have choice in answering the questions asked. They must be assured that their decision whether or not to answer will not impact the quality of care they receive.

Practice Examples:

“You do not have to answer questions you don’t want to.”

“If there are any questions you are not comfortable answering, that’s no problem. You can just tell me to pass and we’ll move on.”

“I appreciate that you have talked with a number of people today, and it can sometimes feel like a lot. If at any point you need a break, just let me know.”

Questioning Informally

As described above, some programs and practitioners choose a more relational and informal approach to screening and assessment for experiences of trauma. Others may combine both formal and informal approaches. The following questions aim to inquire about past trauma in a non-threatening way, while remaining present focused.

Practice Examples:

“How do you connect your experience (as a child, when you were younger, while in combat, in your home country, with the accident, etc.) with how you are feeling/managing/coping now?”

“Are there things in your past that still bother you in an ongoing way?”

“Are there things in your life now that worry you? What are your thoughts about any connection with something that might have happened to you in the past?”

“What would you like me to know about you?”

“What is hardest for you these days?”

“What are you dealing with right now?”

“What are your current stressors?”

“What is your sense of what your sleep troubles might be related to?”

“Is there anything in your history that might make seeing a practitioner or ... (staying in residence, working in a group, getting to the program, etc.) difficult? If there is, I would like to hear about it so that we can find solutions together.”

Eliciting Strengths

Trauma-informed assessments are also strengths-based assessments. Practitioners purposefully draw out what is working, strengths, interests, goals, and skills in order to foster self-efficacy, support empowerment, and highlight resiliency. This can be done through the use of resource mapping (developing creative visual depictions to guide and support self-reflection). Here are some other open questions to assist practitioners in a strengths-based conversation.

Practice Examples:

“How have you managed to get through the tough times in your life?”

“What/who are your supports?”

“What is your source of strength?”

“What would your friends say are your biggest strengths?”

“What keeps you going?”

“What are your hopes for the future?”

“What are some of your interests or passions?”

“What has kept you going, even when you weren’t sure you could?”

“What are you already doing to look after yourself (family, children etc.)?”

Practice Traps—Asking About Trauma

There are a number of practitioner responses related to asking about trauma and disclosure that can get in the way of providing trauma-informed care—sometimes to the point that they may even be harmful to engagement, trust, and safety.

- **Asking for details** (e.g., “Tell me from the beginning how it started.”) Sometimes curiosity, as well as personal or professional beliefs about how people heal from trauma (e.g., people need to tell their story) can influence the amount and depth of information gathered. Questions should be limited to a ‘need to know’ basis as they relate to current care.
- **Confronting** (e.g., “It makes sense now why you would feel this way—it sounds like you were abused.”) Practitioners may see strong connections between present health and past experiences of trauma and feel compelled to share their opinions or observations—to the point of confronting the individual. In their attempts to be helpful, this approach could hurt the well-being of the individual seeking help and damage the relationship. Making the links with past trauma needs to be done skilfully (see *Section 4.4: Making the Links with Trauma*), taking into consideration timing, support, and individual capacity to integrate this information.
- **Minimizing or ignoring the experience** (e.g., “It happened a long time ago. That’s history now,” or “After this accident, I’m sure you’ll never drink and drive again.”) Factors such as time pressures and uncertainty or discomfort with how to respond could lead to minimizing or even ignoring the disclosure.
- **Focusing on the negative** (e.g., “Something like that can ruin your life.”) Overstating or dwelling on the negative is disempowering and can evoke a sense of hopelessness. It also may give the message to the individual that their story is too horrible to listen to.

- **Making assumptions** (e.g., “I am sure that life is much better without your partner controlling you.” or “You and your family must be so much happier here in Canada.”) Rushing, not listening carefully, and wanting to be helpful are just three factors that can lead to assumptions and inappropriate responses.
- **Making promises you can’t keep** (e.g., telling a child or youth “If you tell me your secret I won’t tell anyone,” which, if it includes a report of abuse, may need to be reported).

Skills & Strategies for Responding to Disclosure

If practitioners are going to ask about trauma, they must be prepared to respond to disclosures and when working with children and youth. They need to be prepared to report to child welfare or police, if necessary. For some, this may be the first time the individual has spoken of their experience out loud. Others may be in different stages of healing. Similarly, some individuals may find it helpful to eventually talk about what happened, while others find it is enough to have their experience recognized and validated. There is no pressure and no timeline for healing.

Healing takes many forms. In the screening or assessment phase of the conversation, the primary role of trauma-informed practitioners is to maintain safety, validate the experience, and respectfully contain the amount of information shared. It is not to delve into details. There are a number of considerations in response to disclosure [16, 53], including awareness of the need for age, developmental, and cultural considerations and adaptations.

- **Acknowledge the information and express empathy.** Pause the conversation and acknowledge the information has been heard through an affirmation or reflection, e.g., “I appreciate your honesty with me.” Offer a sincere empathic statement without patronizing or minimizing, e.g., “You have been through so much.”
- **Revisit confidentiality.** Review the extent of confidentiality. This will differ when working with children and youth. If appropriate, practitioners may ask individuals what they would like recorded in their health record, e.g., “This is a very important conversation, and I am wondering what, if anything, you would like me to write in your file?” And in situations where recording information is ethically or medically required, the practitioner could ask, “I’m wondering how you would like me to note what you have told me on your health record.”
- **Offer a larger context for the trauma.** Depending on the conversation, and if it’s helpful, there may be opportunity to provide a larger context to help the individual understand that they are not alone in their experience, e.g., “Many people who struggle with mental health and/or substance use concerns have had different experiences of trauma in their lives, for example violence, abuse, or car accidents.”
- **Validate what has been shared.** It is important that individuals see and hear from practitioners that their experience is believed and there is appreciation of the courage it took to share their story, e.g., “I can see that it took a lot of courage for you to share this with me today and you are exhausted. I will take your lead in terms of taking a break for now, perhaps finishing another day, or continuing with our conversation.”

- **Offer hope.** Assure the individual that the information they have shared will help with their care and that people do recover, e.g., “What you have shared with me today will help us determine the best way to assist you. Although it may be hard to believe right now, over time and with support, people do recover.”
- **Address time pressures.** Communicating time limits requires a balance of being respectful/ honouring the individual’s story and at the same time containing the conversation, e.g., “This is a very important conversation for us to have and I want to be able to give you my full attention. We only have 10 minutes left for today, so I wonder about setting up another meeting to have more dedicated time.”
- **Debrief the conversation and work together to create a self-care plan for the immediate future.** Depending on current functioning, resources, support, etc., individuals respond differently to disclosure. Practitioners are encouraged to watch for signs of trauma responses and let people know that they may react in different ways to the conversation. Some people may not require any action and others may need a more detailed self-care plan (see *Section 4.5: Skill Building and Empowerment*), e.g., “People respond differently to talking about upsetting memories. How are you feeling right now?... (pause)... I encourage you to check in with yourself throughout the day and notice what is happening for you (tired, anxious, at ease, sad, etc.). What is one thing you could do today to take care of yourself?”
- **Respond to immediate safety concerns** (threats of violence in the home, self-harm or suicidal thoughts, child safety, etc.). Practitioners use their clinical judgement to shift the conversation to more detailed safety planning and crisis intervention. Some British Columbia based resources to assist in safety planning and crisis intervention include the following:
 - If anyone has a concern that a child is being abused or neglected, they have a legal duty to report those concerns to the local child welfare authority. For more information, refer to The B.C. Handbook for Action on Child Abuse and Neglect For Service Providers: www.mcf.gov.bc.ca/child_protection/pdf/handbook_action_child_abuse.pdf
 - To ensure the safety of the individual, help them connect to Community Based Victim Services or other anti-violence outreach programs in your community. If you are unsure about what resources are available in your community, you can call **VictimLink BC** at 1-800-563-0808. A victim service worker can identify counselling and other services in your community.
 - Ending the Violence Association of BC, Freedom from Violence: Tools for working with trauma, mental health, and substance use. (2007) www.endingviolence.org/files/uploads/FreedomViolence3.pdf
 - You Are Not Alone: Violence, Substance Use and Mental Health— A peer approach to increasing your safety. (2009) www.endingviolence.org/files/uploads/PAVEWorkbook.pdf

- High Risk Cases of Violence Against Women in Relationships: Collaborative Safety Planning, Community Coordination for Women’s Safety. (2011) www.endingviolence.org/files/uploads/ning_in_High_Risk_VAWIR_Cases_Nov_2011_FINAL.pdf
- BC Crisis Centre www.crisiscentre.bc.ca
- Youth in BC, a program of the BC Crisis Centre <http://youthinbc.com>
- MCFD Suicide Prevention website for youth, family/caregivers and professionals www.mcf.gov.bc.ca/suicide_prevention

Making Referrals

Through screening and assessment, it may become clear that additional support could be beneficial to the individual or family. As offering choice is a core principle woven throughout trauma-informed care, it is important that practitioners are aware of options and make referrals accordingly (with the permission of those they are working with). Options may include peer support programs (16 Step Groups for Women, 12 Step Groups, parenting groups); community resources (lunch programs, clothing donation, child care); trauma-specific services that address the impact of trauma and support overall recovery (Seeking Safety groups, trauma counsellors, men specific trauma services). Whatever the next step might be for someone struggling with MHSU concerns and experiences of trauma, it is important that the individual knows that the final decision is ultimately up to them. Practitioners can support individuals in their decision-making process while offering assurance that people do recover and there is no one right way that works for everyone.

In addition to collaboratively identifying the type of support needed/wanted, there are other ways practitioners can help individuals prepare for and show up for referrals. Questions like “What would support look like for you? What would you need from the next person you speak with in order to feel safe and supported?” are important considerations that will guide the referral process and help to collaboratively envision the next step. Practitioners may also want to explore the possibility that the next conversation with another practitioner may not be the same, in terms of a trauma-informed approach. Brainstorming strategies on how to handle this and self-care can help people in their preparation.

Other practical ways that practitioners increase the likelihood of follow-up engagement are:

- Make the referral call with the individual, before they leave the appointment
- Provide a hand written follow-up note of encouragement and reminder
- Follow-up with a phone call after the initial visit
- Introduce the individual directly to the referral service or subsequent practitioner

An Integrated Screening Tool

This instrument was developed in California by a state wide coalition concerned with co-occurring disorders. It was designed to help service providers include questions about all three topics of mental health, alcohol and drug use, and trauma in brief screening.

Appendix 4a – COJAC Screening Tool

#1 Just Ask the Primary Screening Questions . . .

3 Questions for Mental Health

- Have you ever been worried about how you are thinking, feeling or acting?
- Has anyone ever expressed concerns about how you were thinking, feeling, or acting?
- Have you ever harmed yourself or thought about harming yourself?

3 Questions for Alcohol & Drug Use (Health Canada Best Practice Report):

- Have you ever had any problem related to your use of alcohol or other drugs?
- Has a relative, friend, doctor, or other health worker been concerned about your drinking or other drug use or suggested cutting down?
- Have you ever said to another person, “No, I don’t have an alcohol or drug problem,” when around the same time you questioned yourself and felt, maybe I do have a problem?

3 Questions for Trauma/Domestic Violence:

- Have you ever been in a relationship where your partner has pushed or slapped you?
- Before you were 13, was there any time when you were punched, kicked, choked, or received a more serious physical punishment from a parent or other adult?
- Before you were 13, did anyone ever touch you in a sexual way or make you touch them when you did not want to?

#2 If index of suspicion is high for mental health, substance abuse, and/or trauma, then complete either:

- GAIN Short Screener (SS)
- OR
- Modified MINI

(Adapted from Collaborative Care Project, Canada and Co-Morbidity Screen, Boston Consortium.)

To learn more about the context and application of this tool go to
<http://www.adp.ca.gov/cojac/screening.shtml>

For a PDF copy of the tool go to
http://www.adp.ca.gov/cojac/pdf/cojac_screening_tool.pdf

See also: Brown, V. B. (2012). Integrated Screening, Assessment and Training as Critical Components of Trauma-Informed Care In N. Poole & L. Greaves (Eds.), *Becoming Trauma-informed* (pp. 319-329). Toronto, ON: Centre for Addiction and Mental Health.

APPENDIX 5

Info Sheet on Strategies for Sharing Information About Trauma

Skills and Strategies for Sharing Information About Trauma

The approach taken to make the links and share information is critical. Practitioners listen for opportunities to reframe individual statements and responses from a strengths-based and empowering perspective, and share information in a respectful way that honours the individual as the expert in their own life. Information may be shared in one-on-one or group formats and, when appropriate, supported by print materials. No assumptions are made about what people do or do not know; what information may be helpful; that more information is better; or, that the information alone will be enough for change. Practitioners remain empathically attuned throughout the information sharing process and offer grounding and containment as needed (see *Section 4.5: Skill Building and Empowerment*). Communicating in this way helps to avoid powering-over and becoming the expert. Your emphasis continues to be to strengthen safety and empowerment.

Reframing

Reframing involves communicating and responding in a way that offers a new or different perspective. In trauma-informed practice, practitioners explicitly reframe symptoms as adaptations or coping strategies to help de-stigmatize trauma responses. The impact can be quite powerful. For example, understanding symptoms as adaptations may reduce individual guilt and shame, and create an opportunity to learn a healthier adaptation to current situations and experiences [25].

Practice Examples:

Individual: “I don’t know why I respond like that...it’s like I lose my mind.”

Practitioner: “Given everything that you have described, it sounds like a pretty normal response to abnormal events.”

Individual: “I feel like such a failure. Here I am back in the hospital again.”

Practitioner: “No matter how bad things get, you don’t give up. You know what you need to do to keep yourself safe.”

Individual: “I don’t know why I freak out like that when my partner is late. I hate myself afterwards.”

Practitioner: “Based on what you have described, your childhood experiences of never knowing if your parents were going to follow through, it makes sense that it is important to you that people are reliable and dependable. You are doing the best you can, based on what you know, and trying to communicate this with others...(pause)... I wonder if you’d be interested in looking at some other options for how you might express this to your partner and others.”

Elicit—Provide—Elicit

To ensure collaboration, respect for autonomy, and active involvement of those receiving the information, practitioners need to be aware of how they provide information. A motivational interviewing strategy for sharing information, known as elicit—provide—elicit (EPE) [80], is noted to integrate well with a trauma-informed approach [78] and could be used in an individual or group format. The practitioner begins by drawing out from the individual/group what they may already know about a specific topic (e.g., the connection between depression and trauma); builds from that by offering, with permission, information tailored to the individual/group and their situation or topic; and ends by again eliciting the individual's/group's voice and understanding of the information shared. This flow helps to avoid making assumptions, respects readiness to receive information, and clarifies what has been heard and how it may or may not fit with their experience.

Practice Examples:

Elicit

Find out what the individual knows or what their understanding is: “What have you heard about ...?” “What are your thoughts about how some of your past experiences may or may not be influencing what is going on in your life now?”

Ask permission to share more information: “Would you like to know more about...?”

Provide information

Avoid making assumptions or jumping to conclusions.

Create safety for the individual to be able to say that it doesn't fit for them: “This may or may not fit for you, but from what you've told me, I'm wondering if there might be some connection between...”

Offer factual information: “I have some information on the different ways that trauma can impact people's lives. Some people want a lot of information, and some only a little. Please let me know what works best for you. We can stop at any time.”

Elicit

Inquire about how the individual understands the information: “What do you make of this?” or “How does this fit with your experience of...?”

Provide Written Information

Having print materials available can be helpful to support the discussion of the links with trauma, and provides something concrete for people to take away with them and review as needed. Be sure to ask permission to provide the materials (as it will not be appropriate for all) and offer to read them with the individual to avoid making assumptions about literacy levels. This may be a lot of new information and hard to digest verbally, especially if English is not the individual's first language or if the individual is overwhelmed, exhausted, anxious, or even triggered by what is being shared. At the same time, the practitioner should not assume that the information will be distressing for most people.

The materials you use will vary depending on your service and who you are working with. Some considerations when choosing print information include:

- Who is the audience?
- What is the language level? Is the information available in any other languages?
- Is the information presented in a culturally appropriate way?

Examples (Canadian Print):

Common questions about the effects of trauma

http://www.camh.ca/en/education/about/camh_publications/Pages/common_questions_trauma.aspx

Women: What do these signs have in common? Recognizing the effects of abuse-related trauma

http://knowledgex.camh.net/amhspecialists/resources_families/Pages/women_recognize_trauma.aspx

Information on Post Traumatic Stress Disorder (PTSD) for refugees and new immigrants

http://knowledgex.camh.net/amhspecialists/resources_families/Pages/ptsd_refugees_brochure.aspx

Practice Traps—Making the Links with Trauma

There are a number of practice traps to keep in mind as you share information overall and support individuals in making links to their experiences of trauma:

- Getting caught in the need to give information without careful consideration of pacing and readiness.
- Prioritizing providing information over staying connected.
- Providing information without asking permission.
- Talking more than the individual and not checking in around their understanding and perspective.
- Using technical language they don't understand or that isn't culturally or age appropriate.
- Not sharing information with families/caregivers that could help them to understand and support their children or youth.
- Not sharing information that, ethically, you need to share. Avoiding bringing up the topic of trauma.
- Sounding like an expert or mixing information with advice: "What you need to do is" or "What I suggest you do is..."

APPENDIX 6

Info Sheet on Grounding Skills and Self-Care Strategies

Skills & Strategies for Teaching Grounding and Containment Skills

Learning grounding, containment, self soothing and self compassion skills can be important for staff and clients in trauma-informed organizations and systems. These skills should be taught by trained practitioners, included in client safety plans and reinforced by everyone in trauma-informed organizations. In addition to supporting individuals to learn specific grounding techniques, practitioners can offer safety, hope, trauma awareness, and validation by staying connected with and attuned to them. As a practitioner, your own capacity to stay present and grounded is crucial when recognizing an individual's emotional reactivity, aggression, withdrawal, isolation, and silence as possible trauma responses. Within the limits of safety, you build collaboration and empowerment in your willingness to let them set the agenda and the pace. When a trauma response 'pulls their legs out from under them' [67], you stay present and help them stay connected to you and your shared environment. In this 'teachable moment'—they gain a direct experience of recovering when knocked off balance by emotions, sensation, or thoughts [67]. They borrow your confidence while strengthening their own. Many grounding/containment skills and self-care strategies for clients are available and can be successfully adapted for individual and group contexts, as well as working with adults and youth [14, 24, 83].

Grounding/Containment Skills

Grounding is the immediate therapeutic approach for dealing with any form of dissociation or flashback. The following skills were selected for their simplicity and transportability across situations and settings.

Begin with resource-mapping by asking the individual what they are already doing in real life situations that is helpful to contain or eliminate distressing feelings, thoughts, images, or sensations. What is working for them now or has worked in the past? Are there grounding strategies that they have tried in the past that don't work for them? For example, breathing exercises can trigger intrusive memories of past events. It can be helpful to ask parents/caregivers if there are particular things that they believe may help their child or youth to remain grounded. They may already have grounding strategies in place that can be built on. Ideally it is best to practice grounding skills daily, rather than only when distressed [66].

The goal of any grounding technique is to have less fear around emotions, establish a sense of balance, and:

- Reconnect the individual to the present/orient the individual to the here and now
- Connect the individual to their body and personal control
- Connect the individual to the practitioner and a safe environment [17]

As a trauma-informed practitioner, you provide safety for yourself and the individuals you work with when you maintain connection while offering containment for difficult sensations, thoughts, and feelings. You send the message that the individual is neither ‘broken’ nor ‘needs to be fixed’. When you help them stay connected to you, their own internal sensations, and your shared external environment, they have a choice and a container for overwhelming sensations. In these practice-based moments, you are teaching portable skills.

In the examples below, the practitioner is speaking in a calm, clear, warm, and strong voice with an individual seeking service. The timing of the practitioner’s words, with frequent pauses to allow integration, follows the rhythm of the individual’s breathing (the practitioner’s eyes remain open and watching). Some examples of grounding skills follow. If you have already taught scaling as depicted below, you can then choose to use it as the beginning and end point of any grounding practice. The guided practices below offer choice to practitioners and those receiving support and can be adapted to individuals of any age or from any cultural background. Also be aware of language, as some phrases or words may be triggering for survivors of interpersonal violence (e.g., “relax,” “you’re safe”). It is also suggested that individuals keep their eyes open during the grounding exercises, to support connection to the present moment. Dialogue examples are included.

1. Scaling

Scaling offers practical, active learning and feedback opportunities that contribute to an increasing sense of empowerment. Invite the individual to name their current sensations (“I feel like I’m going to be sick,” “my heart is racing,” “I can’t catch my breath”). Then ask them to scale their level of distress from 0-10, where 10 is very high. After the grounding practice, invite them to scale again and reflect on any change in the number. If the number of distress is still above 5, do the grounding practice again.

- *Titration* (“the difference between a 6 and a 10”)
- *An experiential repertoire of resources* (“drinking a full glass of water helped bring my anxiousness down from 6 to a 3”)
- *Earlier recognition and intervention* (“my depression doesn’t immobilize me if I recognize its early warning signs and get myself outside”)
- *Wisdom* (“changing what I do affects how I feel and what I think”)

2. Breathe

Breath is a subtle sensation in the face of a powerful emotion. With practice, it can become an ever-present ‘friend’ and an alternative, encompassing focal point. When you focus on breath, breathing tends to slow down, which in turn slows down the heart rate and mind chatter. In preparing for a session, you might have available the following script:

“While still noticing your feelings, let’s now include into your awareness the soothing feeling of your breath. On your next inhale, breathe through your nose; notice the stirring of breath on your upper lip; the temperature of the breath in your nostrils; the touch of the breath in the back of your throat. On your exhale, notice your emptying sensations and the natural pause between when all your breath is out, but before your next inhale begins. Continue to breathe in and out, noticing all the different sensations and contact points of your breath with your body.”

Continue to notice the sensations of breath; notice now the natural pause after in-breath and the natural pause after out-breath. Breath comes and goes in its own rhythm.

Now let's take a 3-part breath, starting in the belly; relaxing and filling your belly on in-breath; filling your ribs and lower lungs; and now the upper chest. Breathe out with a long slow breath, emptying in reverse order; now the upper chest; now the ribs and lower lungs; now the belly. Continue breathing this 3-part breath at your own natural rhythm, with no strain, relaxing every muscle that doesn't need to be working."

3. Feet to the Floor

"Let's stand and feel our feet. Bring your awareness to your feet, noticing your connection to the floor/ground. Imagine your feet as if deep tap roots into the earth, embedded in solid, strong, stable earth that nourishes and supports you. Notice how your weight is distributed between your feet; perhaps one foot feels like it has more pressure or feels different than the other; maybe you are leaning more into your toes or your heels. Continue to feel into your feet, breathing out through your feet into the earth; breathing in from the earth to your feet. Now stamp your feet and feel how solid, strong, and unbreakable the ground is beneath you, no matter how hard you stamp. Stretch and flex your toes and take a few slow deep breaths."

4. A Solid Chair

"Notice the support of the chair underneath you; how solid the chair feels. Relax fully into the chair's support; let go of every muscle that does not need to be working right now. Notice how your back contacts the chair; notice how your back straightens as you sink into the chair."

5. Focusing on Senses: 5-4-3-2-1

This is a very focused activity and especially helpful in strong emotions, bringing awareness to the environment and external senses. What do you notice that you are seeing? Hearing? Feeling through touch?

The individual begins with 5, for example: *"5 things I see: my reflection in the glass; the striped shirt; the blue coffee cup; the fan; the light. 5 things I hear: the buzz of the computer; the hum of florescent lights; the sound of my breathing; the hum of the lights; my breath. 5 things I feel: my fingers pressing the keyboard; the chair beneath me; my foot on the floor, my legs crossed"...*

They then continue with *"4 things I see; 4 things I hear; 4 things I feel; 3 things I see" down to "1 thing I see, 1 thing I hear, 1 thing I feel, 1 thing I see."*

6. Embodied Affirmations

Guide the individual to find realistic, self-generated, strengths-based statements that resonate within them. For a more embodied approach, suggest they tap alternative thighs (Shapiro, 2012) or gently tap the sternum with an open hand while repeating the affirmation, allowing time to feel and digest every word.

Affirmation examples:

- Everything passes; this (strong emotion) too is changing.
- Just this next step is important right now.
- Even if my thoughts try to drag into the future or past, I am here, breathing, now.
- Sensations are just sensations. Thoughts are just thoughts. I watch them come and go.
- I *can* do this (something small, specific, concrete, positive, e.g., wash the dishes, sweep the floor, step outside).
- This *is* enough.

7. Clap Your Hands Together

“Clap strongly and feel the slight sting as your hands meet. Now clap softly and feel for the movement of air between your hands. Put your full attention on this one simple act and see how many things you can notice about what your hands feel.”

Now rub your hands together vigorously until they generate some heat. Feel the heat in your palms and then bring your hands to rest over your eyes and take a few slow deep breaths.”

8. A Safe or Calm Place

“When I ask you to recall a time or place where you can remember feeling calm and safe, with no negative connections, what comes to mind? (You can prompt if necessary, perhaps by a body of water, beside a favourite tree, in a favourite chair by a window). As you remember this place and see it now in your mind’s eye, tell me about any colours (textures, shapes, smells) you notice. Now check into how you feel; tell me what you’re noticing now in your body (in your hands and feet, your heart, your stomach). As you share this place with me, is there one word that describes it, that anchors you in this experience? We’ll do this a few times together now, silently to yourself: Bring up this safe place again, notice how you’re feeling and anchor your word in your mind (pausing in between). I encourage you to do this at home, several times a day when you’re already feeling calm, to strengthen this connection between the word and feeling and image. It can become your instant home, a safe and calm place, and especially helpful when you want to ‘change the channel’ from an upsetting thought or feeling.”

Examples:

“To help young children ground, I’ll blow bubbles with them. It focuses on slow, deep breathing and is fun and distracting. Other imagery-based exercises can be helpful for children (going to a safe place, focusing on the five senses). I warn teens that relaxation/imagery-based approaches could bring up images, in which case I use more strict grounding approaches.”
(Psychologist, Youth Concurrent Disorders Program)

Recognizing a service gap for women with trauma and MHSU concerns in terms of early strategies for coping and safety, the Victoria Women’s Sexual Assault Centre collaborated with the Vancouver Island Health Authority to adapt the Seeking Safety model [24]. The group support, led by a substance use counsellor and trauma counsellor, is offered in two parts:

- 1. Seeking information—3 weeks, focusing on coping strategies*
- 2. Seeking Understanding—12 weeks, where specific topics related to trauma and substance use are examined in more depth.*

The response from women has been positive on many levels.

In their Seeking Information groups and TIP trainings, the Victoria Women’s Sexual Assault Centre facilitators teach skills such as grounding, containment, reframing trauma, mindfulness practice, and self-compassion.

Increased self compassion has been found in research by Dr. Kristin Neff [84] to be associated with gains in mindfulness, compassion for others, social connectedness, life satisfaction, happiness, depression, anxiety and stress.

Many other services have found teaching of breathing, grounding and self soothing to be important skills for clients and have made tools available on the internet.

Appendix 6a – 33 Quick Ways to Ground

Regular practice of favourite grounding technique(s), when already feeling calm, helps you to:

- shift focus-of-attention and strengthen access to positive memory networks [66]
- establish personal safety, choice, and power by identifying, containing, and/or eliminating any intrusive thoughts/feelings/sensations
- immediately connect to this present moment, time, and place, here and now
- feel into the senses and the body's way of knowing
- offer safety, hope, and choice with others, when you can remain connected and grounded

1. Drink 3 glasses of water, slowly.
2. Use strong sensory input to quickly ground. Place your hands in a bowl full of ice and water. Suck on an ice cube.
3. Peel an orange or a lemon; notice the smell; take a bite.
4. Change your environment. Get outside. Go for a walk.
5. Breathe slowly, consciously, in 4 part awareness: breathe in for a count of two; hold for a count of two, breathe out for a count of two, hold out for a count of two.
6. Spend time with a pet. Watch a squirrel. Study a colony of ants.
7. Take an unhurried shower or a bath. Sense a full connection with the water.
8. Dig in the dirt in your garden.
9. Play your favourite upbeat song and sing along.
10. Move around. Feel your body. Experience a full stretch of your arms, hands, fingers.
11. Splash water on your face.
12. Turn lights on.
13. Hug a tree.
14. Describe what is around you in the smallest detail.
15. Picture your calm place. Look at an actual picture of a vacation spot, child, or pet. Carry this picture with you.
16. Carry a grounding object in your pocket. Touch it for grounding.
17. Get down on the floor and stretch like a cat.

18. Walk *very* slowly, noticing the sensations as your heel lifts, your weight shifts through the arch and into your toes, the foot lifts. Marvel at the body's precision.
19. Buy one beautiful flower.
20. Light a candle and study the flame. Notice the darker inner flame.
21. Go out in the middle of the night and watch the stars. Embrace the intelligence of the universe where everything belongs and has its place.
22. Turn off the TV. Go outside. Develop a pattern, then walk it into new environments. 'I'll turn right after 3 blocks, left after 2, right after 1'. Repeat. Make sure you can find your way home.
23. Feel the aliveness of green grass on bare feet.
24. Name your 3 favourite colours, foods, animals, etc.
25. Really listen to nature's sounds: waves, wind, birds, rain.
26. Hum your favourite upbeat song.
27. Boil cinnamon in water. Enjoy the fragrance. Google the exotic history of cinnamon.
28. Sample flavours in an ice cream store.
29. Suck on a piece of your favourite hard candy.
30. Really taste the food you eat; chew slowly and mindfully.
31. Put clean sheets on the bed.
32. Blow bubbles.
33. Develop an inner smile.

Skills & Strategies for Teaching Self-Care Strategies

Individuals are encouraged to build on the positive things they are already doing to create healthier lifestyles and strengthen resources, capacities, and balance. When a particular strategy becomes a regular part of their day or week, they have a ready resource for difficult and distressing situations. The practitioner helps the individual build on current strengths and passions, and focus on small steps to sustain momentum.

Self-Care Strategies

1. **Eat regular, healthy, and balanced meals** including breakfast and a variety of fruits and vegetables. Minimize or eliminate refined sugars, carbohydrates, and caffeine.
2. **Get adequate sleep.** Getting enough sleep is as important as nutritious food or water. (http://www.health.harvard.edu/newsletters/Harvard_Mental_Health_Letter/2009/July/Sleep-and-mental-health.) When developing regular sleep habits, consider including the following guidelines: don't nap during the day; get exercise every day; reduce evening activities that disturb your sleep (caffeine, alcohol, watching TV); develop a bedtime routine (calming drink, face washing, teeth brushing); go to bed at the same time every night (before 11pm) and wake up at the same time every morning; if not asleep within 30 minutes, get up and do something rather than lying there tossing and turning (repeat as necessary).
3. **Meditation/mindfulness** strengthens your capacity to stay centred and watch sensations, thoughts, images, and emotions come and go. With no judgment, you can practice bringing your attention again and again to the space between your thoughts; the blue sky behind the clouds; the watcher who is watching the thoughts; the horizon. The benefits of meditation (a sense of calm, peace, and balance) can help carry you more calmly through your day. The emotional benefits of meditation include a new perspective on stressful situations; skills to manage stress; increased self-awareness; and attention and focus in the present moment. Types of meditation include guided visualization, mantra meditation, mindfulness meditation, Qi gong, Tai chi and Yoga (<http://www.mayoclinic.com/health/meditation/HQ01070>).
4. **Yoga** has benefits that are far-reaching: reduced stress; sound sleep; reduced cortisol levels; allergy/asthma symptom relief; lower blood pressure; lower heart rate; spiritual growth and sense of well-being; reduced anxiety and muscle tension; increased strength and flexibility; slowed aging process (<http://www.mayoclinic.com/health/yoga/CM00004>). Before retiring at night, rest in the Child's Pose. With your head touching the ground, intentionally release any impressions you have absorbed through the day that are no longer helpful.
5. **Rhythmic physical activities and movements to support self-regulation and grounding.** Music, movement, singing, and use of rhythm have been noted to help with dysregulation of internal physiological rhythms [85]. In addition, regular, safe aerobic movement increases the 'feel-good' natural endorphins and helps the blood nurture and refresh every organ and fiber of your being.

6. **Worry once.** There are a number strategies to help manage worrying:
 - Ask “is this a problem that I can solve now or not?” If it is a problem that can be solved, you can engage in concrete problem-solving strategies. If it is not solvable (e.g., what if there’s an earthquake?) then encourage riding the wave of emotions and tolerating the uncertainty.
 - Know the difference between planning and worrying. Scale your confidence levels after completing a well-thought out plan. This will support success and prevent the constant revisiting of worry.
 - Carry a worry notebook with you. Notice everything you worry about and every time you worry. Write it down in your worry book.
 - Give yourself a daily worry time. Pull out your notebook and “fly at it.” The rest of the day, when worry surfaces, write it down and promise yourself that you will worry, but only in the designated worry time.
 - Instead of worrying ‘on demand,’ do something that takes your undivided attention where unwanted thoughts can’t ‘drive the bus’: work on a puzzle, play an instrument, dance.
7. **Consult a spiritual advisor.** Many people have cultural and religious beliefs that include traditional methods of healing and spiritual connection. Check to see whether people identify with such beliefs and whether they are aware of how they can access this type of support.

Practice Traps—Skill Building and Self-Care Strategies

Some of the possible practice traps to be aware of when supporting skill development include:

- Jeopardizing collaboration and safety by becoming the expert and telling those you are supporting what they need to do next.
- Not tailoring the approach; telling the individual what skill is needed without first asking what they are already doing, what they are interested in trying.
- Overloading and identifying too many skills or tools to practice and overwhelming the individual.
- Being too general or not providing enough direction. Containing overwhelming and distressing emotions requires regular practice and purposefulness. This requires planning and SMART goals: specific, measurable, achievable, realistic and timely goals.

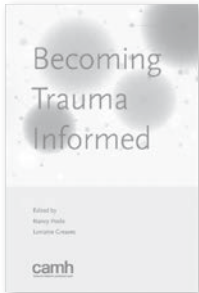
Appendix 6b – Self-Care Strategies

- Listen to how you ‘speak’ to yourself. Practise words of self-respect and recognition.
- Foster a balanced, healthy diet, and regular sleep cycle.
- Mobilize a support system. Reach out and connect with others.
- Move/exercise/sweat regularly to increase your natural endorphins and strengthen your heart, lungs, and whole body. Walk, dance, swim, jog, cycle, hike.
- Regularly do a slow body scan, from head to foot, bringing awareness to your body. Breathe slowly, and give yourself a number from 0-10, assessing your overall level of comfort and ease (10 is high comfort) in this moment. Breathe into areas where the breath does not reach; into areas of pain or tension.
- Develop an awareness/relaxation practice that resonates with you, e.g., meditation, yoga, stretching, guided imagery.
- Nurture a mutual relationship with at least one person, where you each feel heard, understood, and accepted.
- In safe relationships, develop shared agreements to resolve conflict early and practice ‘fair fighting’.
- Listen more.
- Create space and time for yourself and intimate relationships: unplug from cell phones, social media, TV.
- Laugh more. Do something regularly that you love to do.
- Have annual medical and dental check-ups.
- Find and/or create beauty in your life. Enjoy music and art.
- Practise safe sex.
- Commit to something personally meaningful and important every day.
- Hug often those you love, pets included.
- Take your core-values inventory, using a value card sort (www.guilford.com/etc/miller11/pers_val.pdf). Do it again when life circumstances change.
- Drive substance-free.

APPENDIX 7

Trauma-Informed Practice Related Resources

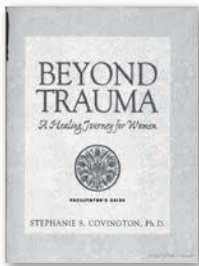
The following includes a selection of treatment related resources and curricula. Some are focused solely on trauma-informed practices and others incorporate elements of both trauma-informed and trauma-specific approaches.



Becoming Trauma-Informed

Published by the Centre for Addiction and Mental Health in Ontario, this book offers examples of the ways in which practitioners have applied principles of trauma-informed practice in their work with diverse populations and in diverse settings within the MHSU field.

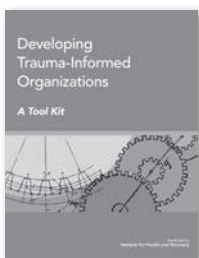
http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/Documents/becoming_trauma_informed.pdf



Beyond Trauma: A Healing Journey for Women

Created by Dr. Stephanie Covington, this trauma treatment manual makes the connection between women's experiences of trauma and their substance use. It can be used in a variety of settings, including residential and outpatient treatment settings, mental health programs, and criminal justice settings.

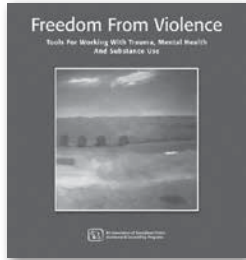
www.stephaniecovington.com/b_beyond.php



Developing Trauma Informed Organizations: A Tool Kit

The Tool Kit is designed to help organizations improve the quality of services offered by integrating an understanding of the impact of trauma and violence into the organization's policies, procedures, and interactions with those being served. It includes the principles for trauma-informed treatment, a self-assessment for provider organizations, an organizational assessment and instructions for using the assessments to provide trauma-informed, integrated care.

http://www.healthrecovery.org/services_and_products/products/detailTrue.asp?ProductID=30



Freedom from Violence: Tools for working with Trauma, Mental Health and Substance Use

Developed by the Ending Violence Association of BC, this comprehensive toolkit offers specific, practical trauma-informed strategies for working with women who have substance use and mental health concerns. Strategies for discussing substance use, mental health concerns and for safety planning are included.

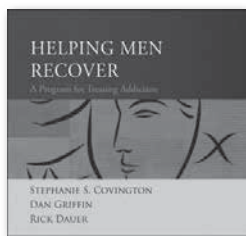
www.endingviolence.org/node/459



Handbook on Sensitive Practice for Health Care Practitioner: Lessons from Adult Survivors of Childhood Sexual Abuse

Published by the Public Health Agency of Canada, the handbook presents information designed to help health care practitioners practice in a way that is sensitive to the needs of adult survivors of childhood sexual abuse and other types of interpersonal violence.

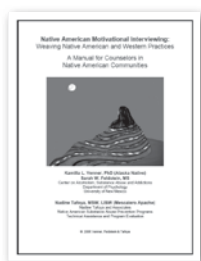
www.phac-aspc.gc.ca/nfcv-cnivf/pdfs/nfntsx-handbook_e.pdf



Helping Men Recover: A Program for Treating Addiction

This resource, developed by Dr. Stephanie Covington, describes a trauma-informed treatment program for men, making the links between substance use and trauma. There is also a version for women.

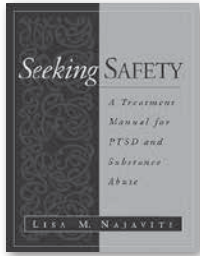
www.stephaniecovington.com/b_helping_men.php



Native American Motivational Interviewing: Weaving Native American and Western Practices

This practice manual, developed by Kamilla Venner and colleagues in New Mexico, is a cultural adaptation of a motivational interviewing approach. Although the connection with trauma is not explicit, practitioners will notice how the overall approach aligns with trauma-informed practices.

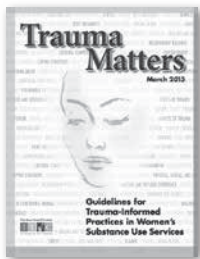
<http://casaa.unm.edu/mimanuals.html>



Seeking Safety

Created by Lisa Najavits, Seeking Safety is a widely used curriculum for Stage I trauma support. There are 25 topics that can be presented individually and in any order. The focus is on creating safety and recognizing the connection between substance use and trauma. It has been used in a variety of settings and with both men and women, as well as with youth.

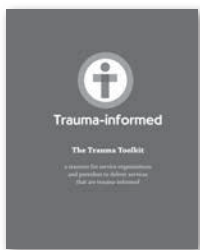
<http://www.seekingsafety.org/>



Trauma Matters

Guidelines developed by the Jean Tweed Centre, in consultation with service providers, experts, and women with lived experience from across Ontario, to support organizations that provide substance use treatment services for women. Designed to aid in understanding the interconnections of trauma and substance use, and provide better care for substance-involved women who have experienced trauma.

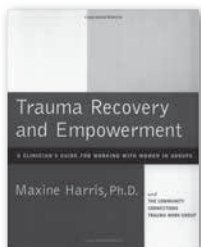
<http://traumaandsubstanceabuse.files.wordpress.com/2013/03/trauma-matters-final.pdf>



The Trauma Toolkit (1st and 2nd Edition)

Developed by Klinik Community Health Centre in Winnipeg, MB, this resource offers general guidelines for trauma-informed practice to assist service providers and agencies to increase their capacity in delivering trauma-informed services. The 2nd Edition is in press

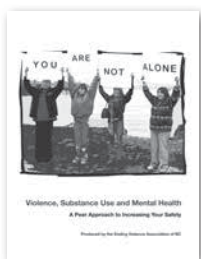
www.trauma-informed.ca/



Trauma Recovery and Empowerment Model (TREM)

Offered by Community Connections in Washington DC, the TREM curriculum consists of 29 sessions focusing on empowerment, education about trauma, and building coping skills. There are versions for working with women, men, and youth.

www.communityconnectionsdc.org/web/page/657/interior.html



You are not alone: Violence, Substance Use and Mental Health— A peer approach to increasing your safety

Created by the Ending Violence Association of BC, this resource is for peer helpers and service providers to assist in discussions about relationship violence and sexual assault among women who may also have MHSU issues.

www.endingviolence.org/files/uploads/PAVEWorkbook.pdf

Web Resources

Canada

Aboriginal Healing Foundation

An organization dedicated to encouraging and supporting, community-based Aboriginal directed healing initiatives which address the legacy of physical and sexual abuse suffered in Canada's Indian Residential School System, including inter-generational impacts.

<http://www.ahf.ca/>

British Columbia Centre of Excellence for Women's Health (BCCEWH)

The BCCEWH offers a range of information and resources on women's health issues, including substance use, mental health, and trauma-informed approaches through the Coalescing on Women and Substance Use website

www.coalescing-vc.org

Building Bridges

A cross-sectoral initiative to support women experiencing violence, MHSU issues, led by the Woman Abuse Response Program at BC Women's Hospital and Health Centre Vancouver, BC.

www.bcwomens.ca/Services/HealthServices/WomanAbuseResponse/Building+Bridges.htm

CAST Canada

CAST Canada helps professionals and corporations better understand the role of trauma and unresolved grief in addictions, homelessness, chronic unemployment, and other concerns through workshops, trainings and keynote speaking throughout Ontario and across Canada.

www.cast-canada.ca/

Centre for Addictions and Mental Health (CAMH)

This knowledge exchange section on the CAMH website offers information for MHSU specialists. There are numerous links to trauma-related issues, as well as culturally sensitive approaches.

knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/first_stage_trauma/Pages/default.aspx

Homeless Hub of Canada

A site with extensive links to articles and resources related to connections between trauma, substance use, mental health and homelessness.

www.homelesshub.ca/

Info-Trauma

A website with information for practitioners, as well as those who have experienced various forms trauma. There are a range of case studies including a motor vehicle accident, workplace injury, and terrorism, as well as other learning resources.

www.info-trauma.org/

Kelty Mental Health Resource Centre

A child and youth focused resource for practitioners, parents, and caregivers and school-based professionals on MHSU related topics, including links to trauma specific information.

www.keltymentalhealth.ca

kidsLINK

kidsLINK provides a broad range of programs and services to help children, youth, and their families facing or at risk of social, emotional, and mental health challenges. kidsLINK also provides consultation and training for professionals who work with children and youth. Consistent with its commitment to help children and youth achieve their potential, kidsLINK specializes in enabling wellness, building resiliency, and reducing the impact of emotional trauma.

<http://kidslinkcares.com>

Ontario Women Abuse Screening Project

This website offers in-depth information, tools, and training guides to incorporate trauma-informed approaches into MHSU programs and transitional houses. Resources include violence/trauma screening assessments and a number of informational videos and presentations on the connections between violence/trauma, mental health, substance use, and housing.

<http://womanabusescreening.ca>

PHSA BC: Indigenous Cultural Competency Training Program

This website includes information about the Indigenous Cultural Competency (ICC) Online Training Program delivered by the Provincial Health Services Authority of British Columbia (PHSA BC). Information for registering for core training is provided and, once completed, there is access to supplementary training, resources, and on-going support.

<http://www.culturalcompetency.ca>

United States**Community Connections**

A treatment and training agency focusing on trauma-informed and trauma-specific approaches for working with those seeking MHSU services.

www.communityconnectionsdc.org/

National Centre on Family Homelessness

This site offers a number of articles and toolkits to help organizations become trauma-informed.

www.familyhomelessness.org/

SAMHSA's National Center for Trauma-Informed Care

A comprehensive website that provides information on trauma-informed practices and implementation.

www.samhsa.gov/nctic/

Seeking Safety

Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. The treatment is available as a book, providing both client handouts and guidance for clinicians.

<http://www.seekingsafety.org>

National Council Magazine (2011, Issue 2)

This issue, titled *Breaking the Silence: Trauma-Informed Behavioural Healthcare*, provides a number of perspectives on trauma-informed care with diverse populations including veterans and children.

www.gmhcn.org/files/NC_Mag_Trauma_Web-Email.pdf

National Centre for Child Traumatic Stress

A resource for policy, practice, research, and training related to child trauma.

www.nctsn.org/

Stephanie Covington, PhD, LCSW

A leader in gender-responsive and trauma-informed work, Dr. Covington's website includes numerous publications, treatment guides, curricula, and training opportunities. Her training modules include *Helping Women Recover*, *Beyond Trauma*, *Voices*, and *A Woman's Way through The Twelve Steps*.

www.stephaniecovington.com/

Australia

Adults Surviving Child Abuse

ASCA's *PRACTICE GUIDELINES FOR TREATMENT OF COMPLEX TRAUMA AND TRAUMA INFORMED CARE AND SERVICE DELIVERY* focus on trauma-specific approaches to recovery for people with unresolved "complex trauma" - child abuse in all its forms, neglect, family and community violence and other adverse childhood events – and they also include discussion of trauma-informed practice.

www.asca.org.au

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