Trauma informed practice

Nancy Poole, British Columbia Centre of Excellence for Women’s Health
Agenda

Choose what works for you

Learning together

1. Foundations
2. Understanding trauma
3. Applying principles of TIP
4. Examples of TIP in action
5. Attending to gender and culture
6. TIP at the organisational level
   - Supporting workers, preventing and reducing secondary trauma
System change work with a number of Canadian provinces and territories towards trauma informed practice, and the work of contributors to a book entitled *Becoming Trauma Informed*.
Intervention is not a specialist problem but a broad social responsibility that should be shared by many public and private sectors.

Carroll & Miller, 2006

*Rethinking substance abuse: what the science shows, and what we should do about it.*
1. FOUNDATIONS
Adverse Childhood Experiences Study (ACE’s)

- prevalence of adverse childhood experiences
- linkages with physical/mental health & substance use

Mechanisms by which Adverse Childhood Experiences influence Health and Well-being throughout the lifespan

Felitti & Anda, 2010
From women’s health advocates and those working on social determinants of health

- Poverty
- Disability
- Experience of Grief and Loss
- Racial Discrimination
- Substance Use Problems
- Mental Ill Health
- Gender based Violence
- Resilience
- Punishment/Incarceration
- Isolation
- Colonization
- HIV/AIDS
- Social support, Partnership, Friendship
- Mothering policy
- Access to health care
- Trauma
From indigenous scholars

• Recognition of trauma caused by colonization & racism
  – Historical trauma (Indian Residential Schools, Indian Hospitals, 60’s scoop)
  – Intergenerational trauma
  – Efforts to redress trauma related to residential schools

(Maria Yellow Horse Brave Heart, Michael Yellow Bird, Renee Linklater. Karina Walters)
From neurobiology

Neurobiological explanations and interventions
Influencing social conditions creating need for TIP

Interagency and inter-sectoral collaboration

Important to inform trauma focus on practice and policy at all levels these levels

Interactions with our clients

Service cultures

Important to know what we apply from these disciplines
Questions?

We are creating a welcoming and compassionate environment for all our patients.
2. UNDERSTANDING TRAUMA
Definitions of trauma

- Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional or spiritual wellbeing.

- It generally overwhelms an individual’s or community’s resources to cope, and it often ignites the “fight, flight or freeze” reaction at the time of the event (s). It frequently produces a sense of fear, vulnerability or helplessness.

SAMHSA, 2014
Interpersonal trauma will be defined as experiences involving disruption in trusted relationships as the result of violence, abuse, war or other forms of political oppression, or forced uprooting and dislocation from one’s family, community, heritage, and/or culture.

(Bierman, Mason et al., 2010)
A range of trauma examples

- Caused naturally – wildfire, flood, tornado, tree falling
- Caused by people through accidents and technological catastrophes – train derailment, oil spill
- Caused by people via intentional acts - sexual assault, warfare, domestic violence, mob violence, home invasion, bank robbery, school shooting, terrorism, genocide . . . .
- Can be individual, group, community or mass trauma
- Can be interpersonal, developmental, political, or system-oriented (retraumatization)

SAMHSA 2014
The terms violence, trauma, abuse, and post traumatic stress disorder (PTSD) often are used interchangeably. One way to clarify these terms is to think of trauma as a response to violence or some other overwhelmingly negative experience (e.g., abuse).

Trauma is both an event and a particular response to an event.

PTSD is one type of disorder that results from trauma.

(Covington, 2003)
## Trauma Effects

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

Haskell, 2003; Haskell, 2001; Schachter et al., 2009
Trauma effects can also be organized by the PTSD symptom clusters as identified in the DSM V

- **Intrusion/re-experiencing** e.g. memories, nightmares, flashbacks, intense emotional or psychological response to reminders of event

- **Avoidance** e.g. people, conversations, situations, places, objects and feelings, thoughts and bodily sensations

- **Arousal/reactivity** e.g. irritability, hyper vigilance (always on guard), difficulties with concentration and sleep

- **Negative mood/cognitions**, which may include, feeling detached, inability to experience emotions (numbing) and depressive symptoms, for instance, loss of hope, interest, persistent guilt, anger and/or fear
There are predictable response patterns in the brain resulting from extreme threat.

Two important examples of this are:
- fight/flight (defense) – on the hyperarousal continuum
- freeze/surrender – on the dissociative continuum

Predominant style of the individual in acute trauma will determine specific effects
- hyperarousal or dissociative

(Perry et. al., 2006)
Hyperarousal

Sympathetic Arousal: high activation

Hyperarousal

Overload: frozen, emotionally reactive, racing thoughts, impulsive, aggressive

Hypoarousal

Parasympathetic Arousal: low activation

Hypoarousal

Numb, lethargic, collapsed, cognitively slowed, psychomotor retardation

Window of Tolerance

Optimal Arousal Zone

(Siegel, 1999; Perry; Ogden, 2007)

Retrieved from:
http://www.traumacenter.org/announcements/TConf.09_SMART_Handouts.pdf
When abuse/neglect take place:
- Dsysregulation occurs with no repair/recovery
- Must dedicate all of their regulatory resources to reorganizing dysregulation
- Increased levels of stress hormones
- Initially – alarm response, hyperarousal
- Chronic stress can result in profound dissociation/detachment - hypoarousal

(Tronick & Weinberge, 1997; Schore, 2001; Perry et al, 1995)
## 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
Implications for service access

- Trauma affects service access and engagement:
  - Difficulty with trust and relationships
  - Reluctance to engage, and quick to drop out
  - Vigilance and suspicion
  - Previous traumatic experience caused by health care system/providers
  - Ambivalence to give up or change coping mechanisms

- In the moment trauma responses . . .

Harris & Fallot, 2001
“In many cases, people who endured childhood abuse and neglect develop what might seem like a bewildering array of problems throughout their lives.

Many service providers, and in many cases the survivors themselves, can misunderstand these difficulties as self-inflicted because they do not understand how abuse, trauma and their effects reverberate throughout a person’s life.” (Haskell, 2012)
What do trauma-informed services look like?

The Four 'R's (SAMSHA, 2014)

“A program, organization or system that is trauma informed:

1. **REALIZES** the widespread impact of trauma and understands potential paths for recovery;
2. **RECOGNIZES** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. **RESPONDS** by fully integrating knowledge about trauma into policies and procedures, and practices;
4. **Seeks to actively** **RESIST RETRAUMATIZATION.”**
Questions?

Grounding Activities

Effects of Trauma

sleep problems chronic pain
chest pain asthma heart palpitations nausea
BOD
breathing pelvic problems pain tension headaches digestive problems chronic fatigue

nightmares dissociation anger flashbacks avoiding certain places hypervigilance people, situations overwhelmed feeling out of control with family and friends nervous mood swings suicidal thoughts anxiety lots of time
3. Principles
Trauma Informed principles

Key Principles (SAMSHA, 2014)

1. Safety
2. Trustworthiness and Transparency
3. Collaboration and Mutuality
4. Empowerment, Voice and Choice

Grounded in Peer Support and addressing Cultural, Historical, and Gender Issues
All services taking a trauma-informed approach begin with building awareness among staff and clients of:

- The high prevalence of trauma
- How the impact of trauma can be central to one’s development
- The wide range of adaptations people make to cope and survive
- 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.
Trauma Survivors:

- Likely have experienced boundary violations and abuse of power
- Need to feel physical and emotionally safe
- May currently be in unsafe relationships

Safety and trustworthiness are established through:

- Welcoming intake procedures
- Adapting the physical space
- Providing clear information and predictable expectations about programming
- Ensuring informed consent
- Creating safety plans
Service Providers:

- The safety and mental health needs of service providers are also considered within a trauma-informed service approach.

Key component of Service Provider safety:

- Education and support related to vicarious trauma.
Trauma-informed services create safe environments that foster a client’s sense of efficacy, self-determination, dignity, and personal control.

Service providers are encouraged to:
- Communicate openly
- Equalize power imbalances
- Allow the expression of feelings without fear of judgment
- Provide choices as to treatment and support preferences
- Work collaboratively
Service providers:

- Help clients identify their strengths
- Further/develop resiliency and coping skills
- Teach and model skills for recognizing triggers, calming, centering and staying present
- Support an organizational culture of ‘emotional intelligence’ and ‘social learning’
- Maintain competency-based skills, knowledge, and values that are trauma informed
Strengths and Opportunities:

Port of Entry – TIP provides a safe space with which to hold challenging conversations about colonization, oppression, intergenerational trauma, racism, etc.

• Informs general services about Indigenous-specific history in Canada.

• Potential to broaden perspectives and strengthen relationships.

TIP provides a common language and is driven by principles that are aligned with Indigenous values and beliefs – gaining huge momentum in Aboriginal communities.

Source: Kat Hinter – Aboriginal Knowledge Exchange Lead, IH BC
Applying principles: Trauma awareness

- Acknowledge common connections between substance use and trauma
- Recognize range of responses people can have
- Recognize that because of trauma responses, developing trusting relationships can be difficult
- **Disclosure of trauma is not required**
- Recognize when someone is triggered or experiencing the effects of trauma & support

Gender Matters, 2013
TIP can be seen how we view clients who experience difficulty accessing services

Shift from: “What is wrong with her” to “What happened to her”

Change in language away from:
- Controlling
- Manipulative
- Uncooperative
- Untreatable
- Masochistic
- Attention seeking
- Drug seeking
- Bad mother
- Not believable, etc.

(Williams & Paul, 2008)
<table>
<thead>
<tr>
<th>From...</th>
<th>To...</th>
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</thead>
<tbody>
<tr>
<td>Controlling</td>
<td>The individual seems to be trying to assert their power</td>
</tr>
<tr>
<td>Manipulative</td>
<td>The individual has difficulty asking for what they want</td>
</tr>
<tr>
<td>Attention seeking</td>
<td>The individual is trying to connect the best they can</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Adaptations</td>
</tr>
<tr>
<td>Borderline</td>
<td>The individual is doing their best given their early experiences</td>
</tr>
<tr>
<td>Malingering</td>
<td>The individual is seeking help in a way that feels safer</td>
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</tbody>
</table>
“Trauma is the emotional response when an injury overwhelms us. The injury could be physical, sexual, or emotional.”

(Centre for Addiction and Mental Health, 2000)
Trauma informed intake practices - TIP can be seen in flexible intake and assessment processes that:

- Create safety (including cultural safety)
- Engage – establish a relationship
- Do not “press for compliance.”
- Screen for present concerns
- Normalize client experience(s)
- Set boundaries
- Identify symptoms

2011 focus groups of BC addictions and mental providers
TIP in early interactions

All staff collaborate with clients to:

- Provide clear, practical information at initial contacts about what to expect, choices for being contacted and rationale for processes
- Provide opportunities for questions
- Respond to people who arrive in distress

- Trauma-informed Organizational Assessment for programs serving families experiencing homelessness, 2003
- Creating Cultures of Trauma-informed Care, 2009
- Trauma Matters, 2013 (Jean Tweed Centre)
- The Trauma Toolkit 2nd Edition 2013 (Klinic)
Consider:

- Signage with welcoming messages, avoiding “do not” messages
- Waiting areas - comfortable and inviting
- Lighting in outside spaces
- Accessibility and safety of washrooms
- In counseling rooms – choice about whether door is open or closed

Fallot & Harris, 2009, & Ontario Guidelines, 2013
Illustration of applying the principles

- Identifying triggers
- Noticing precursors of distress
- Implement sensory integration and sensory modulation opportunities
- Promote thinking skills and choice making skills
- Ensure opportunity for relational development
- Wrap around

Questions?

We are offering children, youth and families opportunities to be involved in decisions about their care.

We appreciate the strengths of the people we work with everyday.
4. Examples of TIP in various settings
Involve clients

Trauma survivors cannot learn the essential ability of defending their own boundaries if people who are supposed to care for them, trample them. Client rights are about being treated as full citizens in the mental health and addictions treatment systems. Creating an environment in which these rights flourish is the first step to making a space where real healing can happen.

TIP in primary care settings

This handbook presents information that will help health care practitioners practise in a manner that is sensitive to the needs of adult survivors of childhood sexual abuse and other types of interpersonal violence.

It is intended for health care practitioners and students of all health disciplines who have no specialized training in mental health, psychiatry, or psychotherapy and have limited experience working with adult survivors of childhood sexual abuse.

Trauma-informed programming was implemented in Boston metropolitan homeless shelters. Evaluation results indicated positive outcomes: *high levels of support for the organizational shift to trauma-informed programming, increased staff confidence, fewer resident conflicts, better relationships among staff and residents, and fewer resident terminations*.

A trauma-informed child welfare system is one in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, families, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skills into their organizational cultures, policies, and practices.

**Essential Elements of a Trauma-Informed Child Welfare System Addressed**

- Maximize Physical and Psychological Safety for Children and Families
- Identify Trauma-Related Needs of Children and Families
- Enhance Child Well-Being and Resilience
- Enhance Family Well-Being and Resilience
- Enhance the Well-Being and Resilience of Those Working in the System
- Partner with Youth and Families
- Partner with Agencies and Systems that Interact with Children and Families
Families living in urban poverty – Trauma Adapted Family Connections (TA-FC)

Phase 1
- Engagement
- Assessment
- Helping families meet their basic needs
- Safety
- Planning

Phase 2
- Family psycho-education
- Emotional regulation
- Strengthening family relationships

Phase 3
- Family shared meaning of trauma
- Closure and endings

TIP in interventions on specific substances
Trauma informed tobacco interventions

Provides questions that guide the practitioner to:
1. emphasize safety
2. build trustworthiness
3. maximize choice and control
4. collaborate
5. empower
Oregon hospital committed to a cultural shift of healing and flexibility
- Daily community meetings held for problem solving
- Labels designating people by type of disorder are avoided
- Admissions occur in a comfortable room with family members present, instead of entering a locked unit via an “ante” room escorted by security.
- Clients are full participants in planning and decision making for their own treatment.
- Staff attend regular training to hone therapeutic and coping skills.

Use of seclusion and restraint reduced by 87%

TIP in community setting – using Seeking Safety group model

- Outpatient group run by trauma counsellor and addiction counsellor – based on community collaboration to provide integrated services with the Island Health Authority (VIHA)

- Adapted Seeking Safety model:
  1. **Seeking Information** sessions (3): focus on coping strategies
  2. **Seeking Understanding** (12 weeks): in-depth examination of topics related to trauma and substance use

www.seekingsafety.org

Peer Driven Program Development – Women’s Advisory Committee

Drum Group and opportunities for healing related to the drum

Low Threshold Intake process

Valuing of Experiential Wisdom

Oriented towards kindness

TIP tools – Motivational Interviewing, building space with TIP in mind, gardening, food as medicine, yoga and mindfulness activities.

Dedication to participant engagement and consent to share information.

System navigation and interdisciplinary collaboration
5. GENDER AND CULTURE
Trauma informed, gender responsive work with men

- **Safety and trustworthiness** - Empathize with the ‘disconnection dilemma’, i.e. the conflict between their identity as men and their experience of powerlessness.
- **Skill building** - A key trauma recovery skill for men is developing a broader range of options for expressing emotions.
- **Collaboration and connection** – Men who have been sensitized to abuse of power in relationships may need to hear offers of collaboration repeatedly.
- **Strengths based** – acknowledgement of relational strengths may be ‘water in the desert’ for male survivors.

Fallot, R., & Bebout, R. (2012). Acknowledging and Embracing "the Boy inside the Man": Trauma-informed Work with Men. In N. Poole & L. Greaves (Eds.), Becoming Trauma Informed (pp. 165-174). Toronto, ON: Centre for Addiction and Mental Health
1. Recognize the Impact of Trauma on Development and Coping Strategies  
2. Identify Recovery from Trauma as a Primary Goal  
3. Employ an Empowerment Model  
4. Maximize Choices and Control Over Recovery  
5. Base Services in a Relational Collaboration  
6. Create an Atmosphere Respectful of the Need for Safety, Respect, and Acceptance  
8. Minimize the Possibility of Retraumatization  
9. Understand each Client in the Context of Experiences and Culture  
10. Solicit Consumer Input and Involvement in Designing and Evaluating Services


Roca’s core strategies include outreach and street work, transformational relationships, peacemaking circles, and engaged institutions.

Four key principles shape the trauma-informed work at the Jean Tweed Centre:

1. Avoiding re-traumatisation
2. Empowering women
3. Working collaboratively with flexibility
4. 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.
Collaborative research project (2005) led by Dr. Colleen Dell, between the National Native Addictions Partnership Foundation, the Canadian Centre on Substance Abuse and the University of Saskatchewan.

Empathy
• Relay empathy for the struggles that women face due to their problematic substance use (for example, loss of custody of their children).

Acceptance /
Having a non-
judgmental
attitude
• Be accepting and non-judgemental about women’s past behaviours (for example, women’s involvement in prostitution for survival).

Inspiration
• Provide inspiration by acting as a role model (for example, when appropriate share parts of your own healing journey to show it is possible to gain further education as an adult and secure meaningful employment).

Recognition
• Recognize 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).

Communication
• Open lines of communication for two-way, non-hierarchical dialogue with the women.

Care
• Show care for the women and passion for your own role as a treatment provider.

Link to spirituality
• Support the link to spirituality in women’s healing through Aboriginal culture as well as any other traditions and teachings with which the women identify.

Momentum
• Promote momentum in the women’s healing journeys; that is, assist the women in moving toward the future after acknowledging the past (promoting accountability). For example, assist the women in developing healthier relationships and parenting skills. Fostering the women’s ties to their communities will help break generational cycles.

Participatory research project (Stilettos to Moccasins) led by Dr. Colleen Dell, See http://www.addictionresearchchair.ca/
Indigenous Culture as Intervention for healing from addictions

Download these resources from http://tinyurl.com/CultureAsIntervention
Questions?
6. TIP AT THE ORGANIZATIONAL LEVEL
Influencing social conditions creating need for trauma informed practice

Interagency and inter-sectoral collaboration

Our service culture

Our interactions with our clients

Trauma informed practice and policy is relevant at all these levels
Healthy organizations are emotionally well regulated

Organizational TIP is “an approach to a whole culture that increases the emotional IQ of everyone and the organization as a whole”

Blooms 7 qualities of TI Organizational culture
1. Culture of non-violence
2. Culture of emotional intelligence
3. Culture of inquiry and social learning
4. Culture of democracy
5. Culture of open communication
6. Culture of social responsibility
7. Culture of growth and change
Secondary Trauma

Secondary traumatic stress is the distress that results from hearing about the firsthand trauma experiences of others. Symptoms of STS in child welfare workers include:

• Cynicism, anger, or irritability
• Anxiety, fearfulness
• Emotional detachment or numbing
• Sadness, depression
• Intrusive imagery or thoughts about clients’ traumas
• Nightmares and sleep disturbance

• Social withdrawal
• Pessimistic worldview
• Diminished self-care
• Increased physical complaints and illness
• Use of alcohol/drugs to “forget about work

(Osofsky, Putnam, & Lederman, 2008)
<table>
<thead>
<tr>
<th>Job performance</th>
<th>Morale</th>
<th>Behavioural</th>
<th>Interpersonal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsession about detail</td>
<td>Loss of interest</td>
<td>Frequent job changes</td>
<td>Poor communication</td>
</tr>
<tr>
<td>Decreased productivity</td>
<td>Apathy</td>
<td>Overwork</td>
<td>Staff conflicts</td>
</tr>
<tr>
<td>Avoidance of certain task</td>
<td>Dissatisfaction</td>
<td>Tardiness</td>
<td>Withdrawal from others</td>
</tr>
<tr>
<td>Low motivation</td>
<td>Decreased confidence</td>
<td>Exhaustion</td>
<td>Impatience</td>
</tr>
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Richardson, 2001
Vicarious Traumatization
(Trauma Exposure Response)

“refers to the cumulative transformative effect on the helper working with the survivors of traumatic life events”

Saakvitne and Pearlman, 1996

The impact of vicarious trauma occurs on a continuum, influenced by factors such as:

- role
- amount of exposure to traumatic information
- degree of support in the workplace
- personal life support
- personal experiences of trauma

Protective Practices

- Empathic engagement
- Develop mindful awareness
- Embracing complexity
- Active optimism
- Professional satisfaction
- Countering isolation
- Holistic self-care
- Honoring limits
- Creating meaning

Harrison, R.L. and M.J. Westwood, 2009
Attend to mental and physical health through:

- Active & ongoing self-care strategies
- Engagement with colleagues
- Adequate time to “de-stress”
- Attention to personal needs

Courtois & Ford, 2013
ABC Model – promoting wellness

**A**wareness – attunement to one’s needs, limits, emotions and resources

**B**alance – balancing the multiple aspects of self & one’s activities

**C**onnection – to oneself, to others and to something larger

Saakvitne, K.W. and L. Pearlman, 1996
Addressing secondary trauma - Resilience Alliance Intervention

Who
- new and veteran staff at all levels of the organizational structure (child protective specialists, supervisors, managers and deputy directors).

What
- 3 core concepts – optimism, mastery and collaboration
- Teaches / helps staff apply emotion regulation and other resilience related skills

Outcome:
- increasing self-reported resilience and perceived coworker and supervisor support
- decreasing negative emotions and perceptions of themselves and their work.
Questions?

Accessible Information

We recognize the importance of communication.

We are making our programs and services safe and accessible for everyone.
TRAUMA INFORMED PRACTICE: A SYSTEM-WIDE QUALITY IMPROVEMENT STRATEGY
For system leaders

- Build a system-wide learning culture about trauma: provide forums for training and learning
- Identify staff who can serve as trauma champions to promote change on the local and regional levels
- Link with leaders in other systems to collectively:
  - provide opportunities for learning about trauma
  - share trauma-informed resources across systems
  - adapt practice and policy, and
  - create a trustworthy service network of support and treatment
Becoming trauma informed requires a range of adjustments in practice and system designs, supported by research, innovative change and inspired leadership. This is a tall order, and requires complex thinking.

Becoming trauma informed benefits from collaboration and cooperation between all levels of service delivery.

Becoming trauma informed is an ongoing process of system change and quality improvement, requiring constant adaptations and ongoing monitoring.

Poole, N., & Greaves, L. (Eds.). (2012). Becoming Trauma Informed. Toronto, ON: Centre for Addiction and Mental Health
There are many reasons to be hopeful

- Strong interest by practitioners - e.g. online web workspace, and CoPs
- Great contributions by survivors – e.g. Grounding Trauma conferences
- Interest at the level of systems improvement – for example in mental health and substance use plans, in collaborations between substance use and child welfare systems
Nancy Poole
www.bccewh.bc.ca
www.coalescing-vc.org
Blog: fasdprevention.wordpress.com